Approved: March 19, 2001
Date

MINUTES OF THE HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES.

The meeting was called to order by Chairperson Garry Boston at 1:30 p.m. on March 12, 2001 in Room 210 Memorial Hall

All members were present except: Representative Geraldine Flaharty, Excused
Representative Lana Gordon, Excused

Committee staff present: Dr. Bill Wolff, Kansas Legislative Research Department
Renae Jefferies, Revisor of Statute's Office
June Evans, Secretary

Conferees appearing before the committee: Phyllis Gilmore, Executive Director, Behavioral Sciences Regulatory Board
Michael Moser, M.D., M.P.H., KDHE

Others attending: See Attached Sheet

The Chairperson stated the minutes of March 5, 7 and 8 would be approved at the end of the meeting.

The Chairperson opened the hearing on **SB 186 - Behavioral Sciences Regulatory Board Investigations Procedures and Subpoena Power.**

Dr. Bill Wolff gave a briefing on **SB 186.**

Phyllis Gilmore, Executive Director, Behavioral Sciences Regulatory Board, testified as a proponent, stated that **SB 186** was the result of discussion during the interim meetings of the Health Care Reform Oversight Committee. **SB 186** amends current law to grant subpoena power in connection with investigations to the Behavioral Sciences Regulatory Board, subject to the scrutiny of the district court. It also allows for confidentiality of information obtained during investigations. The language of this bill was taken from the Board of Healing Arts Act.

Under current law the BSRB can only ask for information. If a respondent chooses not to cooperate, there is no recourse. This ties the board's hands and offers little public protection (Attachment 1).

The Chairperson closed the hearing on **SB 186**.

The Chairperson opened the hearing on **SB 64 - HIV and AIDS Reporting.**

Dr. Bill Wolff gave a briefing on **SB 64**.

Michael Moser, M.D.,M.P.H., KDHE, testified in support of **SB 64**, stating it is primarily concerned with maintenance of the requirement that reports of HIV infection made to KDHE contain the name of the person with this infection. This occurred after years of discussion involving KDHE, community-based organizations, HIV infected individuals, and health care providers. There are some concerns and uncertainty concerning the impact of a name reporting requirement on HIV testing usage. A requirement was attached to the authorizing legislation requiring the Secretary of Health and Environment to make a report about the testing program to the Legislature by January 8, 2001 associated with this requirement was another provision repealing the requirement for reporting of HIV and AIDS cases on July 1, 2001 in the absence of legislative action to re-authorize them. **SB 64** was introduced to remove the sunset provision and makes reporting of names with reports of HIV and AIDS an established feature of public health practice in Kansas.

The report submitted was based on the first 12 months of named reporting for HIV, covering the period July 1, 1999 to June 30, 2000.

Without repeal of the sunset provision in the current law, HIV and AIDS would no longer be reportable conditions in our state. This would prevent KDHE from conducting critical epidemiologic activities, such as confidential partner counseling and referral services (Attachments 2, 3 and 4).

The Chairperson closed the hearing on **SB 64** and stated the committee would work bills that had hearings earlier and the committee would work **SB 50** on Tuesday, March 13. Two committee members were missing and one has indicated she would like to be present when action is taken on **SB 50.**

The Chairperson stated the committee would be working **HB 2229**, and although we don't normally work the bill the same day we have hearings, we are getting at the point in the session where if there are no strong objections, we could work **SBs 64 and 186**, but if anyone on the committee would rather not work those two bills we will not do so.

The Chairperson asked what the committee's pleasure was on **SB 64.**

Representative Long moved and Representative Lightner seconded to move **SB 64** out favorably. The motion carried.

The Chairperson asked what the committee's pleasure was on **SB 186.**

Representative Long moved and Representative Lightner seconded to move **SB 186** out favorably. The motion carried.

The Chairperson asked the committee what their wishes were on **SB 212.**

Representative Lightner moved and Representative Storm seconded to move **SB 212** out favorably and place on the Consent Calendar. The motion carried.

The Chairperson said hearings were held earlier on **HB 2229 - Kansas senior caregiving initiative**. A balloon stripping the 85% rule was distributed (Attachment 5).

Representative Palmer asked if there was a fiscal note?

The Chairperson stated as the bill was originally written there was a fiscal note but the balloon struck the 85% rule and made it within the limitations of appropriations so therefore there would be no fiscal note.

Representative Palmer stated she would like to look at the information that was distributed earlier before making a determination.

The Chairperson stated action would be taken on **HB 2229** on Tuesday, March 13 or we would not take any action.

Representative Long moved and Representative Swenson seconded approval of the minutes of March 5, 7 and 8. The motion carried.

The meeting adjourned at 2:15 p.m. The next meeting will be March 14.

HEALTH AND HUMAN SERVICES

DATE March 12, 2001

NAME	REPRESENTING
Nancy Pierce	KHCA
Karl Milhon	KDHE
Kevin Barone	Hein/Weir Chtd
[illegible]	Federico Consulting
[illegible]	KDHE
[illegible]	KDHA
David [illegible]	KBEMS
Dave Halferty	KDOA
Debra Zehr	KAHSA
Kevin Robertson	KDA
R.S. McKenna	SRS
[illegible]	Ks. Public Health Assn.
[illegible]	KANP
Tom Bell	KHA
Mike Huttles	Beverly Enterprises
Philip Hurley	Pat Hurley & Co. / KAFD
John Federico	KDA
Bill [illegible]	KS Gov't Consulting

State of Kansas
Behavioral Sciences Regulatory Board

BILL GRAVES
Governor

PHYLLIS GILMORE
Executive Director

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HOUSE TESTIMONY
HEALTH AND HUMAN SERVICES
MARCH 12, 2001

SB 186

Mister Chairman and Committee Members:

Thank you for the opportunity to testify today in support of SB 186. I am Phyllis Gilmore the Executive Director of the Behavioral Sciences Regulatory Board (BSRB).

The BSRB is the licensing board for most of the state's mental health professionals, the doctoral level psychologists, the master level psychologists, the clinical psychotherapists, the bachelor, master and clinical level social workers, the master and clinical level professional counselors, and the master and clinical level marriage and family therapists. Additionally, some of the drug and alcohol counselors are registered with the board, although most of them are certified with SRS at the present time.

SB 186 was submitted as a result of discussion during the interim meetings of the Health Care Reform Oversight Committee.

SB 186 amends current law to grant subpoena power in connection with investigations to the Behavioral Sciences Regulatory Board, subject to the scrutiny of the district court. It also allows for confidentiality of information obtained during investigations. The language of this bill was taken from the Board of Healing Arts Act.

Under current law the BSRB can only ask for information. If a respondent chooses not to cooperate, we have no recourse. This ties the board's hands and offers little public protection. The public is not protected if we cannot compel the production of evidence in a fair and reasonable manner.

In one case the respondent may be exploiting dependent adults. However, we cannot gain enough information to fully know the situation. He refuses to cooperate with an investigation and tells his clients to not talk with us. We believe he may be

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Atch #1

involved in fraudulent billing as well, but we cannot confirm this. We cannot access any of his records, so the investigation is basically halted.

Another example came forth as currently as last week. We have a complaint from a health insurance company that alleges that a licensee has practiced a procedure for which they do not pay, but then has billed for a procedure that is covered for payment. The complaint does not identify the client and the complainant will not identify the client without a subpoena. We are unable to investigate this case until we can supply the licensee with the name of the client.

At times, a respondent does not hold records needed. One example is that a licensee may no longer be working for an agency and we might need to access that agency's records. Another example might be when the records are in the hands of a third party who feels a subpoena is necessary before releasing records.

Passage of SB 186 would allow the Behavioral Sciences Regulatory Board to conduct investigations in a fair and reasonable manner and to obtain information needed to protect the public.

Thank you for the opportunity to speak to you this afternoon. I will be happy to stand for questions.

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January 26, 1998

STATE AGENCIES' SUBPOENA POWER

Summary. The following brief description of subpoena power of state agencies is based upon a discussion of this topic in Professor David Ryan's book, *Kansas Administrative Law*, Kansas Bar Association, (1991). The attached tables display state entities that have subpoena power, the purpose for which that power is granted in statute, procedural limitations on the authority, and bills introduced in the 1998 Legislature that would alter subpoena power of some agencies.

A subpoena is a written order to appear at a specific time and place to provide testimony on a particular matter. A *subpoena duces tecum* demands that the recipient make certain books and records or other items available. In Kansas, many administrative agencies in addition to courts and some legislative committees have subpoena powers. An agency only has subpoena power if it is specifically authorized in statute. The *United States Constitution*, the rules of civil procedure, and the Kansas Administrative Procedure Act (KAPA), and some of the authorizing statutes, all place limitations on the use of subpoena power by state agencies.

Briefly, one must satisfy three elements for relevancy of subpoenas:

1. The agency must be authorized to make the inquiry.
2. The demand must be specific.
3. The information sought must be reasonably relevant.

Statutes granting power of subpoena are generally liberally construed to permit inquiry. The trial court has discretion to:

1. modify subpoenas,
2. quash subpoenas,
3. weigh reasonableness, and
4. require showing of relevancy.

United States Constitution. The Fourth Amendment to the *United States Constitution* provides that "the right of the people to be secure in their persons, houses, papers and effects against unreasonable searches and seizures, shall not be violated." This amendment is not limited to law enforcement officers. It also provides protection from searches and seizures by

administrative agencies. Furthermore, the Fourth Amendment does not require a criminal investigation or arrest relative to searches or inspections for administrative or fact gathering purposes by agency inspectors or regulatory control officers. In short, no exceptions are stated in the amendment except that the search must be reasonable. "Reasonableness" has generally come to mean the presence of a warrant for inspections, and a protection against unreasonable subpoena requests.

The Fifth Amendment protection against self-incrimination also limits agency subpoena powers. However, the self-incrimination defense is subject to significant limitations. The defense is *not* available to a corporation or a union. Additionally, the custodian of records for a corporation or a union may not refuse to produce documents. But the custodian may have his or her own privilege to refuse to answer specific questions. In an appropriate case an agency may compel testimony by granting immunity from prosecutions.

Statutory Authority. The basic method of satisfying the government's need for information where an individual or business will not voluntarily comply is the use of the subpoena to compel the production of documentary evidence, witnesses, or materials. The subpoena power is generally not implied. If the enabling act is silent on subpoena, no subpoena power exists. There is currently no indication Kansas common law is any different for state-level and local agencies not covered under KAPA. (*Yellow Freight v. KCCR*, 214 Kan. 120, 519 P. 2d 1092 (1974); *Kansas Department of Revenue v. Coca Cola Company*, 240 Kan. 548, 731 P. 2d 273 *(1987)*; See also, *Olathe Community Hosp. v. Kansas Corporation Commission*, 652 P.2d 726, 232 Kan. 161 (1982); *Woods v. Midwest Conveyor Co., Inc.*, 648 P.2d 234, 231 Kan. 763, appeal after remand 697 P.2d 52, 236 Kan. 734 (1982); and more recently, *Patel v. Kansas State Board of Healing Arts*, 920 P. 2d 477, 22 Kan. App. 2d 712 (1996), review denied; *Appeal of Alex R. Masson, Inc.*, 909 P. 2d 673, 21 Kan. App. 2d 863 (1995); *Cline v Meas.*, 905 P. 2d 1072, 21 Kan.App2d 622 (1995), review denied.)

Subpoenas are authorized for all agencies that are covered by KAPA at K.S.A. 77-522. A number of state-level agencies have statutory subpoena power which the attached table reflects. In addition to procedures that may be articulated in authorizing statutes, subpoenas generally must be issued in accordance with the Rules of Civil Procedure (K.S.A. 60-245 and 60-245a).

Reasonableness. Kansas common law does not require the agency to know of wrongdoing before a subpoena is issued. Basically, the test is one of "reasonableness" and not "probable cause." Kansas courts apply the test used in *Yellow Freight* for judicial review of agency subpoena issuance. That is, if there is a possibility of relevancy in documents subpoenaed and there is no showing that the subpoena is unreasonable or oppressive, then the statutes granting subpoena power will be liberally construed to permit inquiry.

Three questions should be asked in reference to the issuance of subpoenas by state agencies:

1. Is the subpoena authorized?

2. Is the subpoena within the agency's scope of authority?

3. Is the subpoena "reasonable"?

Enforcement. While the agency issues the subpoena, a court must enforce it. Enforcement is generally considered to require such interference with liberty or property as to be a purely judicial type power, constitutionally limited to the judiciary in most jurisdictions. Consequently, courts must enforce agency subpoenas.

The standard of "reasonableness" incorporates "seizure" and "due process," constitutional limitations on agency power. The scope of the request may not be unreasonable which means among other things, that the agency cannot impose an undue burden for production of documents.

A subpoena that is so vague that the respondent does not know what document or material is requested will not be enforced by a court. Subpoenas are frequently challenged because of vagueness. If the court feels that the burden of compliance is too great, it may compel the agency to reduce its request. The court may also request the agency to treat information received as confidential, or require the agency to inspect documents where they are located.

Kansas Case Law. Kansas opinions have generally held that the agency is free to use its investigative powers, subject to the standard court review test for enforcement.

- In *Kansas Commission on Civil Rights v. Carlton,* 216 Kan. 735 (1975) and *Atchison, Topeka & S.F. Railway v. Lopez,* 216 Kan. 108 (1975), the court recognized that if the KCCR subpoena was "oppressive or unreasonable" it was subject to modification or quashing by the district court.

- *KCCR v. Sedgwick County Mental Health Clinic,"* 220 Kan. 653 (1976) held the limits of subpoena power are subject to the sound discretion of the court.

- *Cessna Aircraft Co. v. KCCR,229 Kan. 15 (1981)* found that in determining whether the subpoena is oppressive or unreasonable, the court must apply the statute liberally. Some showing of relevancy must be made. Due process places limitations upon the agency powers and "it cannot exercise unbridled power based purely on whim and speculation."

- *Matter of Collingwood Grain Inc.,* 891 P.2d 422, 257 Kan. 237(1995) found that the Board of Tax Appeals (a quasi-judicial entity) has discretion in the enforcement of a subpoena filed by the Department of Revenue. Such subpoenas are subject to the Rules of Civil Procedure, must be relevant, and not unreasonable or oppressive.

Enforcement of many state-level agency subpoenas is under the Judicial Review and Civil Enforcement of Agency Action Act (K.S.A. 77-624). That Act allows a private party to a proceeding to bring a subpoena, discovery order, or protective order enforcement by bringing a Petition for Civil Enforcement in district court. For agencies outside the Judicial Review Act, most subpoena enforcement is by court issuance of its own subpoena when requested by the agency, thereby utilizing the standard court enforcement and judicial subpoena procedures.

January 26, 1998

AGENCIES WITH SUBPOENA POWER

Agency/Official	Purpose	Special Procedures[1]
Any agency head or designee serving as a presiding officer in accordance with the Kansas Administrative Procedure Act (KAPA)	Conduct of hearings governed by KAPA (K.S.A. 77-522)	None
Kansas Commission on Governmental Standards and Conduct	Investigations under campaign finance laws (K.S.A. 25-4158)	Must be authorized by affirmative vote of at least three-fourths of the Commission after the subject has had 30 days to respond to written allegations
	Investigations under ethics laws (K.S.A. 46-260)	
	At the request of any party to a campaign finance or ethics hearing (K.S.A. 25-4163, 46-257)	None
Healing Arts Board	Enforcement of laws under its jurisdiction (K.S.A. 65-2839a)	Within five days of service recipient may petition the board to revoke, limit, or modify the subpoena
Healing Arts Board—Disciplinary Counsel	Investigation of matters that may result in action against a licensee (K.S.A. 65-2840a)	Must apply to court for issuance of subpoena
Professional Practices Commission (appointed by the State Board of Education)	Investigating cases related to the State Board's rules and regulations governing certification of teachers and school administrators (K.S.A. 72-8507)	In accordance with an order of the State Board of Education
Interstate Grain Marketing Commission	Enforcement of compact under K.S.A. 2-3101	Majority vote of Commission and then application to any state or federal court for a subpoena
Child Death Review Board	Investigations of certain child deaths (K.S.A.22a-243)	Apply to district court for subpoena.

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Agency/Official	Purpose	Special Procedures[1]
District Judges	Summoning witnesses under Uniform Act to Secure Attendance of Witnesses From Without State (K.S.A. 22-4202)	Hearing required
	Inquisitions in certain criminal cases (K.S.A. 22-3101)	Action initiated by filing of application by Attorney General, County or District Attorney
Secretary of SRS or law enforcement officer	Child abuse or neglect investigations—request for disclosure of child abuse documents under K.S.A. 38-1523	Application to the district court for a subpoena or order
	Child in need of care hearing—interested party entitled to subpoena for witnesses' attendance (K.S.A. 38-1537)	None
	Juvenile offender hearing--party entitled to subpoena for witnesses (K.S.A. 38-1633)	None
Secretary of SRS	In any Title IV-D (child support enforcement) case in order to obtain information about a parent's whereabouts or finances (K.S.A. 39-7,144)	Respondent has 14 days to comply; served only by personal service; subject to an administrative hearing or a *de novo* review by court
	In connection with investigations of claims and vouchers and persons and businesses who provide services to the Department or to its clients, and eligibility of clients and vendors (K.S.A. 75-3306)	None
Legislative Investigating Committees	Investigations of authorized subjects of inquiry (K.S.A. 46-1001, *et seq.*)	If to compel attendance at a hearing, must be served at least three days prior to the hearing
Secretary of Health and Environment	Hearings under the food and drug law (K.S.A. 65-673)	None

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Agency/Official	Purpose	Special Procedures[1]
	Hearings regarding enrichment of flour and bread (K.S.A. 65-2305)	None
	Food and lodging licensee hearings (K.S.A.36-509)	None
	Hearings and investigations under the mined land conservation laws (K.S.A. 49-405)	None
Dairy Commissioner	Enforcement of milk and dairy product laws (K.S.A. 65-702)	None
Dental Board	Enforcement of dental regulatory laws (K.S.A. 65-1452)	None
Barber Board	Enforcement of barber regulatory law (K.S.A. 65-1824)	None
Board of Adult Care Home Administrators	Enforcement of laws under its jurisdiction (K.S.A. 65-3503)	None
Emergency Medical Services Board	Enforcement of laws under its jurisdiction (K.S.A. 65-6130)	None
Corporation Commission	Hearings of complaints about municipal utilities (K.S.A. 66-133)	None
	Hearings under laws governing the production and sale of oil and gas (K.S.A. 55-605, 55-706, 55-1310)	None
State Board of Education and any state facility providing special education services	In connection with a hearing or review under the special education laws (K.S.A. 72-975)	None
Board of Nursing	Investigations and proceedings under its jurisdiction (K.S.A. 74-1106)	None
Board of Examiners in Optometry	Enforcement of laws under its jurisdiction (K.S.A. 74-1504)	None

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Agency/Official	Purpose	Special Procedures[1]
Board of Mortuary Arts	Enforcement of laws under its jurisdiction (K.S.A. 74-1704)	None
Board of Tax Appeals	Enforcement of laws under its jurisdiction (K.S.A. 74-2437a)	None
Abstracters' Board of Examiners	Enforcement of laws under its jurisdiction (K.S.A. 74-3902)	None
Law Enforcement Training Commission	Enforcement of laws under its jurisdiction (K.S.A. 74-5607)	None
Crime Victims Compensation Board	Enforcement of laws under its jurisdiction (K.S.A. 74-7304)	None
Behavioral Sciences Regulatory Board	Enforcement of laws under its jurisdiction (K.S.A. 74-7508)	None
Lottery	Enforcement of laws under its jurisdiction (K.S.A. 74-8704)	None
Racing and Gaming Commission	Enforcement of laws under its jurisdiction (K.S.A. 74-8804)	None
State Gaming Agency	Enforcement of laws under its jurisdiction (K.S.A. 74-9805)	None
Board of Accountancy	Enforcement of laws governing licensed municipal accountants (K.S.A. 75-1119)	None
Public Employee Relations Board	Enforcement of laws under its jurisdiction (K.S.A. 75-4323, 75-4332)	None
Secretary of Corrections	Investigations of alleged improper conduct of department employees (K.S.A. 75-5251)	None

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Agency/Official	Purpose	Special Procedures[1]
Secretary on Aging (Long-Term Care Program)	In connection with investigations of claims and vouchers and persons and entities providing services to the department or to its clients and eligibility of clients and vendors (K.S.A. 75-5945)	None
Director of Taxation	Enforcement of tax laws under the director's jurisdiction (K.S.A. 79-908, 79-3419, 79-4224, 79-5207)	None
Secretary of Revenue	Enforcement of tax income laws (K.S.A. 79-3233)	None
	Enforcement of bingo laws (K.S.A. 79-4705a)	None
Director of Division of Motor Vehicles	Suspension of driving priviledges under K.S.A. 8-255	None
	Commercial motor vehicle licensee may request director to issue subpoena for witnesses on his or her behalf in license suspension hearing under K.S.A. 8-2,145	None
	Alcohol or drug test refusal or failure hearing under K.S.A. 8-1002 where licensee requests subpoena of witnesses	None
Secretary of Agriculture	Hearings regarding pest control licensure (K.S.A. 2-2463)	None
	Enforcement of Kansas Chemigation Safety Law (K.S.A. 2-3316)	None
Consumer Credit Commissioner	Investigation of certain licensees' business practices under K.S.A. 16a-2-305	None
	Investigation of prohibited acts under K.S.A. 16a-6-106	None
Kansas Securities Commissioner	Kansas Securities Act investigations (K.S.A. 17-1265)	None

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Agency/Official	Purpose	Special Procedures[1]
Attorney General	Investigations of Medicaid fraud and abuse (K.S.A. 21-3852)	None
	Investigations of suspected violations of laws regarding unfair trade practices (K.S.A. 50-153)	None
	Investigations of suspected violations of consumer protection or odometer fraud laws (K.S.A. 50-631, 50-653a)	None
	Enforcement of laws governing private investigators (K.S.A. 75-7b15)	None
Attorney General or County or District Attorney	Investigation of violations of the Charitable Organizations and Solicitations Act under K.S.A. 17-1767	None
	Investigations under the Kansas Standard Asset Seizure and Forfeiture Act (K.S.A. 60-4118)	None
	Inquisitions in certain criminal cases (K.S.A. 22-3101)	None
Prosecutor and Person Charged	To obtain attendance of witnesses in accordance with criminal procedure (K.S.A. 22-3214)	None
Credit Union Administrator	investigation of credit union business under K.S.A. 17-2206	None
Kansas Parole Board	Hearings under K.S.A. 22-3720	None
Coroner	Inquest under K.S.A. 22a-230	None
Court Trustee	Child support enforcement under K.S.A. 23-496	None
State Fire Marshal	Hearings regarding orders of the Fire Marshal under K.S.A. 31-141	None
Secretary of Kansas State Grain Inspection Department	Examine licensee books and records under K.S.A. 34-230a	None

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Agency/Official	Purpose	Special Procedures[1]
Secretary of Senate	Impeachment proceedings under K.S.A. 37-106	None
Insurance Commissioner	Hearings related to insurance under K.S.A. 40-281	None
	Liquidation of insurance company under K.S.A. 40-3625	None
Director of Division of Alcohol Beverage Control	Licensure hearings under K.S.A. 41-209	None
Secretary of Department of Revenue	Licensure appeal under liquor laws (K.S.A. 41-322)	None
Director of Workers Compensation and the Board	Hearings under K.S.A. 44-549	None
Workers Compensation Administrative Law Judges	Powers listed under K.S.A. 44-551	None
Secretary of Human Resources	Investigations of employer-worker disputes under K.S.A. 44-611 and 44-635	None
	Enforcement of laws governing teacher contracts (K.S.A. 72-5432, 72-5442)	None
Secretary of Human Resources, Chairs of Appeal Tribunals, or Appeal Referees	Hearings under the unemployment law (K.S.A. 44-714)	None
Agricultural Labor Relations Board	Implementation of the law under its jurisdiction (K.S.A. 44-820)	None
Human Rights Commission	Implementation of the law under its jurisdiction (K.S.A. 44-1004)	None
Secretary of State	Enforcement of the Kansas Athlete Agent Act (K.S.A. 44-1514)	None
Adjutant General	Gathering information under the emergency preparedness laws (K.S.A. 48-912)	None

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Agency/Official	Purpose	Special Procedures[1]
Military Judge of a Court Martial or a Summary Court Officer, Military Courts	In connection with proceedings under the Kansas Code of Military Justice (K.S.A. 48-2711, 48-3107)	None
Securities Commissioner	Hearings and investigations under the securities laws (K.S.A. 50-1009)	None
	Hearings and investigations under the Uniform Land Sales Practices Act (K.S.A. 58-3311)	None

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

Testimony on Senate Bill 64
to
House Committee on Health and Human Services

Presented by Michael Moser, M.D., M.P.H.

March 12, 2001

Chairperson Boston and members of the Committee on Health and Human Services. I am pleased to appear before you today to discuss Senate Bill 64.

Senate Bill 64 is primarily concerned with maintenance of the requirement that reports of HIV infection made to the Kansas Department of Health and Environment (KDHE) contain the name of the person with this infection. HIV name-associated reporting was first approved by the Kansas Legislature in 1999. This occurred after years of discussion involving KDHE, community-based organizations, HIV infected individuals, and health care providers. By 1999 there was a broad support for this requirement. However, some concerns and uncertainty remained concerning impact of a name reporting requirement on HIV testing usage. For this reason a requirement was attached to the authorizing legislation requiring the Secretary of Health and Environment to make a report about the testing program to the Legislature by January 8, 2001; associated with this requirement was another provision repealing the requirement for reporting of HIV and AIDS cases on July 1, 2001 in the absence of legislative action to re-authorize them. The Secretary has made the required report to the Kansas Legislature detailing the absence of significant adverse impacts from name-associated reporting of HIV. SB 64 was introduced to remove the sunset provision and makes reporting of names with reports of HIV and AIDS an established feature of public health practice in Kansas.

The report submitted to you by Secretary Graeber was based on the first 12 months of named reporting for HIV, covering the period July 1, 1999, to June 30, 2000. During this period, 99 new cases of HIV infection were diagnosed and reported to KDHE. Eleven of these cases were diagnosed as a direct result of public health case follow-up which had been impossible before name-associated HIV reporting. As a result of such early diagnosis, persons with HIV are able to receive medical treatment at a time when it can provide the greatest health benefit. In addition, over one hundred persons were identified during case follow-up who were still uninfected but at high risk of future infection because of high risk behavior. These individuals were offered and received professional prevention counseling to reduce their risk of infection.

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During the first year of HIV name-associated reporting, the number of individuals seeking HIV testing and counseling at publicly funded sites was virtually unchanged compared to the same period of the year before name-associated reporting was implemented. All public sites continue to offer an anonymous testing option, as required by state law, but the vast majority of test requests submitted to our state laboratory contained the name of the individual being tested. No anonymous HIV tests performed in the first year of name-associated reporting generated a positive test result.

During the implementation of the new reporting requirements it became clear that many HIV reports are being submitted by hospitals on behalf of their physicians, as it is customary for most reportable conditions. However, K.S.A. 65-6002 does not specifically require or authorize hospitals to report cases of HIV or AIDS. For that reason, while these reports are essential for the good functioning of the HIV surveillance system, they are not afforded the same level of protection granted by state laws to reports submitted by physicians and laboratories. When it requested introduction of SB 64, KDHE proposed that hospital administrators be added to the list of individuals required to report HIV infection to address this problem. Following testimony during the Senate hearing on this bill, this portion of the bill was amended to include administrators of medical care facilities other than hospitals and the designees of hospital and other medical facility administrators among those required to report cases of laboratory confirmed HIV infection with identifying data and afforded immunity from civil liability for making such a report in good faith.

KDHE strongly supports passage of SB 64 as amended by the Kansas Senate. Without repeal of the sunset provision in the current law, HIV and AIDS will no longer be reportable conditions in our state. This would prevent KDHE from conducting critical epidemiologic activities, such as confidential partner counseling and referral services. In addition, our ability to monitor the progress of the HIV/AIDS epidemic in Kansas will be significantly impaired, with adverse consequences on our ability to access federal prevention and care funding and on program effectiveness.

I thank you for the opportunity to appear today and now stand for your questions.

Reported HIV infections in Kansas between 07-01-1999 and 06-30-2000

Kansas Department of Health and Environment
Bureau of Epidemiology and Disease Prevention

For further information, contact the HIV/STD section at 785-296-5587

December 2000

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GLOSSARY OF TERMS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome.
Case Count	The number of people with AIDS.
CTS	Counseling and Testing Site.
DHEL	Division of Health and Environment Laboratory.
DIS	Disease Intervention Specialist.
ELISA Test	Enzyme-Linked Immuno-Sorbent Assay. A blood test which indicates the presence of antibodies to HIV. The HIV ELISA test does not detect the disease AIDS, but only indicates if viral infection has occurred.
Epidemiology	The study of disease patterns in populations.
HIV	Human Immunodeficiency Virus.
Incidence	The number of new cases in a specific time
KDHE	Kansas Department of Health and Environment.
NIR	No Identified Risk.
Opportunistic Infection	A disease caused by agents that are commonly in our bodies or in the environment, but cause disease only when there is a change from health conditions, such as when the immune system becomes depressed.
PCRS	Partner Counseling and Referral Services.
Prevalence	The estimated total number of cases at a specific point in time.
Prevalent cases	For this document, prevalent cases are those people presumed to be living with HIV or AIDS. If no date of death is reported for an individual, that individual is presumed to be still living.
Rate	The proportion of people in the population with a disease over a specific time period.
Statistically significant	A mathematical test used as a guide to determine whether the change(s) seen are likely due to chance alone or to some other factor(s).
STD	Sexually Transmitted Disease.

Surveillance	The ongoing, systematic observation of a population for rapid and accurate detection of changes in the occurrence of particular diseases.
Western Blot	A blood test used to detect HIV antibody. It is often used to confirm the results of an ELISA test. It is more specific and more expensive than an ELISA test.

Reported HIV infections in Kansas, 07/01/99 and 06/30/00

Executive Summary

This report represents a summary of the first year of HIV reporting in the state of Kansas and is submitted pursuing KSA 65-6011, which requires that "On or before January 8, 2001, the secretary of health and environment shall report to the legislature concerning the impact of the changes made to K.S.A. 65-6001 et seq."

Number of HIV cases - Ninety-nine cases of HIV disease were diagnosed and reported from July 1, 1999 through June 30, 2000. This compares to 96 cases of AIDS, a condition that has been reportable since the early 1980's.

Distribution by gender, race, and ethnicity - Among people with newly recognized HIV infection, women, African Americans, and Hispanics are found more often than among individuals diagnosed with AIDS, who were probably infected many years ago. The rates of infection in minority populations are also out of proportion to their numbers within the population as a whole. Similar trends have been observed in other states.

Five Hispanic women were diagnosed and reported with HIV, representing 20% of all newly diagnosed and reported cases of HIV in women for the period. No Hispanic women were reported as having AIDS, underscoring how AIDS reports are not indicative of current trends in HIV infection. These data suggest that HIV infection may be spreading among Hispanic women at a higher rate than in the past and is more common than among women of other ethnic and racial backgrounds.

Distribution by geographical area - Most individuals with newly identified HIV infections live in the metropolitan areas of the state.

Impact of new reporting requirement on testing - There was no reduction in the number of tests performed in publicly funded HIV Counseling and Testing sites as a result of incorporating confidential (i.e., name linked) testing for HIV and subsequent reporting of positive results to the KDHE. Confidential tests comprise 87% of all HIV tests performed through public sites. Over half of the newly diagnosed and reported cases of HIV were reported by private physicians. Over a quarter of new cases were found through publicly funded testing sites including CTS, STD clinics and corrections settings. Disease intervention specialists utilizing behavior change oriented partner counseling and referral services tenets interviewed 103 persons with HIV disease during the period and found 11 previously undiagnosed cases as a result of their activities.

Link of patients to care services - One of the primary goals of the HIV/STD program is to refer individuals into clinical care services. Forty-seven of the 99 newly diagnosed and reported HIV positive individuals were effectively referred to publicly funded Ryan White Care Services. The remaining individuals either had other sources of care or were under investigation at the time this report was completed.

Background

Beginning July 1, 1999, HIV reporting was implemented in Kansas. The new law requires physicians and laboratories to report all confirmed positive HIV test results to the Kansas Department of Health and Environment (KDHE). The confidential case reports submitted to KDHE include the name of the person tested, demographic information, physician's name, testing facility and risk factor information, including pregnancy status.

The KDHE uses the information gathered to determine trends in disease, set policies, develop interventions, assure access of patients to care and services, and distribute information that may be useful to the public.

Reporting completeness is essential for a complete understanding of the impact that HIV disease is having upon Kansas. An unrelated study to assess the proportion of women known to be infected with HIV giving birth indicated that at least 74 women were known to be infected with between 1989 and 1998 and that 47 of these were never reported with no known follow-up on the mother or child because of a lack of reporting. HIV reporting will allow for follow-up on pregnant women to ensure that they receive information that will allow them to make choices that include the taking of medications that can reduce the risk of infecting their child by almost two thirds. Further, follow-up can also be performed on the children to ensure adequate care.

HIV information included in this report refers to results reported to KDHE between July 1, 1999 and June 30, 2000. Data presented as HIV data **DO NOT** include information on individuals that were diagnosed with AIDS during the same period; information on those individuals is analyzed and presented separately.

Results of Analysis

Case count and demographic characteristics

Between 07/01/99 and 06/30/00, 201 confidential HIV case reports were submitted to KDHE on individuals with a positive HIV test in Kansas. Although anonymous testing is available in Kansas through public sites, no anonymous positive tests were reported after July 1, 1999. Although reported during the period, 102 of the 201 individuals were initially diagnosed with a positive HIV test prior to July 1999 when HIV infection was not reportable (see Table 1). This is a normal phenomena that results from the required reporting from all physicians and laboratories.

Table 1 - Date of testing* of the 201 HIV positive individuals reported in Kansas, 07/01/99 and 06/30/00

Date of testing	Number (%)
7/1/99-06/30/00	99 (49)
1/1/95-6/30/99	63 (32)
1/1/90-12/31/94	23 (11)
Before 1990	16 (8)

Percentages do not add up to 100 due to rounding.

* date of testing = date of first known EIA positive test confirmed by Western Blot.

Unless otherwise specified, the rest of this analysis will only include the 99 persons with positive HIV tests performed and reported between 07/01/99 and 06/30/00. Of the 99 individuals with a positive HIV test first performed and reported during this period, over 50% were first tested through private physicians, as seen in Table 2.

Table 2 - Testing facility of individuals in Kansas with HIV positive tests first tested and reported between 07/01/99 and 06/30/00

Facility	Number	(%)
Private Physicians	52	(53)
Counseling and Testing Sites	20	(20)
STD Clinic	3	(3)
Correctional Facility	3	(3)
Hospital, Inpatient	6	(6)
Hospital, Outpatient	3	(3)
Emergency Room	3	(3)
Plasma/Blood Bank	3	(3)
Other*	6	(6)
Total	**99**	**(100)**

Percentages do not add up to 100 due to rounding.
* *Includes life insurance and out-of-state reports*

Table 3 compares individuals with positive HIV tests to the 96 individuals with AIDS, diagnosed and reported during the same period by selected characteristics. HIV/AIDS surveillance data categorizes race and ethnicity together. "Hispanic " refers to those who self-identify as Hispanic of any race. "Other" includes Native Americans/Alaskan Natives, Asians/Pacific Islanders, those who identify as "mixed race", and those for whom no race information is obtained. Risk behaviors listed are mutually exclusive, that is a person will be categorized with only one risk behavior. If multiple risk behaviors are found, a Centers for Disease Control and Prevention derived hierarchical algorithm is used.

Table 3 - Selected characteristics of individuals in Kansas diagnosed with HIV or AIDS and reported between 07/01/99 and 06/30/00

Characteristic	HIV (N=99) Count	%	AIDS (N=96) Count	%
Sex				
Male	74	(75)	82	(85)
Female	25	(25)	14	(15)
Race/ethnicity				
White, non-Hispanic	56	(57)	62	(65)
African-American, non-Hispanic	22	(22)	21	(22)
Hispanic	13	(13)	11	(11)
Other	8	(8)	2	(2)
Age				
Mean (average) age, years	34.0		38.4	
Age range, years	2-62		10-68	
Risk factors				
Male-male sex	34	(34)	47	(49)
Male-male sex and Injection drug use	8	(8)	6	(6)
Injection drug use	16	(16)	14	(15)
Heterosexual sex	19	(19)	15	(16)
with an injection drug user	*1*		*1*	
with bisexual male	*1*		*1*	
with HIV-infected individual	*17*		*13*	
Risk not identified	20	(20)	9	(9)
Other*	2	(2)	5	(5)

** Includes pediatric cases, transfusion/organ recipients, hemophiliacs, and risks not otherwise classified*

One fifth (20) of the individuals with a positive HIV test are considered to have no identified risk (NIR) at this time. This is within the range expected. Further investigation of these reports can be expected to reduce the number of cases without an identifiable risk. There were three times as many men as women and more whites than persons of color with a positive HIV test. However, among women, newly diagnosed HIV and AIDS cases were highest for women of color as seen in Table 4. Also, more women were diagnosed with HIV than diagnosed with AIDS during this period. These differences do not reach statistical significance which may be due to small numbers.

Of note, is the number (5) and percentage (20%) of Hispanic women diagnosed and reported with HIV during the period as a portion of all reports (Table 4). In addition, is the fact that no Hispanic women were diagnosed and reported with AIDS during the period. Although the low numbers do not yet allow for any firm conclusions, these data suggest that HIV infection may be spreading among Hispanic women at a higher rate than in the past and is more common than among women of other ethnic and racial backgrounds. A similar trend has been observed in other states.

Table 4. Race/Ethnicity distribution for women diagnosed with HIV or AIDS and reported between 07/01/99 and 06/30/00

	HIV		AIDS	
Race/Ethnicity	**Number**	**(%)**	**Number**	**(%)**
White, non-Hispanic	8	32	5	36
African American, non-Hispanic	9	36	8	57
Hispanic	5	20	0	0
Native American	0	0	1	7
Unknown	3	12	0	0
Total	**25**	**100**	**14**	100

Geographical distribution

Information on the county the person was living in is known for all 99 individuals with a positive HIV test and all 96 individuals with AIDS diagnosed and reported during this period, as shown in Table 5. This location may not reflect where the person was tested or may be seeking care. To protect the confidentiality of those persons, information on county of residence is presented by HIV/AIDS case management region. A map of the case management regions is attached to the end of this report. The highest number of reported cases were for individuals living in areas with the highest population density, that is, Regions 1 and 2 (which include the Kansas City metropolitan area). Region 4 (which includes Topeka), and Region 8 (which includes the Wichita area). Given the relatively small number of reports, meaningful rates by region could not be calculated. There were no individuals with a positive HIV test performed and reported during this period living in Region 3.

Table 5 - Region of residence at the time diagnosis with HIV or AIDS and reported between 07/01/99 and 06/30/00

Region	HIV (N=99)	AIDS (N=96)
1	20	16
2	8	14
3	0	2
4	15	10
5	3	2
6	6	5
7	3	3
8	39	43
9	5	1

Testing patterns

During the first year after the implementation of confidential HIV reporting, 12,727 specimens were submitted for HIV testing to the KDHE Division of Health and Environment Laboratory (DHEL) from KDHE contracted Counseling and Testing Sites (CTS) throughout Kansas. This is slightly higher than the 12,407 tests submitted between July 1, 1998 and June 30, 1999 before the implementation of HIV reporting. All public CTS offer either a confidential HIV test (i.e., with the name, demographic information and risk factor of the tested individual) or anonymous HIV test (with a unique identifier for the individual is created but no name is collected). During the first year after implementing confidential HIV reporting, 87% (11,072) of all tests submitted by CTS to DHEL had a name. The proportion of confidential testing at CTS has increased from 79% in July 1999 to 91% in June 2000. Of the 20 HIV positive individuals tested at CTS, 11 (54%) are now enrolled in Ryan White Services, one in Medicaid, one has private health insurance, and 7 have no known care services.

Prevention Linked Testing

As a part of the evaluation of federally funded HIV/AIDS programs, a system has been set up to evaluate the impact of referrals from external sources to HIV counseling and testing sites. Funded CTS personnel are asked to elicit how a person was referred to a site using one of 43 designated codes. Funded Health Education and Risk Reduction (HERR) projects are required as part of their contract to refer individuals to counseling and testing. Although this referral coding system is still being developed, 1,049 referral codes were identified from persons tested at CTS. Of

the 20 positive HIV individuals from CTS, two had referral codes listed. One was from a KDHE supported HIV prevention project, the other was a referral by an infected partner.

Referral to Services

One of the goals of HIV surveillance is to identify infected individuals so they can be offered medical services to prevent the development of AIDS and to control other complications of HIV infection. All HIV positive persons are referred to medical services, and other forms of assistance, including case management services. If a patient does not have the resources to purchase his or her own medical care or other needed services, federal and state support is available. There were 124 new persons enrolled into the Ryan White Title II (i.e., publicly funded) care services between July 1, 1999 and June 30, 2000, 23 of whom were among the 99 newly identified HIV-infected individuals. The 124 new enrollees during this period compares with 104 between July 1, 1998 and June 30, 1999 illustrating the increase in individuals seeking care through Ryan White Title II. 24 individuals were linked to Ryan White Title I and III services. Medical coverage as of June 30, 2000 for the 99 persons newly diagnosed and reported with HIV between July 1, 1999 and June 30, 2000 in Kansas is summarized in Table 6.

Table 6 - Medical Coverage * for newly identified HIV-infected individuals reported in Kansas between 07/01/99 and 06/30/00.

Medical coverage	**Number of persons**	
	count	**percentage**
Ryan White, Title I	4	(4)
Ryan White, Title II	30	(30)
Ryan White, Title III	13	(13)
Medicaid	5	(5)
Private insurance	10	(10)
Clinical Trial	3	(3)
No coverage to date	4	(4)
Unknown	30	(30)
TOTAL	**99**	**(100)**

Percentages do not add up to 100 due to rounding.

** As of 12/14/2000*

Of the 30 persons with unknown coverage, 11 are residents of counties where Ryan White Title I coverage is available, but at this time have not enrolled in that program. Investigation to determine the medical coverage for the individuals with unknown coverage is continuing.

Partner Counseling and Referral Services (PCRS)

Disease Intervention Specialists (DIS) from the HIV/STD section of KDHE perform partner counseling and referral services (PCRS) for persons reported with an STD, including HIV and AIDS. For HIV-infected individuals, DIS attempt to interview all individuals reported to have a positive laboratory test for HIV from public sites and those reported from private sites, upon agreement with the physician. All HIV-positive persons interviewed by DIS are given extensive prevention counseling on how to minimize the risk of transmission of infection to sexual and needle sharing partners. All HIV positive persons are referred to medical services, and other forms of assistance, including case management services (see previous section for details). In addition, infected individuals are offered assistance contacting their partners. For partner notification purposes, partners are defined as those with whom an HIV-infected individual had either sexual contact or shared injection drug equipment within twelve months prior to the individual's positive test result. After an interview with an HIV-infected individual, the DIS assists the individual in contacting and informing any sexual and/or needle sharing partners who can be located of their exposure to HIV or assists the infected individual in notifying his/her sexual and/or needle sharing partners of their exposure to HIV. Federal legislation requires that efforts be made to notify persons who have been a spouse of an HIV-infected person at any time within the 10 year period prior to the first positive HIV test. All PCRS are provided in person and in a confidential setting. All partners are strongly encouraged to be tested for HIV.

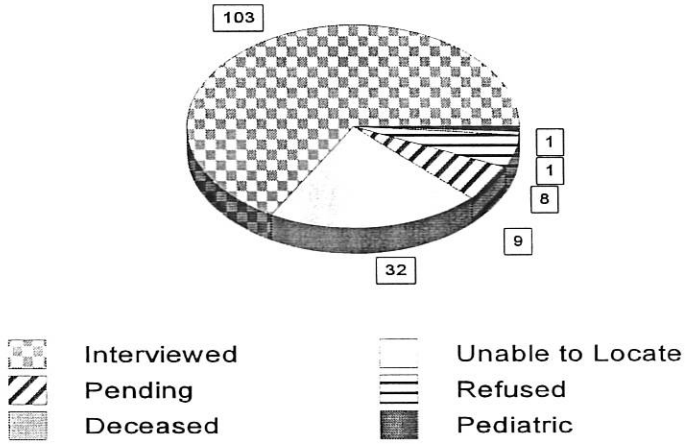
Table 7 -Partner Counseling and Referral Services Interviews and Field Activity 7/1/1999 - 6/30/2000

INDICATORS	Number
Reported HIV Infections	201
New & other HIV+ persons referred for partner counseling and referral services	154
New & other HIV+ persons located and interviewed for partner counseling and referral services	103
Number of interview period partners (sex &/or needle sharing) elicited	463
Partners initiated for follow-up	192
Partners tested	139
New HIV+ partners identified	11

As noted earlier, there were 201 HIV case reports from 7-1-99 through 6-30-00 including reports on individuals diagnosed before the implementation of HIV named reporting but seeking care after July 1, 1999. Table 7 provides a detailed breakdown of the field activity generated by these cases. DIS were assigned to interview a total of 154 HIV-infected individuals in Kansas from July 1, 1999 to June 30, 2000. Forty-seven of the 201 reported HIV cases were not initiated to DIS due to documentation of previous follow-up. One hundred and three (103 or 67%) of the 154 individuals assigned to DIS were interviewed using PCRS principles. The others were not interviewed for reasons indicated in figure 1. This percentage is similar to that of other STD's investigated by DIS. Based upon information discovered through these DIS follow-ups and provider reports to the surveillance office, it was determined that only 99 of the 201 initial HIV reports were newly diagnosed cases of HIV during the time period of July1,1999 to June 30, 2000.

From the 103 completed interviews, 463 partners were indicated. Of these, 192 (41%) had sufficient information to locate them and were initiated for follow-up. From these, eleven previously undiagnosed individuals tested positive for HIV infection. DIS investigations for this period uncovered and tested 115 individuals who had not previously been tested that were engaging in high risk behavior. Eleven new cases of HIV were diagnosed and reported as a result of PCRS activity. These individuals did receive HIV prevention counseling targeting behavior changes. In addition, under reciprocal agreements, DIS were also assigned 19 interviews for HIV+ individuals tested in other states but living in Kansas. There were no new cases found as a result of these interviews.

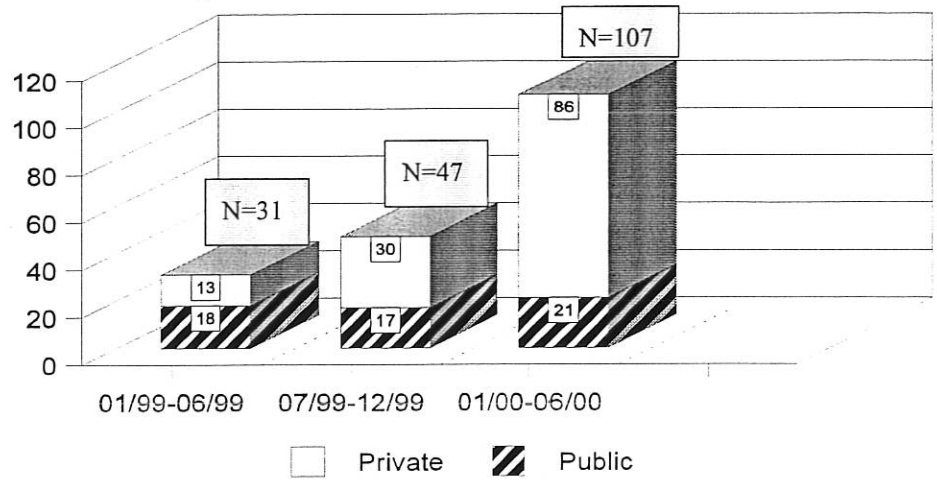
Figure 1 - Results of 154 HIV + Reports Referred for Interviews



3-15

A larger proportion of the requests for interviews came from private health care providers in the first half of 2000 as compared with the first half of 1999 with an overall increase for interview, as shown in Figure 2.

Figure 2 HIV Interviews assigned to DIS, Kansas 01/99 - 06/00



As a part of standard policies and procedures, all positive persons identified through reporting and PCRS are referred to care services. Six of the 11 new infected individuals identified through PCRS have enrolled in Ryan White Care Services as seen in Table 8.

Table 8 - Medical Coverage for HIV cases discovered through partner counseling and referral services in Kansas 07/01/99 and 06/30/00

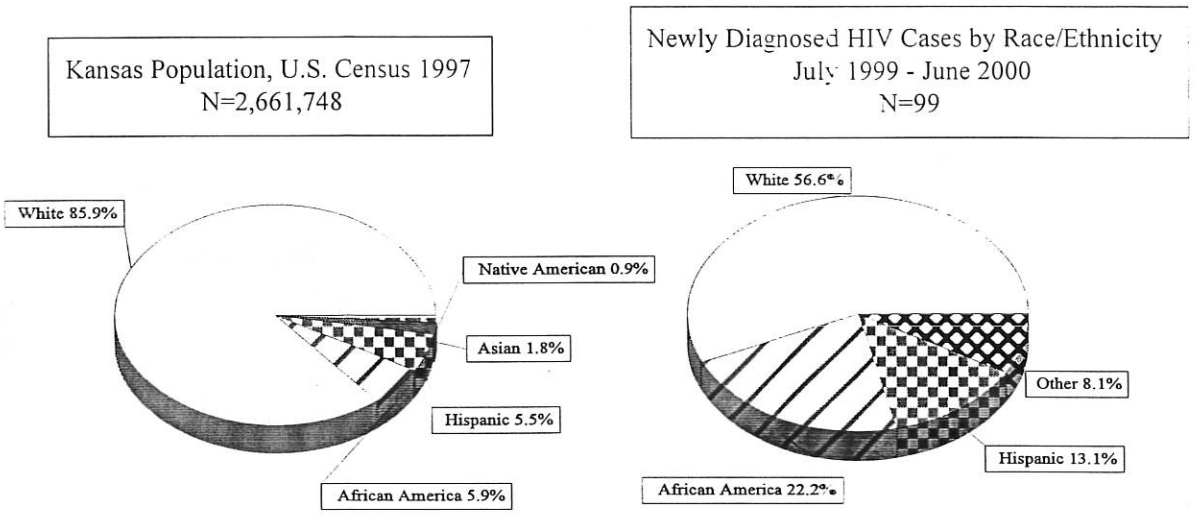
Medical Coverage	Number of persons	
	number	percentage
Ryan White, Title I	1	(9)
Ryan White, Title II	4	(36)
Ryan White, Title III	1	(9)
Medicaid	1	(9)
Private insurance	1	(9)
Other	1	(9)
Unknown	2	(18)
Total	**11**	**(100)**

Percentages do not add up to 100 due to rounding

Discussion

The information presented in this report on the results of HIV reporting and associated service delivery for the first year of HIV reporting contributes new information to our knowledge of HIV in Kansas. Although a diagnosis of HIV non-AIDS does not indicate the length of time a person has been living with the disease, it can be used as an indicator of more recent risk and transmission patterns and point to where primary HIV prevention efforts should be focused.

There were more men than women, and more whites than African-Americans among people with a positive HIV test identified and reported between July 1, 1999 and June 30, 2000. Although more whites were identified as positive, the distribution of newly identified HIV positives among African-Americans and Hispanics is extremely high when compared to their distribution within the Kansas population as shown in figure 3. In addition, among women with a positive HIV test or newly diagnosed with AIDS during this period women of color represented the highest group as shown in Table 4. Hispanic women in particular reflect a large percentage of newly diagnosed and reported cases of HIV in the first year.



These differences may reflect a change in demographic and risk factors associated with HIV infection in Kansas. Another possible explanation is that women and minorities are seeking care and are identified as having a positive HIV test earlier than other groups. This explanation cannot be excluded, although it is contrary to trends observed in other areas of the country. Alternatively, newer therapies may be more effective among women in slowing the progression from HIV to AIDS than in men. These hypotheses can be tested as more people with HIV are identified and reported and as the surveillance system gathers more information on individuals with HIV infection.

Eleven previously unrecognized HIV infections were discovered and reported as a result of DIS investigations that were not possible before HIV results were reported with names. Seven of these individuals are known to be enrolled in federal or state programs.

Since the implementation of HIV name reporting, the number of requests for partner counseling and referral services from private sources continues to increase. This primary and secondary prevention can be an important factor in slowing transmission of HIV in Kansas. The shorter the time interval from an initial identification to the time of reporting, the more likely that DIS will be able to locate the index patient and partners for interview and follow-up and refer the person to existing care services. This underscores the importance of prompt and timely reporting. Eighty four percent of the newly diagnosed HIV cases were reported within 60 days of the initial HIV test date. This compares favorably with national averages.

The number of HIV-positive individuals in Kansas for whom there is no identifiable risk (NIR) is 19.4% and exceeds that for AIDS cases (3.6%). This is similar to what has been seen nationally. The national NIR rate is 9% for AIDS cases and 30% for HIV. One possible explanation is that the longer a person has been identified as having HIV infection, the more likely he or she is to acknowledge risk behavior. However, the NIR rates for HIV should continue to decline with partner counseling and referral services now more accessible with HIV name reporting.

This analysis is based on a relatively small number of HIV records over a short period of time compared to AIDS data. This analysis shows that HIV reports are generating important information that is used for prevention, counseling, and referral activities. Despite the limitations of the available data, it appears clear that HIV reporting and the public health interventions that arise from the activity can be used to define the extent and characteristics of the infection, to identify individuals with HIV infections, and to refer infected individuals to available counseling and care services.

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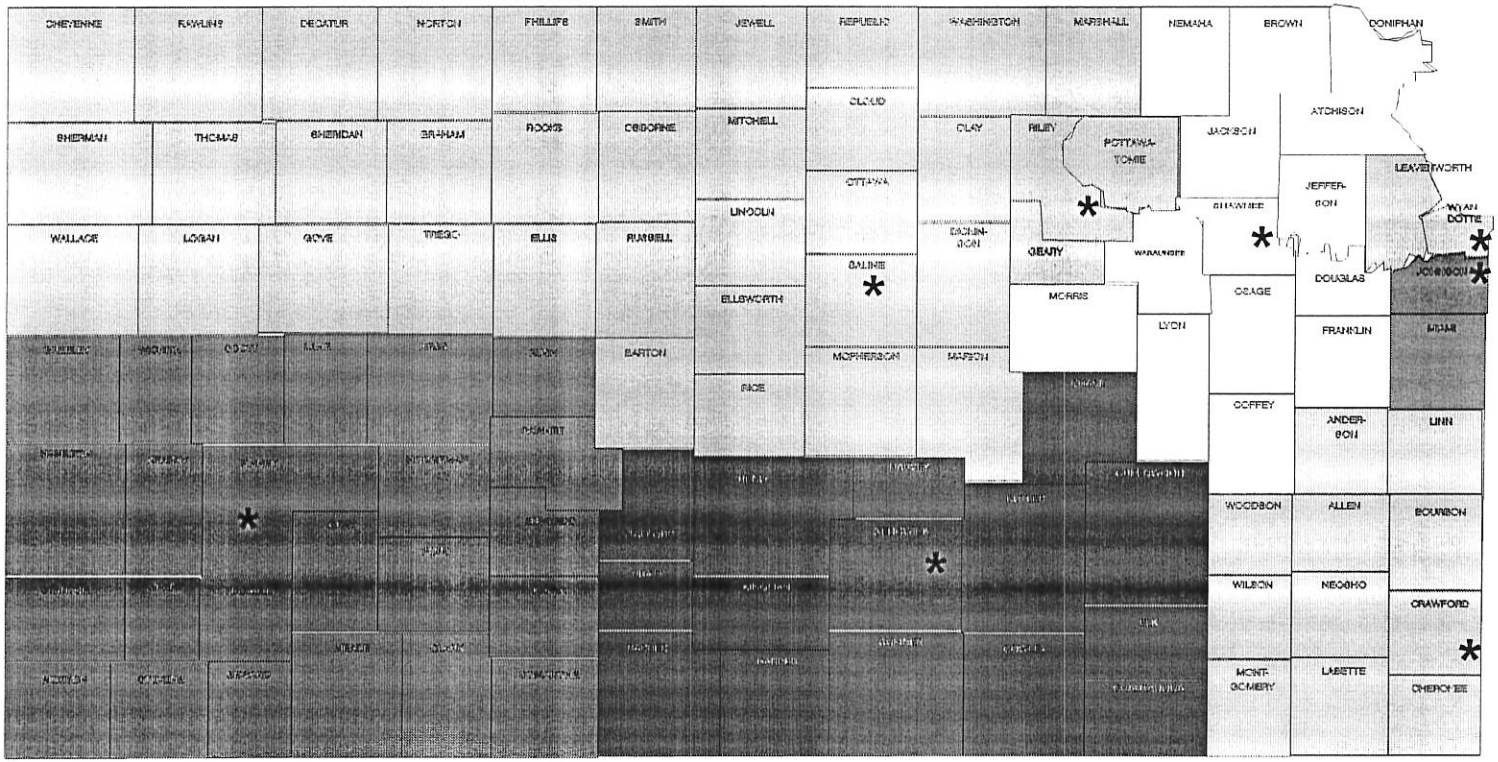
FIGURE 4 - HIV Case Management Regional Map

HIV REGIONS in KANSAS



- Region 1 - Kansas City
- Region 2 - Shawnee Mission
- Region 3 - Lawrence
- Region 4 - Topeka
- Region 5 - Pittsburg
- Region 6 - Manhattan
- Region 7 - Salina
- Region 8 - Wichita
- Region 9 - Garden City

KANSAS HIV/STD SURVEILLANCE UPDATE

Kansas Department of Health and Environment
Bureau of Epidemiology and Disease Prevention

HIV NAME BASED REPORTING- THE FIRST YEAR

"We have entered an era in which HIV prevention needs are greater than ever before, and accurate data about where new HIV infections are occurring are critical"

All quotes in this article are from a pre-release statement by Helene Gayle, M.D., M.P.H. Director, National Center for HIV, STD, and TB Prevention Centers for Disease Control and Prevention, December 9, 1999 regarding the publication of "Guidelines for National HIV Surveillance" MMWR Dec. 10, 1999 / Vol. 48 / No. RR-13.

(See "HIV Named Based Reporting the First Year", page 3)

October 2000

Our Mission:
The HIV/STD section works to promote public health and enhance the quality of life for Kansas residents by the prevention, intervention, and treatment of HIV and other STDs. The mission will be accomplished through policy and resource development, clinical data collection and analysis, research, education, prevention programs, disease detection, and the provision of treatment and clinical care services.

H+HS
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SURVEILLANCE BENEFITS FROM BUREAU STAFFING CHANGES

Recent reorganization in the Bureau of Epidemiology and Disease Prevention (BEDP) combines the STD and HIV/AIDS sections into one HIV/STD section. As of June 12, 2000, the two sections were merged and restructured to formally integrate the functions and operations of programs that have worked in tandem for several years. The director of the HIV/STD section is Karl Milhon. Allen Mayer, formerly section director of the STD section, is now deputy director and directly responsible for the activities of the Surveillance Program and Field Operations of the combined section.

The Field Operations Supervisor and Chlamydia Coordinator is Derek Coppedge. In the field, Laurie Sheerin is a new Disease Intervention Specialist in STD region C (Wichita and SE Kansas). In the Surveillance Program Liatris Studer is the Surveillance Program Manager and the HIV/AIDS Epidemiologist is Anthony Merriweather.

What Is Surveillance?

Surveillance: "The ongoing and systematic collection, analysis, and interpretation of health data in the process of describing and monitoring a health event. This information is used for planning, implementing and evaluating public health interventions."

In order to provide better service the Surveillance Program welcomes your suggestions regarding the contents of this Update. Please send them to the address at right c/o "Surveillance Program".

ACKNOWLEDGMENTS

A special thanks to the following persons who contributed to this update: Mindee Reece, Director, TB Section; Karl Milhon, Director, HIV/STD Section; Anthony Merriweather, HIV/AIDS Epidemiologist; Derek Coppedge, Chlamydia Coordinator; Scott Snyder, Teen Pregnancy Coordinator; Gail Hansen, Epidemiology Services; Barb VanCortlandt, Prevention Training; David Tritle, Ryan White Care Services.

Liatris Studer, Editor

HIV/STD Surveillance Update is a semi-annual publication of the Kansas Department of Health and Environment with funding assistance from the Centers for Disease Control and Prevention.

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The Kansas AIDS Ribbon was designed by the Kansas Capitol Area Chapter of the American Red Cross to raise hope and awareness in the state of Kansas and support the fight against HIV/AIDS.

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HIV NAME BASED REPORTING - THE FIRST YEAR

"In the wake of treatment advances, which have slowed the progression from HIV to AIDS for many individuals, data on AIDS cases alone are no longer reflective of new HIV infections." Helene Gayle, M.D., M.P.H.,Director, NCHSTP, CDC, Dec. 9, 1999.

The following pages contain data that have been collected, analyzed, and prepared to meet the needs of those committed to the prevention and treatment of viral and bacterial sexually transmitted disease.

In some aspects this newsletter is similar to updates and reports published in the past. However, with the inclusion of (name based reporting) HIV statistics in Kansas, the HIV/STD Section has reached a significant milestone in HIV surveillance.

"Data that clearly identify the leading edge of the epidemic are urgently needed."
Helene Gayle, MD, MPH

The process began In July, 1999, when statutory HIV name based reporting took effect requiring laboratories and physicians to report positive HIV tests.

In order to accommodate and facilitate HIV name based reporting, a decision was made to increase the surveillance staff to three persons enabling active pursuit and follow up on the diagnosis and reporting of HIV infections. Time and resources now exist to acquire valuable information from laboratories, blood banks, hospitals, medical service providers and vital records databases.

As part of the requirements of the statute, the surveillance program has reassessed confidentiality policies and procedures in the last year. This will be an ongoing process. Name based HIV reporting is successful where confidentiality of results is assured to those who are willing to be tested.

In the STD Program field staff absorbed an increased work load of partner notification activity. As HIV took priority, this came at the expense of other STD activities. The work of the field staff is vital to the section's stated mission (see page one for mission statement).

Name based HIV reporting was enabled by statute and regulation; particularly for reporting CD4+ and viral load levels and diagnosis criteria that allow for advances in testing technology. However, it was the cooperation of the hospitals, physicians and laboratories that made HIV surveillance successful in this first year. The surveillance program will work to maintain the partnership.

Continuum of Care-the Impact of Confidential HIV Reporting

"CDC's policy allows flexibility for states to choose the method of HIV reporting they deem most appropriate for their needs"
Helene Gayle, MD, MPH

Confidential HIV reporting allows insight into the impact that HIV disease is having on our society. With it the Health Department is able to target the resources it has to achieve its goals. The role of the Health Department relative to HIV is to first prevent the spread of disease. The Centers for Disease Control and Prevention estimates that approximately 40,000 people are newly infected with HIV each year. Activities and resulting services are designed to reduce that number in the future and improve public health.

This is done through an integrated group of federal and state

(Continued on page 4)

funded prevention interventions that consist of targeted behavioral science based HIV prevention activities and HIV counseling, testing and disease interventions that include partner counseling and referral services. All activities are based on training that incorporates HIV Prevention Counseling (HPC) tenets designed to identify individuals at risk for HIV and then to provide interactive counseling designed to reduce future risk behaviors.

A result of these activities, and indicative of the success of those activities, is that many individuals, as a first step, will begin to internalize their personal risk for contracting HIV and take the initiative to find out if they are HIV positive.

The next step is for the Health Department to refer positive individuals to care services and attempt to maximize the number of individuals that seek medical and other supportive care services. The dramatic impact of Highly Active Anti-Retroviral Therapy (HAART) on the health of individuals infected with HIV is a strong motivator for seeking care and furthering the prevention elements of the continuum of care.

The third step is to ensure that clinical care and medications are available for individuals that get tested and are found to be positive. Ryan White Care Services provide that safety net and also provides an incentive for at risk individuals to get tested.

The implementation of confidential HIV reporting now allows the Kansas HIV/STD program to know facts that it did not know with AIDS confidential reporting. An example is the fact that 20% (5 of 25) of all the women newly diagnosed and reported with HIV in Kansas in the first year were Hispanic. With AIDS only reporting, the data indicated that no Hispanic women were diagnosed (0 of 14). Since numbers are still small, no firm conclusions can be made. Eventually trends will become evident over time that will allow the HIV/STD Program and its community based partners to better serve the citizens of Kansas.

The data provided in this Surveillance Update can only be gathered in a confidential HIV reporting environment. The following is a summary of HIV/STD program activities and the resulting impact that confidential reporting is having on public health:

HIV Prevention Linked Testing (PLT)

- Publicly funded HIV Prevention targeting high risk behaviors interacted with approximately 15,000 individuals during the period, 30,000 interactions with the general population also occurred.
- 178 individuals were referred to HIV Counseling and Testing Sites from the federal and state funded HIV Prevention Projects.
- Of these individuals 1 was found to be positive for HIV.
- There were 871 documented referrals from various sources other than funded HIV Prevention Projects. The other positive case linked with a referral to testing was referred to testing by an infected partner.

Public HIV Counseling and Testing

- There were 12,727 tests performed in publicly funded HIV counseling and testing sites.
- The percentage confidentially tested was 87%, with 13% anonymously tested.
- There were 20 newly diagnosed cases as a result of this testing.
- Of the 20 cases, 11 have enrolled in Ryan White Care Services, 1 has other public insurance and 7 have no known care resources.

(Continued on page 5)

- Of the 99 newly diagnosed and reported cases of HIV, 26% were found through publicly funded counseling and testing activities with 3 found in Sexually Transmitted Disease Clinics, 20 found through counseling and testing sites and 3 found in correctional settings.

Partner Counseling and Referral Services (PCRS)

- Disease Intervention Specialists performed 103 partner counseling interviews. From this activity they were able to test 139 partners. 24 of these had previous testing but 115 (83%) had never been tested before.
- From the 139 tests, 11 (8%) newly diagnosed HIV cases were discovered as a result of this activity.
- Of the 11 newly diagnosed cases found as a result of PCRS, 6 (54%) were successfully referred to Ryan White Care Services, 3 (27%) had other medical insurance coverage and 2 (18%) presently do not have any coverage.

Referral to Care Services

- Of the 99 newly diagnosed and reported cases, 47 (47%) were enrolled in Ryan White Care Services including Ryan White Title I in Kansas City, Kansas, and Ryan White Title II and Ryan White Title III services at the Kansas University Medical Center in Wichita.
- 5 (5%) individuals are in Medicaid.
- 3 (3%) are enrolled in clinical trials for HIV medications.
- 10 (10%) have private insurance.
- 4 (4%) have no coverage.
- 30 (30%) are unknown as to their coverage.

The activities reflected in the data summarize the impact that the Health Department is having on HIV disease in Kansas. The complete first year progress report, "Reported HIV Infections in Kansas Between 07/01/1999 and 06/30/2000", is the source of these data and can be obtained from our office or from our website at: www.kdhe.state.ks.us/hiv-std.

HITS SURVEY

In collaboration with CDC, the surveillance program is conducting a limited, anonymous, HIV Testing Survey (HITS) among at-risk populations. Its purpose is to assess knowledge of state policies regarding testing and counseling; barriers for HIV testing; gaps in outreach, testing, prevention and treatment programs; and information on sex and drug using behaviors.

The study population consists of men who have sex with men, injection drug users, and high risk heterosexuals. The surveys are conducted at gay bars, street sites, and STD clinics located in Wichita and Kansas City. Each interview lasts about 30-45 minutes and the interviewee is given $20 for participating.

Dr. Farrell Webb of Kansas State University is the Primary Investigator for the survey. Surveying began July 7th and will be completed by December 31, 2000. 190 surveys have been completed as of August 21, 2000.

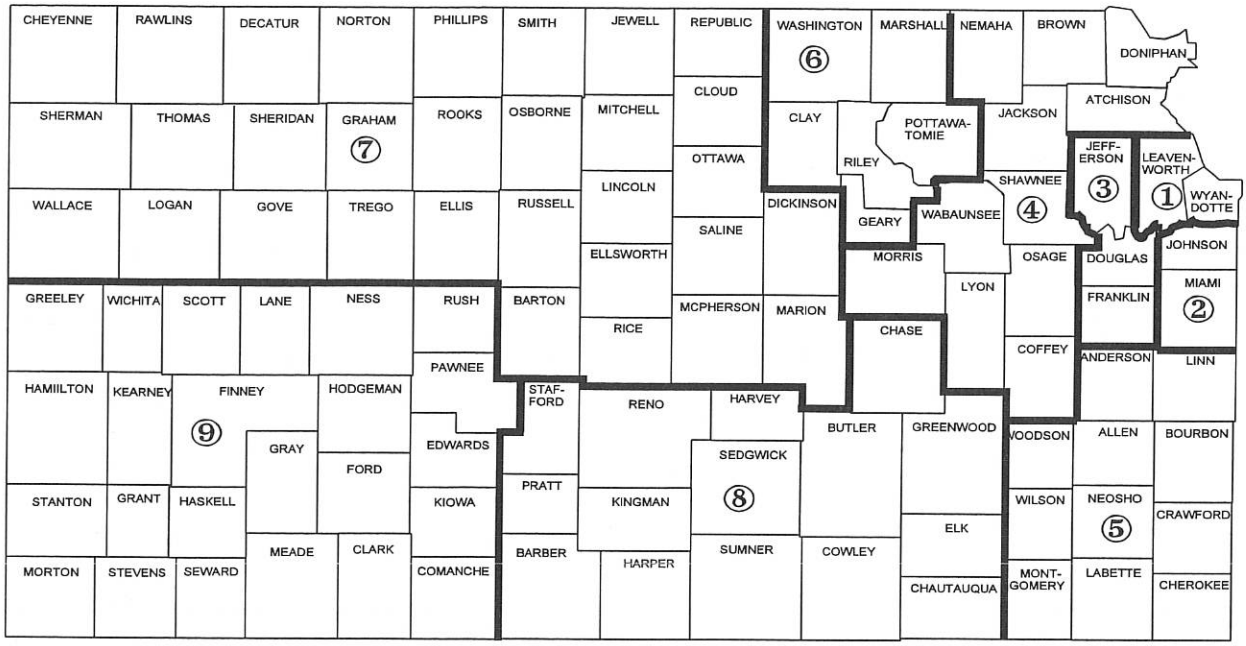
Teen Pregnancy Statistics

Statistics from the Bureau of Children, Youth & Families, KDHE, show decreasing teen pregnancy rates for all age groups in Kansas. Rates are stated as pregnancies per 1,000 women.

The rate for ages 10-14 was 1.3 in 1994, rose to 1.6 in 1995 and then fell to 1.1 in 1998, a decrease of 18.8%. The rate for ages 15-17 fell from 42.6 in 1993 to 33.8 in 1998, a decrease of 20.7%. The rate for ages 15-19 declined from 71.9 in 1994 to 62.0 in 1998, a decrease of 15.4%.

Nationally a new report, "Youth and HIV/AIDS 2000: A New American Agenda", states that HIV infection rates remain steady despite declining risky behavior. The report is available at: www.whitehouse.gov/ONAP.

Kansas Community Planning Regions

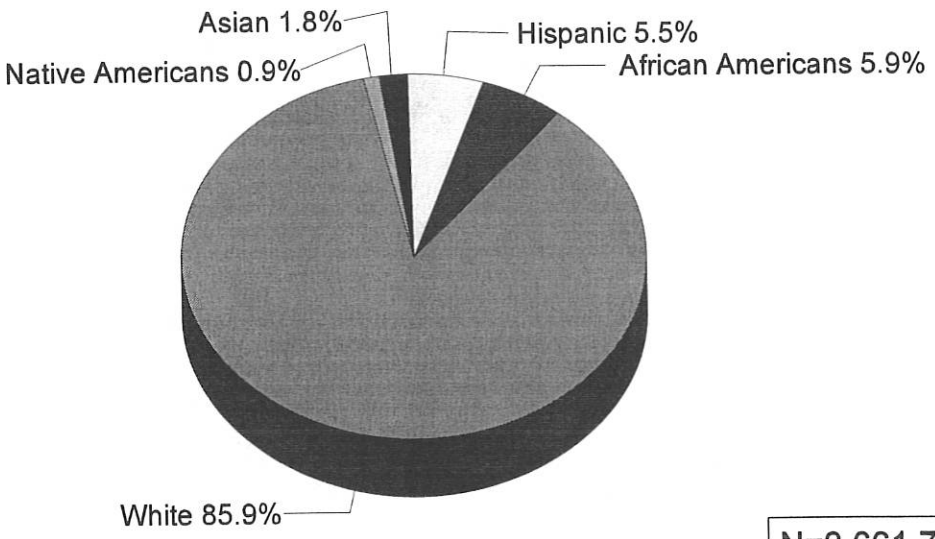


Kansas HIV/AIDS Cases by Community Planning Region
Reported 1981 - June 30, 2000

Region	Newly Diagnosed HIV Cases Reported[1] July 1999- June 2000	Newly Diagnosed AIDS Cases Reported[1] July 1999 - June 2000	Prevalent[2] HIV & AIDS Cases as of June 30, 2000	Cumulative[3] AIDS Cases as of June 30, 2000
1	20	16	246	449
2	8	14	170	389
3	0	2	49	100
4	15	10	101	225
9	3	2	23	106
6	6	5	27	76
7	3	3	37	72
8	39	43	428	783
9	5	1	30	61
Total	**99**	**96**	**1111**	**2261**

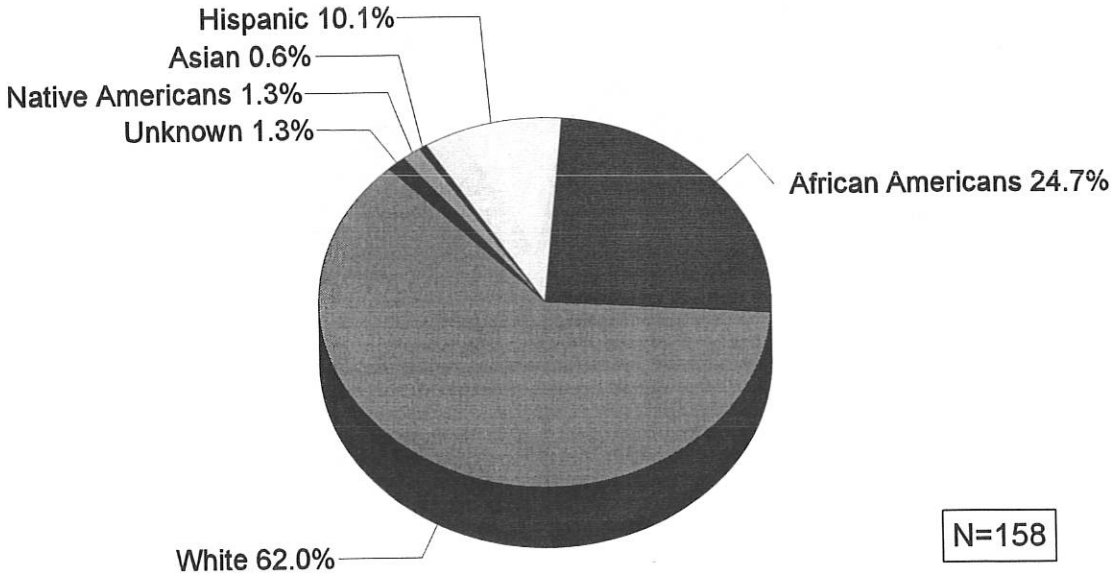
1. Reported or incident cases are the number of cases meeting CDC criteria for reporting in the given time frame.
2. Prevalent cases are those cases presumed still living in Kansas on the indicated date.
3. Cumulative cases are the accumulated total of all reported cases.

Kansas Population 1998 U.S. Census



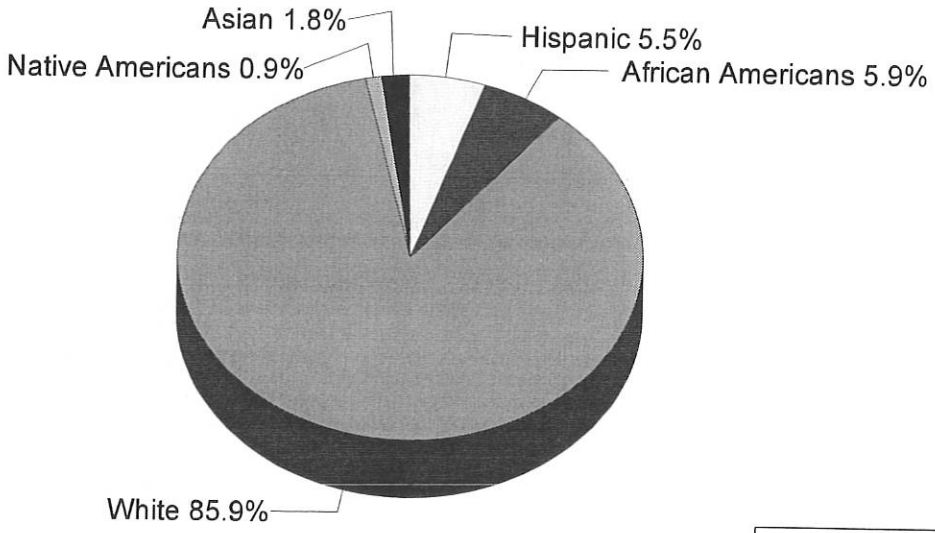
N=2,661,748

Reported Kansas AIDS Cases by Race/Ethnicity July 1999 - June 2000



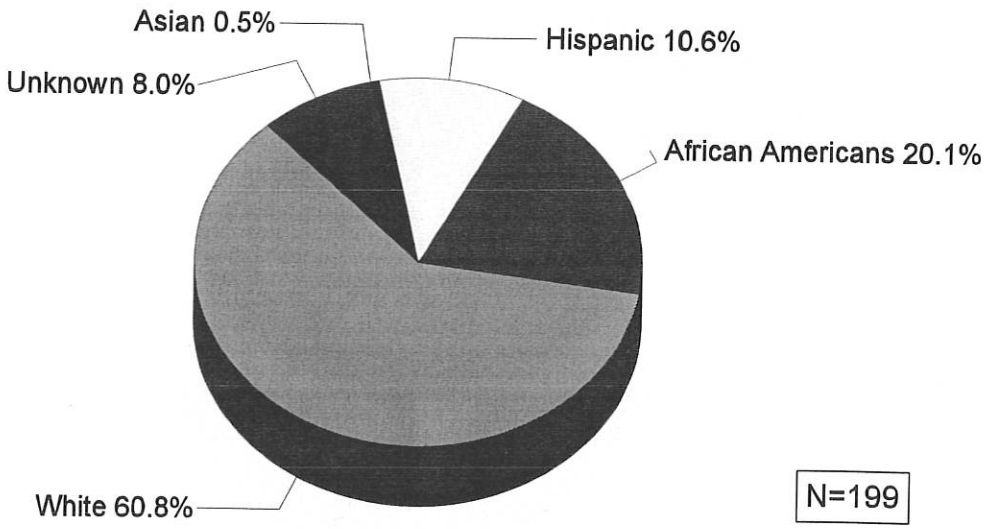
N=158

Kansas Population 1998 U.S. Census



N=2,661,748

Reported Kansas HIV Cases by Race/Ethnicity July 1999 - June 2000



N=199

AIDS Reported[1] and Prevalent[2] Cases, Kansas

Race/Ethnicity	Reported AIDS Cases July 99 - Dec 99	Reported AIDS Cases Jan 00 - Jun 00	Reported AIDS Cases July 99 - Jun 00	Prevalent AIDS Cases as of Jun 00	Percent of Population
White	53 (66%)	46 (59%)	99 (63%)	636 (70%)	86%
African American	18 (23%)	20 (26%)	38 (24%)	185 (20%)	6%
Hispanic	7 (9%)	9 (12%)	16 (10%)	77 (8%)	5%
Asian	1 (1%)	0	1 (<1%)	4 (<1%)	2%
Native American	1 (1%)	1 (1%)	2 (1%)	11 (1%)	1%
Unknown	0	2 (3%)	2 (1%)	1 (<1%)	
Total	80 (100%)	78 (100%)	158 (100%)	915 (100%)	100%

Cumulative[3] HIV[4] AND AIDS Cases, United States and Kansas

U.S. Race/Ethnicity	U.S. Percent of U.S. Population	U.S. Cumulative HIV Cases as of December 99	U.S. Cumulative AIDS Cases as of December 99	KS. Cumulative HIV Cases as of Jun 00	KS. Cumulative AIDS Cases as of Jun 00	KS. Percent of KS. Population
White	(72%)	46,277 (38%)	318,354 (43%)	121 (61%)	1711 (76%)	86%
African American	(13%)	64,299 (52%)	272,881 (37%)	40 (19%)	384 (17%)	6%
Hispanic	(12%)	9,296 (8%)	133,703 (18%)	21 (10%)	133 (6%)	5%
Asian	(4%)	422 (<1%)	5,347 (0.7%)	1 (<1%)	9 (<1%)	2%
Native American	(1%)	742 (<1%)	2,132 (0.3%)	0	2 (<1%)	1%
Other /Unk		1,237 (1%)	957	16 (9%)	22 (1%)	0%
Total	(100%)	122,607 (100%)	733,374 (100%)	199 (100%)	2261 (100%)	100%

HIV Reported[1] and Prevalent[2] Cases, Kansas

Race/Ethnicity	Reported HIV Cases July 1, 99 - Dec. 31, 99	Reported HIV Cases Jan.1, 00 - June 30, 00	Reported HIV Cases July 1, 99 - June 30, 00	Prevalent HIV Cases as of Jun 00	Percent of Population
White	47 (59%)	74 (62%)	121 (61%)	119 (62%)	86%
African American	19 (24%)	21 (18%)	40 (19%)	40 (19%)	6%
Hispanic	10 (12%)	11 (9%)	21 (10%)	20 (9%)	5%
Asian	0	1 (1%)	1 (<1%)	1 (<1%)	2%
Native American	0	0	0	0	1%
Unknown	4 (5%)	12 (10%)	16 (9%)	16 (9%)	
Total	80 (100%)	119 (100%)	199 (100%)	196 (100%)	100%

Percentages may not add up to 100% due to rounding. All Kansas data are as of September 26, 2000.

1. Reported or incident cases are the number of cases meeting CDC criteria for reporting in the given time frame.
2. Prevalent cases are those cases presumed living in Kansas on the indicated date.
3. Cumulative cases are the accumulated total of all reported cases.
4. From 34 areas with confidential HIV infection reporting.

AIDS Cases by exposure category, and sex reported[1] through June 2000, in Kansas

Adult/adolescent exposure category	MALE Prevalence[2] Total No. (%)	MALE Cumulative[3] Total No. (%)	FEMALE Prevalence Total No. (%)	FEMALE Cumulative Total No. (%)	Total Prevalence Total No. (%)	Total Cumulative Total No. (%)
Men who have sex with men	547 (69)	1464 (72)	-	-	547 (60)	1464 (65)
Injecting Drug Use	67 (8)	151 (7)	25 (22)	55 (26)	92 (10)	206 (9)
Men who have sex with men and inject drugs	85 (11)	205 (10)	-	-	85 (10)	205 (9)
Hemophilia/Coagulation disorder	9 (1)	40 (2)	1 (1)	1 (1)	10 (1)	41 (2)
Heterosexual contact (Total)	45 (6)	74 (4)	82 (71)	128 (60)	127 (14)	202 (9)
Sex with injecting drug user	*4*	*10*	*17*	*35*	*21*	*45*
Sex with other high risk partner	*1*	*3*	*14*	*28*	*15*	*31*
Sex w/HIV infected person risk not specified	*40*	*61*	*51*	*65*	*91*	*126*
Receipt of blood,blood components, or tissue	7 (1)	30 (1)	3 (3)	17 (8)	10 (1)	47 (2)
Risk not reported/other	31 (4)	67 (3)	5 (4)	12 (6)	35 (4)	73 (3)
Adult /adolescent Total	790 (100)	2030 (100)	116 (100)	213 (100)	906 (100)	2243 (100)
Pediatric (<13 years old)					9	18
		Total Cases			915	2261

HIV Cases by exposure category, and sex reported[1], July 1, 1999 - June 30, 2000, in Kansas

Adult/adolescent exposure category	MALE Prevalence Total No. (%)	MALE Cumulative Total No. (%)	FEMALE Prevalence Total No. (%)	FEMALE Cumulative Total No. (%)	Total Prevalence Total No. (%)	Total Cumulative Total No. (%)
Men who have sex with men	80 (53)	81 (52)	-	-	80 (42)	81 (41)
Injecting Drug Use	18 (11)	19 (12)	9 (23)	9 (23)	27 (13)	28 (14)
Men who have sex with men and inject drugs	13 (8)	13 (8)	-	-	13 (7)	13 (7)
Hemophilia/Coagulation disorder	0 (0)	0	0 (0)	0	0 (0)	0 (0)
Heterosexual contact	10 (6)	10 (6)	22 (56)	22 (50)	32 (15)	32 (15)
Sex with injecting drug user	*0*	*0*	*2*	*2*	*2*	*2*
Sex with other high risk partner	*0*	*0*	*2*	*2*	*2*	*2*
Sex w/HIV infected person risk not specified	*10*	*10*	*18*	*18*	*28*	*28*
Receipt of blood,blood components, or tissue	3 (2)	3 (2)	0	0	3 (2)	3 (2)
Risk not reported/other	29 (19)	30 (19)	8 (21)	8 (21)	37 (21)	38 1921)
Adult /adolescent Total	153 (100)	156 (100)	39 (100)	39 (100)	192 (100)	195 (100)
Pediatric (<13 years old)					4	4
		Total Cases			196	199

Percentages may not add up to 100% due to rounding. All Kansas data are as of September 26, 2000.

1. Reported or incident cases are the number of cases meeting CDC criteria for reporting in the given time frame.
2. Prevalent cases are those cases presumed living in Kansas on the indicated date.
3. Cumulative cases are the accumulated total of all reported cases.

STD STATISTICS FOR KANSAS
Jan.-July 2000

Chlamydia continues to be the most frequently reported STD in the state, with 88 of 105 counties reporting at least one case during the first half of 2000. Chlamydia is the leading cause of pelvic inflammatory disease, infertility and ectopic pregnancy. 3,023 cases of chlamydia were reported during the first half of 2000. This represents a 3% decrease compared to the same time period of 1999.

The number of reported gonorrhea cases are increasing. There were 1,310 cases reported which is a 3% increase compared to the same period last year. Studies show that gonorrhea, chlamydia and other non-ulcerative STDs can increase the risk of HIV transmission at least two to five fold. Non-ulcerative infections are more endemic in Kansas than ulcerative genital diseases.

Reported cases of early syphilis (less than one year's duration) have been declining since 1991. During the last six months, a total of 10 infections were reported, a 20% (2 case) decrease compared to the same time period in 1999.

Join the HIV/STD Staff for their presentation of "Exploring Partner Counseling and Referral Services and Viral STDs Bridging Theory and Practice". Coming to your area this fall. Hoxie 10/25; Beloit 10/26; Atchison 11/6; and Pittsburg 11/09.

HIV-TUBERCULOSIS CO-INFECTION

In 1944 the Federal Tuberculosis Program was created to provide guidance on TB control measures brought about by the advent of antibiotics. Drug therapies developed in the late 40's, early 50's, and 1971 brought a steady decline in both death and case rates for infection by *Mycobacterium tuberculosis* (TB). This downward trend continued until 1981 when the emergence of HIV created a significant population of immune system compromised, at-risk individuals. In 1987 extra-pulmonary TB disease became an AIDS defining infection for those who are HIV positive and in 1993 pulmonary TB was added.

It is possible to be infected with TB and not manifest active TB disease just as it is possible to be HIV positive without having symptoms of the active disease or an AIDS diagnosis. In Kansas, HIV infection, AIDS, and active TB are reportable diseases. The state case rate is approximately 6 per 100,000 population for AIDS (127 new cases in 1999); and, for active TB disease, approximately 3 per 100,000 (69 new cases in 1999). Since 1994 there have been 23 documented HIV/TB co-infections. Drug regimens are expensive, require high compliance, and drug resistant strains are a serious problem for both diseases. The susceptibility of HIV positive individuals to infection with *M. tuberculosis* and the complications of treating co-infections are matters of concern.

A recent study (MMWR, Aug.4, 2000) showed that few people exposed to active TB are assessed for HIV status and that 25% of those known to be HIV+ are not screened completely for TB. All HIV positive individuals should be screened for TB and those exposed to active TB should receive post exposure prophylactic treatment. The goal of the TB program is to assess at least 75% of all newly reported TB cases between the ages of 25-44 for possible HIV co-infection. Active TB disease is considered a presumptive risk category for HIV testing and all persons with active TB should be tested for HIV. Those having only a positive skin test should have some other risk factor indicated as a basis for HIV testing. HIV positivity or AIDS can also affect interpretation of TB screening tests. It is important that clients share a complete medical history with their care providers to help identify or rule out the potential for false negative results.

HIV/TB Treatment and Drug Interactions

Nucleoside Reverse Transcriptase Inhibitors and Protease Inhibitors used to treat HIV infections have substantive interactions with some of the Rifamycins utilized to treat *mycobacteria* infections. Treatment guidelines can be found in MMWR October 30, 1998, Vol. 47 No. RR-20.

Those wishing more information regarding the diagnosis or treatment of Tuberculosis can contact the TB Section, Bureau of Epidemiology and Disease Prevention, KDHE, at 785-296-5589.

KANSAS INFERTILITY PREVENTION PROJECT

The Kansas Infertility Prevention Project (KIPP) is a collaborative effort between Family Planning and STD Programs in the four states that make up Region VII (Kansas, Nebraska, Missouri, and Iowa) that focuses on the prevention and early treatment of chlamydial infections. We would like to supply relevant useful information to our screening sites concerning STDs other than chlamydia and gonorrhea. For more information contact Derek Coppedge at 785-296-6177

HEPATITIS

Viral hepatitis is a disorder in which viruses produce inflammation in liver cells. Viral hepatitis varies in severity from a self limiting condition and total recovery to a life-threatening or life-long disease and can be either acute or chronic. Acute hepatitis can begin suddenly or gradually, but it has a limited course and rarely lasts beyond one or two months. There is no chronic form of Hepatitis A, however chronic hepatitis B and C can persist for prolonged periods. All forms of Hepatitis are a reported disease in Kansas.

Who Gets Viral Hepatitis

Although there are at least 6 types of viral hepatitis (A, B, C, D, E, and G), hepatitis B and C are most often associated with risk factors for HIV infection. Hepatitis B is found in semen, blood, and saliva. It is spread through blood transfusions, contaminated needles, and sexual contact. Hepatitis B infects more than 200,000 people in the United States each year. Hepatitis C is spread through blood and contaminated needles and is the most common type of hepatitis in the United States. Hepatitis C can be spread through sexual contact though this is rarer than with Hepatitis B. Approximately 30% of the estimated 1 million persons infected with HIV are also co-infected with Hepatitis C.

Symptoms of Hepatitis

Symptoms of acute viral hepatitis may begin suddenly or develop gradually and may be so mild that patients mistake it for flu. Nearly all patients experience some fatigue and mild fever. Gastrointestinal (GI) problems are very common, including nausea and vomiting and a general feeling of discomfort in the abdomen or sharp pain in the area of the liver. This pain tends to increase during jerking movements, such as climbing stairs or riding on a bumpy road. GI problems can lead to loss of appetite, weight loss, and dehydration. After about two weeks, dark urine and jaundice (yellowing of the skin and eyes by bile pigments) develop in some, but not all, patients. Children tend not to develop jaundice nor do 75% of those infected with hepatitis C or 25-40% of those infected with hepatitis B .

Treating Viral Hepatitis

For mild cases of acute hepatitis, no drug therapy or other treatment is necessary or helpful. Hospitalization may be needed for people at high risk for complications, such as those with compromised immune systems. At the onset of hepatitis, periodic visits to the physician may be necessary.

The goals for treating all forms of chronic hepatitis are to relieve symptoms, prevent development of cirrhosis, reduce viral levels, and improve survival. Hepatitis C can be treated with interferon (INF) or a combination of INF and Ribavirin. Only about 15% of HIV/HCV co-infected patients achieve a sustained response to a standard course of INF monotherapy. Experience with Ribavirin is limited and drug-drug reactions with some medications used for treating HIV are possible.

Vaccines and Preventative Measures

Avoiding exposure and preventing transmission are the most important factors in preventing hepatitis. Most exposures are prevented by protected sexual contact, not sharing any blood or body fluids and using sterile syringes for intravenous drugs. HIV positive persons should be screened for hepatitis A, B, and C. Several vaccines are available for hepatitis A and B. Persons with chronic Hepatitis C are encouraged to be vaccinated if they have not been exposed to hepatitis A or B.

Further information regarding the prevention and treatment of Hepatitis can be found online at http://www.cdc.gov/ncidod/diseases/ hepatitis/index.

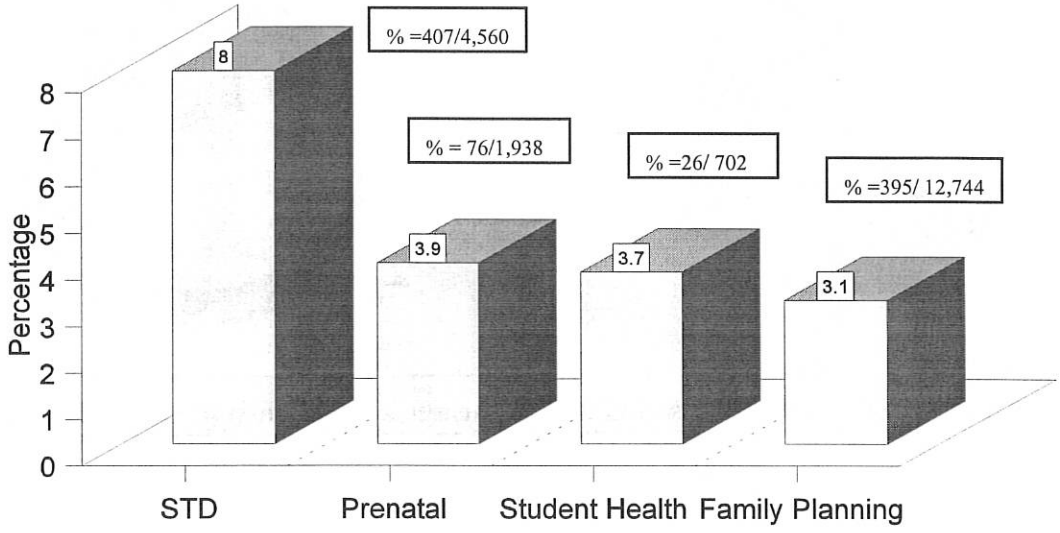
4-12

Kansas Infertility Prevention Project

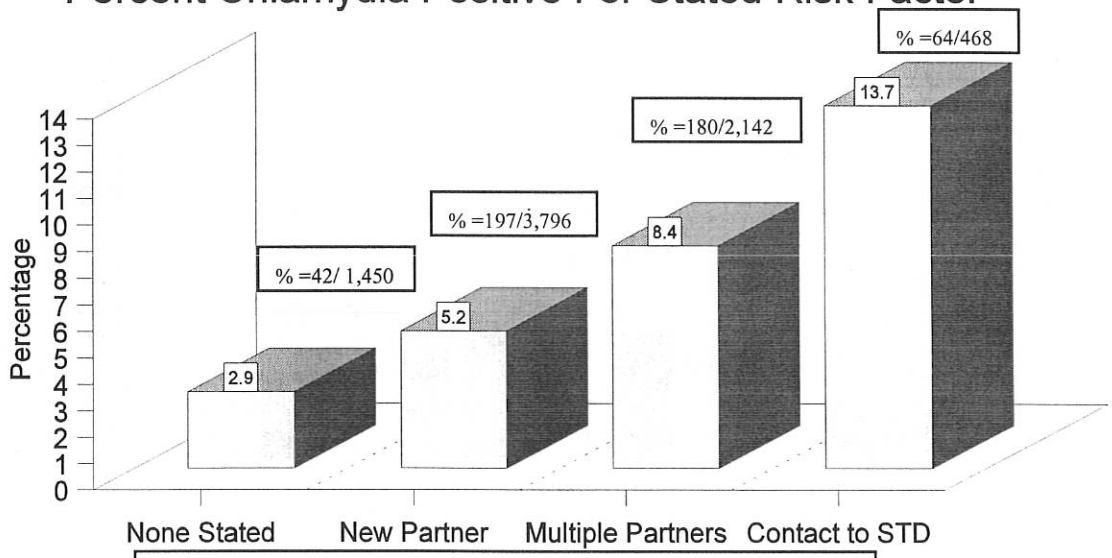
January 1,2000 through June 30, 2000

KIPP Sites Screened 19,944 Patients: 904(4.5%) Were Positive for Chlamydia by Gen Probe

Percent Chlamydia Positive By Clinic Type



Percent Chlamydia Positive For Stated Risk Factor



7,856 specimens indicated these risk factors. 483 were positive.

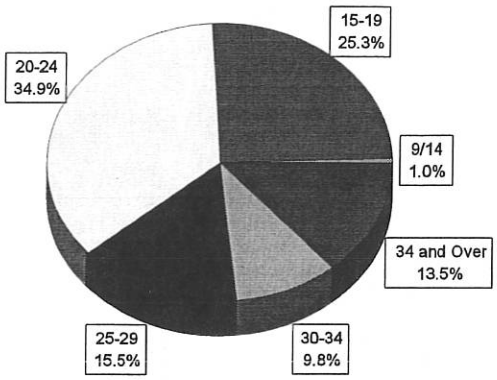
Positivity is highest in STD clinics and contacts to STDs.
This is consistent with screenings across CDC Family Planning Region VII which includes Kansas, Missouri, Iowa, and Nebraska.

4-13

Positive for Chlamydia by Gen Probe

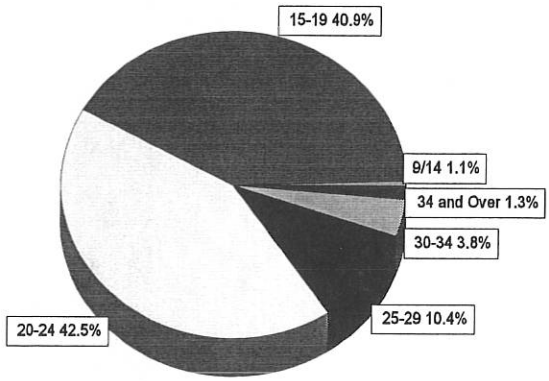
Total Tests By Age Group

n= 19,944



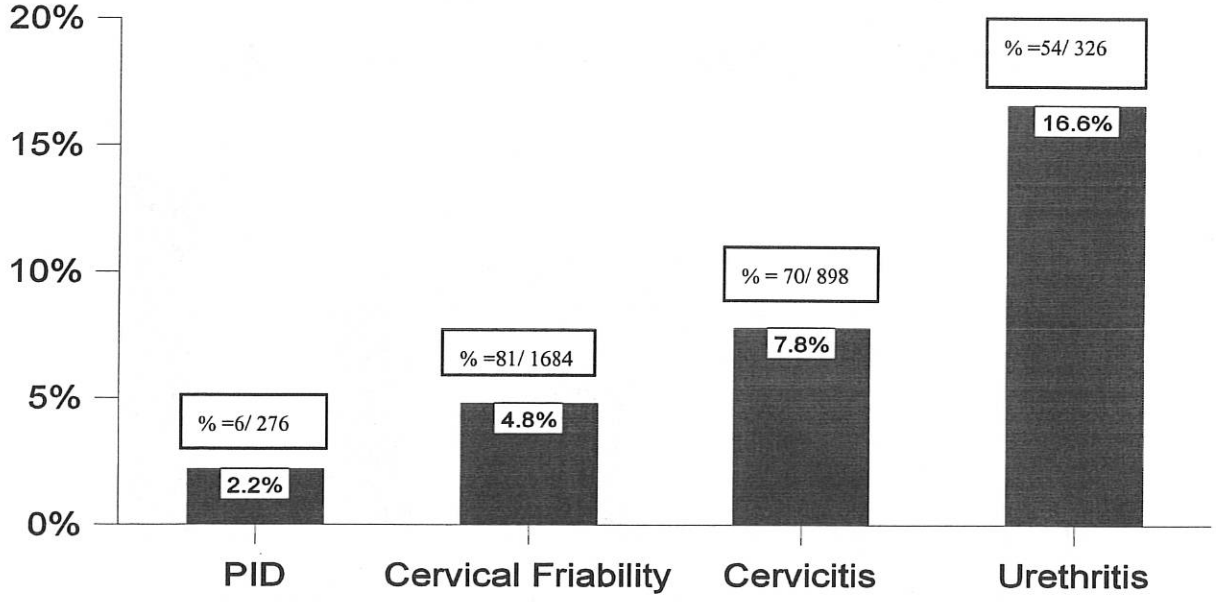
Percent Positives by Age Group

n = 904 positives



Chlamydia screenings are directed at the age groups most at risk in Kansas.

Chlamydia Test Results By Clinical Signs



3184 specimens indicated clinical signs. 211 were positive.

Urethritis is the best indicator of a chlamydial infection.

4-14

01 HIV/STD PREVENTION TRAINING*

WHO SHOULD ATTEND?

HIV Counseling and Testing Site contractors must successfully complete Courses 1 & 2 prior to counseling clients. **Health Education/ Risk Reduction contractors and Ryan White Title II Case Managers** must successfully complete Courses 1, 2, 4 or 6, and 5 during their first year of employment. Contractors are encouraged to attend the culturally-specific Course 6 Fundamentals instead of Course 4 if they are serving specific populations of color. **All Contractors** must attend Course 7. **Other**: nurses, other health care providers, social workers, teachers, counselors, community educators and other interested persons working with individuals or groups of persons at risk of HIV/STD infection are invited to attend.
Registration fees may be waived for HIV-infected persons; contact KDHE at (785) 296-6174. **Continuing Education (CE) hours**: Nursing CE's ($20 per course); KADACA CE's ($15 per course).
For More Information: Contact KDHE at (785) 296-6174 for additional information. Brochures will be sent to all contractors approximately October, 2000.

1. HIV/STD Basic Training - $15 Topics include: current transmission/prevention issues, including human sexuality; drug use; statistics; attitudes and terminology related to risk behaviors; and basic psycho-social needs of infected persons. Includes American Red Cross HIV Starter Facts certification. **Sessions are Tuesdays from 8:00 a.m. to 5:00 p.m. January 9 in Topeka, May 8 in Wichita, September 11 in Kansas City, and November 6 in Salina.**

2. Behavior Change Counseling Strategies for HIV/STD Prevention - $15 *Must have satisfactorily completed Course 1.* Topics include: behavior change counseling concepts and skills; assisting clients in reducing risks of acquiring or transmitting HIV/STD's; helping clients improve perception of risk; negotiating realistic and incremental plans for clients to reduce risk; helping clients integrate test results emotionally, behaviorally, and socially; and referrals/ resources. **Sessions are Wednesdays 8:00 a.m. to 5:00 p.m. January 10 in Topeka, May 9 in Wichita, September 12 in Kansas City, and November 7 in Salina.**

3. STD Clinical Training - $15 Offered for health care providers who will be diagnosing STDs. *Must have satisfactorily completed Courses 1 & 2.* Topics include: presentation of patients; routine history and examination; guidelines for STD specimen collection; management, treatment, and follow-up of patients; and partner counseling. **Sessions are Thursdays from 8:00 a.m. to 5:00 p.m. on January 11 in Topeka, May 10 in Wichita, September 13 in Kansas City, and November 8 in Salina.**

4. Basic HIV Program: Fundamentals - $20 *Must have satisfactorily completed Course 1.* Includes American Red Cross Facts Practice and Instructor Candidate Training certification. Topics include: sharing facts about HIV/AIDS accurately, nonjudgmentally, and sensitively with people from diverse groups and communities; discussing facts related to sensitive issues like sex/sexuality and drugs/drug use; encouraging people to apply facts about HIV/AIDS to their own behavior; practicing using Modules 1 & 2 for working with community groups; assessing group ne planning education sessions; facilitating interactive sessions; and making referrals to community resou **Sessions are Tuesday 1:00 - 5:00 p.m., Wednesd 8:00 a.m. - 5:00 p.m., and Thursday 8:00 a.m. to 12:00 p.m.: February 13-15 in Topeka, June 12-14 in Wichita, and October 16-18 in Kansas City.**

5. Basic HIV Program: Prevention Skills - $20 *Satisfactory completion of Courses 1 and 4 are required before attending.* Topics include: facilitating skill-building activities related to HIV prevention behavior in a factually accurate, culturally sensitive, and nonjudgmental manner; understanding the content and format of activities in Modules 3 and 4; and identifying ways to use activities with persons age 17 and older. **Sessions are Wednesdays and Thursdays from 8:00 a.m. to 5:00 p.m. on April 11-12 in Topeka, August 8-9 in Wichita, and December 12-13 in Kansas City.**

6. Basic HIV Program: Fundamentals for Persons of Color - Free of Charge. *Must have satisfactorily completed Course 1.* At least 50% of course participants must be members of the population for which the course was designed. Participants need not be persons of color to attend, but community classes taught after certification must be co-facilitated with a trainer of color who is currently certified in the course being taught. **African American, Hispanic, and Native American** courses are available. Topics include: awareness of the culture and psycho-social issues involved in the African American, Hispanic, or Native American response to AIDS; basic factual information in a culturally sensitive manner; ways to incorporate cultural elements into HIV prevention; how to answer questions about HIV and AIDS in a culturally sensitive and age appropriate manner; and challenges people of color face in prevention. Courses are taught in a comfortable, safe, fun, and culturally sensitive environment with African American, Hispanic, or Native American instructors. African American and Hispanic courses **are 8:00 a.m. to 5:00 p.m. Tuesday, Wednesday, and Thursday. Native American courses are 1:00 p.m. to 5:00 p.m. Tuesday, 8:00 a.m. to 5:00 p.m. Wednesday, and 8:00 a.m. to mid-afternoon Thursday.**

African American
January 23-25, Junction City; September 25-27, Wichita

Hispanic
May 15-17, Great Bend; November 27-29, Wichita

Native American
March 20-22, Kansas City; July 24-26, Wichita

7. 2001 UPDATE - Plans are to convene all Prevention and CARE contractors the afternoon of **Wednesday, April 25, and end after lunch on Thursday, April 26.** Plans include an evening information-sharing session and a screening of the movie "Shades of Gray." Meals and some travel and lodging assistance will be provided for KDHE contractors. More information will be sent to contractors as it is developed.

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***PLEASE NOTE:** All proposed 2001training information is subject to change. 9/00

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2001 HIV/STD PREVENTION TRAINING SCHEDULE

(Call (785) 296-6174 for training brochures. Actual dates and locations to be confirmed by 11/00.)

Month	1. HIV/STD Basic Training Tuesday	2. Behavior Change Counseling Strategies for HIV/STD Prevention Wednesday	3. STD Clinical Training Thursday	4. Basic HIV Program: Fundamentals Tues-Thurs	5. Basic HIV Program: Prevention Skills Wed-Thurs	6. Basic HIV Program: Fundamentals for Persons of Color Tues-Thurs	7. 2001 Update Wed-Thurs
January	1/9/01 Topeka	1/10/01 Topeka	1/11/01 Topeka			African American 1/23-25/01 Junction City	
February				2/13-15/01 Topeka			
March						Native American 3/20-22/01 Lawrence	
April					4/11-12/01 Topeka		4/25-26/01 Wichita
May	5/8/01 Wichita	5/9/01 Wichita	5/10/01 Wichita			Hispanic 5/15-17/01 Great Bend	
June				6/12-14/01 Wichita			
July						Native American 7/24-26/01 Wichita	
August					8/8-9/01 Wichita		
September	9/11/01 Kansas City	9/12/01 Kansas City	9/13/01 Kansas City			African American 9/25-27/01 Wichita	
October				10/16-18/01 Kansas City			
November	11/6/01 Salina	11/07/01 Salina	11/8/01 Salina			Hispanic 11/27-29/01 Wichita	
December					12/12-13/01 Kansas City		

LEASE NOTE: All proposed 2001 training information is currently subject to change. 9/00

VOL.1, #2 OCTOBER 2000

HIV/STD UPDATE

Kansas Ryan White Title II C.A.R.E. Program

- Providing care services to those living with HIV and AIDS in the State of Kansas -

Ryan White Case Management has been an integral part of the care services program since its inception. Its purpose is to recognize and build upon the diverse approaches taken in case management throughout Kansas, while at the same time ensuring that persons living with HIV/AIDS in this state receive the level of case management services necessary to effectively respond to their needs. Through a collaborative effort, providers and policy makers came together to develop and refine the principles and standards of service. The outcome of this collaborative effort was "The Case Management Standards of Care." Since January 1, 2000, all Ryan White Title II Case Managers have worked under the guidance of "The Case Management Standards of Care" designed to live and change with the needs of clients and providers alike.

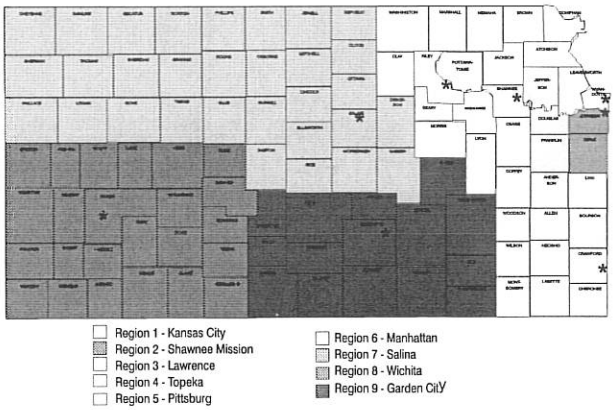
A STATEMENT of PRINCIPLES for CASE MANAGEMENT

Workgroups of people living with HIV/AIDS and Ryan White Title II Case Managers of Kansas prepared the seven statements of principles or "rights and responsibilities" for the consideration and guidance of providers of case management services. These statements serve as an outline of the kind of expectations held by people living with HIV/AIDS and therefore represent an invaluable resource to providers as they seek to center their services around the needs of their clients.

Noted below is contact information on the Ryan White Title II Case Management Sites throughout the state.

If you would like more information regarding Ryan White Title II Case Management or the Ryan White Title II C.A.R.E. Program, call the program offices at 785- 296-8891 or 316 687-9273.

HIV REGIONS in KANSAS



Ryan White Title II Case Management Sites:

Region 3: DCAP (Lawrence) Marilee Janssen 785-843-0040
Region 4: Sojourn (Topeka) Melba Sutton 785-233-5500
TAP (Topeka) Ludy Sapp-Keitzman 785-232-3100
Region 5: ARNOSK (Pittsburg) Deena Ulmer 800-738-AIDS
Region 6: Manhattan-Riley County Health Department (Manhattan) Stacey Broughman 785-776-4779
Region 7: Salina-Saline County Health Department (Salina) Marvena Wilson 785- 826-6600
Region 8: ConnectCare (Wichita) Lori Brewer, Teresa Romey, Randy Whisnant, Sue Lamar 316-265-9468
University of Kansas Medical Practice Assn (Wichita) Jan Danitschek, Angie Martinez 316-293-2617
Region 9: United Methodist Mexican-American Ministries (Garden City) Tina Hahn 316-275-1766

Kansas Ryan White Title II C.A.R.E. Program Statistics:

Effective April 1, 2000, the program has enrolled 51 new Kansans living with HIV and AIDS totaling 581 eligible clients enrolled in Title II Services. Of those eligible for Title II services, 328 have accessed care services since April 1, 2000. 277 have accessed the AIDS Drug Assistance Program (ADAP) since April 1, 2000. Listed below are the statistics of those clients currently eligible for C.A.R.E. Program services as of August 7, 2000:

Race:	109 (21%)	African-Amer.	Age:	17 (3.28%)	<26	Services Accessed:	277 (54%)	ADAP
	38 (7.3%)	Hispanic		158 (30.51%)	26 - 35		66 (13%)	Primary Care
	359 (69.3%)	Caucasian		233 (44.98%)	36 - 45		69 (13%)	Dental Care
	3 (0.6%)	Asian-Pacific Islander		110 (21.23%)	>45		27 (5%)	Mental Health
	7 (1.4%)	Amer. Indian/Native Amer.		Gender:	425 (82%) Male		2 (0.4%)	Home Health
	2 (0.4%)	Other			93 (18%) Female		19 (4%)	Insurance Cont.

Regional Breakdown:

36 (6.9%) Region 1	36 (6.9%) Region 2	24 (4.6%) Region 3	61 (11.8%) Region 4	24 (4.6%) Region 5
23 (4.4%) Region 6	32 (6.2%) Region 7	255 (49.2%) Region 8	27 (5.2%) Region 9	

4-17

Calendar:

Join the HIV/STD Staff for their presentation of "Exploring Partner Counseling and Referral Services (PCRS) and Viral STDs Bridging Theory and Practice". See below for dates and location.

KANSAS AIDS NETWORKING PROJECT, Proposed Future Meeting Dates: Tuesday, December 12, 2000, Wichita; Thursday, March 8, 2001, Topeka; Thursday, June 21, 2001, Hutchinson; Thursday, September 20, 2001, Lawrence; Thursday, December 6, 2001, Wichita.

October 25, 2000: "Exploring PCRS and Viral STDs Bridging Theory and Practice", Hoxie
October 25-26, 2000: HIV Prevention Counseling Training, Lawrence
October 26, 2000: "Exploring PCRS and Viral STDs Bridging Theory and Practice", Beloit
November 1, 2000: CPG Teleconference Meeting
November 6, 2000: "Exploring PCRS and Viral STDs Bridging Theory and Practice", Atchison
November 9, 2000: "Exploring PCRS and Viral STDs Bridging Theory and Practice", Pittsburg
November 12-16, 2000: American Public Health Association Annual Meeting: Boston, Ma.
November 14-16, 2000: Basic HIV Program: "Fundamentals Training", Pittsburgh
December 1, 2000: World AIDS Day "AIDS: All Men-Make a Difference!"
December 12, 2000: KANP, Wichita
December 13-14, 2000: Basic HIV Program: "Prevention Skills", Wichita
January 10, 2001: CPG Meeting, Topeka

Kansas Department of Health & Environment
HIV/STD Section
109 SW 9th Street, Suite 605
Topeka, KS 66612-1271

PRESORTED STANDARD
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4-18

Session of 2001

HOUSE BILL No. 2229

By Committee on Health and Human Services

1-31

AN ACT enacting the Kansas senior caregiving initiative; establishing a program to improve the quality of long-term care services; authorizing grants for and evaluations of new models of long-term care; concerning nursing facility reimbursement and enhanced employee training; establishing a prevention program for the improvement of the quality of long-term care services; providing for an advisory council.

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

Section 1. (a) This act shall be known and may be cited as the "Kansas senior caregiving initiative."

(b) [The] state, in partnership with private providers of long-term care services, shall initiate a comprehensive and sustainable program that provides:

(1) A process for quantifiable and continual improvement in the quality of long-term care and services;

(2) support and training for the workers who provide long-term care and services; and

(3) fiscally prudent funding to prepare for the anticipated increase in the number of older Kansans that will need long-term care services in the years ahead.

(c) [The] secretary of aging shall establish and competitively award grants to nursing facilities to implement and evaluate new models of care that alter the organizational culture of nursing facilities to provide sustainable improvement in the quality of long-term care and services or that reduce employee turnover, or both. Where necessary, the secretary shall apply for and aggressively seek federal waivers to permit the implementation and evaluation of any new models of care that nursing facilities propose through the grant process.

(d) The secretary of human resources shall evaluate the current education and training systems and methods utilized in Kansas for workers that provide long-term care and services for nursing facilities and shall identify and recommend any changes to the current system that will result in improved recruitment and retention of long-term care employees. The secretary shall report this information and any recommendations to the long-term care services task force on or before November 1, 2001.

Proposed Amendments

[material within brackets would be deleted]

[Within the limits of appropriations therefor, the

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(e) The secretary of aging shall modify the current medicaid nursing facility reimbursement mechanism to permit nursing facilities to report expenditures related to increased frontline staff wages and benefits midway through the annual cost reporting cycle and to receive a midyear rate adjustment based on these expenditures. Any minimum occupancy requirement applied to nursing facility costs shall include only those costs that are fixed and unalterable regardless of resident census.

(f) The secretary of aging shall establish and implement a program that provides grants, on a competitive basis, to community colleges, universities, area vocational-technical colleges and not-for-profit educational organizations to provide comprehensive, on-site training of long-term care employees that provide direct resident care. The secretary shall establish goals and minimal requirements that must be met by the institution or organization that provides on-site training under this subsection. The secretary shall further develop a system to objectively evaluate the effectiveness of the on-site training program and make recommendations to the legislature regarding the effectiveness, funding and continuation of the grants and training program.

(g) There is hereby established within the department on aging a prevention program designed to lend regulatory and best care practices expertise to nursing facilities and providers of long-term care and services in order to improve the quality of care provided to residents of nursing facilities and other providers of long-term care. The program shall be overseen by an advisory council appointed by the secretary of aging. The program shall be designed to provide advice and direction to nursing facilities and providers of long-term care and services in regard to the provision of resident care, appropriate situational responses and regulatory requirements.

Sec. 2. This act shall take effect and be in force from and after its publication in the statute book.

Authorized expenditure not otherwise accounted for in the reimbursement rate of the facility, not under the control of the facility and required by the state of Kansas or federal mandates shall be reimbursed by the state as a direct-cost pass-through.

Within the limits of appropriations therefor, the

Within the limits of appropriations therefor, there