Approved: February 20, 2006
Date

MINUTES OF THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE

The meeting was called to order by Chairman Jim Morrison at 1:30 P.M. on February 15, 2006, in Room 526-S of the Capitol.

All members were present.

Committee staff present:
Melissa Calderwood, Kansas Legislative Research Department
Mary Galligan, Kansas Legislative Research Department
Renae Jefferies, Revisor of Statutes' Office
Gary Deeter, Committee Secretary

Conferees appearing before the committee:
Karla Finnell, Executive Director, Kansas Association for the Medically Underserved
Dr. Barbara Atkinson, Dean, University of Kansas Medical Center
Dr. Roy Jensen, Director, Cancer Center, University of Kansas Medical Center
Dr. Howard Rodenberg, Director, Division of Health, Kansas Department of Health and Environment
Dr. Paul Harrison, Chair, Advisory Committee on Trauma
Leanne Irsik, Kansas Hospital Association
Carolyn Middendorf, Kansas State Nurses Association

Others attending:
See attached list (not available on electronic copy).

The minutes for February 14, 2006, were approved.

Karla Finnell, Executive Director, Kansas Association for the Medically Underserved, said the Association exists to provide high-quality comprehensive primary health-care services for the medically underserved, especially those 11% of Kansas citizens who lack health insurance. (Attachment 1) Ms. Finnell focused on the role of primary care safety net clinics and partners, which provide a variety of clinic services, the partnerships developed according to community resources and interests. (Attachment 2) She outlined various clinic models which provide comprehensive primary health care, including oral health, mental health, prescription drugs, and enabling services. She stated that funding resources include the Sunflower and other foundations, federal funding, faith-based support, and inclusion in the Kansas Department of Health and Environment (KDHE) budget.

Dr. Barbara Atkinson, Dean, University of Kansas Medical Center, outlined the mission, the variety of services, and the outreach in Kansas provided through the University of Kansas Medical Center. She noted that the Center has recruited 122 new faculty during the past 4 years and she gave details of the growth in services statewide. (Attachment 3) She commented on the cancer research facilities, and introduced Dr. Roy Jensen, Director, Cancer Center, University of

Kansas Medical Center, who testified of the challenges and bioscience opportunities offered by the Cancer Center. (Attachment 4) He noted the $5 million enhancement in the Governor's budget, commenting on the value provided through the additional funding.

The Chair opened the hearing on **HB 2752.**

Dr. Howard Rodenberg, Director, Division of Health, Kansas Department of Health and Environment, spoke as a proponent of the bill. (Attachment 5) He stated that trauma is a major health issue, noting that in 1999 the Kansas legislature established a statewide trauma system. However, he said KDHE is statutorily limited in fully implementing the system and needs additional authority to designate trauma centers according to the level of trauma care capabilities.

Dr. Paul Harrison, Chair, Advisory Committee on Trauma, testified about the value of a trauma system. (Attachment 6) He said that each trauma region has developed plans for hospital designations which can be implemented upon passage of this bill, with rural hospitals as ports of entry into the system.

Dr. Craig Concannon, Beloit, representing the Kansas Medical Society, spoke in support of the bill, noting his experience in rural areas of Kansas as a trauma physician and the significance of the range of care by designating hospitals according to their level of trauma care.

Leanne Irsik, St. Catherine's Hospital, Garden City, representing the Kansas Hospital Association, spoke as a proponent. (Attachment 7) She said establishing authority to designate levels of trauma care will result in improved standards, in assurance of consistent care, and in encouraging best outcomes through data collection and evaluation.

Carolyn Middendorf, representing the Kansas State Nurses Association and the Kansas Emergency Nurses Association, testified in favor of the bill. (Attachment 8) As a former emergency room nurse, she said the bill will improve the quality of care in trauma centers.

Mary Mulryan, Administrative Officer, Kansas Board of Emergency Medical Services, provided written testimony in support of the bill. (Attachment 9)

Answering questions, Dr. Rodenberg said that bringing rural hospitals to Level 3 standards will be one of the first goals of the agency. He estimated that within a year KDHE would be prepared to begin the designation process.

A fiscal note was provided to the committee. (Attachment 10)

The hearing on **HB 2752** was closed.

The Chair invited consideration of **HB 2829,** which had a hearing on February 14.

Representative Kirk explained her recommended amendments to the bill. (Attachment 11)

A motion was made and seconded to accept the amendments. Members discussed the costs

involved in the bill. (See fiscal note, Attachment 12) Representative Kirk commented on the discrepancy between the number of clinics listed by the Kansas Medical Society and by the Board of Healing Arts. Other members considered the Board of Healing Arts a more fitting agency to inspect medical clinics.

The motion to amend passed.

A motion to replace all references to *KDHE* with the *Board of Healing Arts* failed for lack of a second.

A motion was made and seconded to amend the bill by striking language referring to clinics in general and inserting language that references only abortion clinics. (Attachment 13)

Members expressed concern and dismay that the amendment was discriminatory and selective. Others commented that the amendment would ameliorate the fiscal problems created by the bill and deal with known deficiencies in clinics.

The motion to amend passed, 11-10.

A motion was made and seconded to recommend the bill favorable for passage. The motion passed 10-8.

The meeting was adjourned at 3:25 p.m. The next meeting is scheduled for Thursday, February 16, 2006.

HOUSE HEALTH AND HUMAN SERVICES COMMITTEE
GUEST LIST

DATE: February 15 2006

NAME	REPRESENTING
Dr. Craig Concannon	Kansas Medical Society
Paul B Harrison M.D.	Kansas Advisory Committee on Trauma
Jessica Concannon	Student
Carolyn Harrison	
Kelly Steinle	KDHE
Cathy Heckes	ACT
Kendra Tinsley	KFMC
Kris Hill	South Central Regional Trauma Council ACT
Erin Cook-Wiens	KDHE
Sharon Joseph	Ks Assn
Deborah Osmun	Student Social Work
Rosena Hecker	Student Social Work
Carolyn Middendorf	Ks St Nurses Assn
SARAH LONDON	PPRM
FRED Lucky	KAN. Hosp. ASSN.
Deanne Tisick	Kansas Hospital Association
Kim Lynch	KFMC
John Neetz	KID
Brent Wilcox	SRS

HOUSE HEALTH AND HUMAN SERVICES COMMITTEE
GUEST LIST

DATE: 2/15/06

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NAME	REPRESENTING
Brad Smoot	Bayer Healthcare
Aidan Foster	KDHE
Heather Cloud	KCI
Melissa Stuart	KU Student
Christy Rachow	
Anna Beggs	KU student
Sam Carnes	KU student
[illegible]	KDHE
Dick Morrissey	KDHE
Mary E Mulyan	Bd of EMS
Sarah Cooper	Bethany College student
Katherine Kindred	Bethany College Student
Kevin Sick	TILRC
[illegible]	Hein Law Firm
Dan Morin	Kansas Medical Society
Susan	KDHE
LISA BENLOIT	AMER. CANCER SOCIETY
JACE SMITH	AMER. CANCER SOC.

HOUSE HEALTH AND HUMAN SERVICES COMMITTEE
GUEST LIST

DATE: 2/15/06

NAME	REPRESENTING
Matt Hull	Rep. Holland

Attachment 1
HHS 2-15-06

Primary Care Safety Net Clinics

Providing Access to Primary Care Services for Underserved Populations

February 15, 2006

Karla Finnell, Executive Director
Kansas Association for the Medically Underserved

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KAMU

Who we are

Kansas Association for the Medically Underserved

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- An Association whose membership is a diverse group of primary care safety net clinics
- The mission is to promote accessible high quality comprehensive primary care services for the medically underserved without regard to ability to pay.
  - Underserved face barriers accessing health care -
    - ability to pay, cultural or linguistic barriers, a lack of or insufficient number of health professionals in the community (usually uninsured, Medicaid, persons below 200% of FPL)
- 10 staff positions including administrative and fiscal support staff.
- Governed by Board of Directors

Services

- Inform Policy Makers
- Technical Assistance for Safety Net Clinics
  - Board Training
  - Clinical Network and Training
  - KAMU Fellowship Program (management development program)
  - Financial Management Training
- Community Development
- S.E.A.R.C.H.
  - Supports the rotation and placement of health professional students at CHCs and other safety net providers
- AmeriCorps
  - 20 volunteers provide outreach, translation, and health education services;
  - Workforce development program for health professionals
- Health Disparities Collaboratives (chronic disease management)

Kansas

1-5

- Between 280,000 to 300,000 residents lack access to health insurance (11%). (Lewin Study on the Uninsured; 2004 Census Report; Kansas Health Institute.)
- One in four Kansas lacked health insurance for some period of time during the year. (Kansas Health Institute.)
- 72% of uninsured have family income < 200% of FPL (Kansas Health Insurance Study, Kansas Insurance Commission.)
- Sparse population impacts access to health care
  - 89.5% of 105 counties are classified as rural by the federal government
  - 80% are designated as HPSAs. (Kansas Department of Health and Environment)

* Health Professional Shortage Areas are Federally-Determined Designations based on population and health status factors which make areas eligible for federal resources such as grant funding, NHSC clinicians and J-1 Physicians

Impact of Lack of Health Insurance

- Uninsured are less likely to have a usual source of health care (67.4% vs. 87%)
- Uninsured have a higher utilization of the emergency room (17.7% vs. 12.5%)
- Uninsured are less likely to have had a doctor visit within the last six months (29.1% vs. 53.3%).
- Half of uninsured adults with chronic conditions forgo needed medical care or prescription drugs at much higher rates than their insured counterparts. (Uninsured Americans with Chronic Health Conditions: Key Findings from the National Health Interview Survey, Urban Institute. May 2005)

Primary Care Safety Net Clinics

Different Models

Shared Mission to Create Access to Affordable Primary Health Care Services

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Role of Primary Care Safety Net Clinics

- Provide a medical home for underserved populations
- Provide chronic disease management including patient education
- Promoting and achieving access to preventive services
- Provide supportive or enabling services
- Integration of primary health care with oral and behavioral health care services
  - It is an objective to continually improve service delivery by integrating and coordinating the delivery of oral, primary, and behavioral health services to achieve better health outcomes such as in prenatal care, diabetic care, etc.
- Improve access and eliminate health disparities by targeting population health needs and addressing health literacy, language, and other barriers.

Different Models of Primary Care Safety Net Clinics

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- Community Health Centers
  - Also known as federally qualified health centers; 330 funded clinic
  - Receive consolidated community health center funding from the BPHC
  - May be a faith based organization but does have board of which 51% are consumers
- Federally Qualified Health Center-Look Alike
- Rural Health Clinics
- Faith-Based Clinics
- Indigent Clinics

Community Health Centers

- Consumer Board Governance Structure
- Provide comprehensive primary health care services including dental, mental health, and enabling services on a sliding fee scale to all persons regardless of ability to pay.
- Receive significant Section 330 funding to support access to health care services for underserved populations
- Cost-based reimbursement for services provided to Medicare and Medicaid beneficiaries
- Reimbursement by Medicare of patients 20% deductible ("first dollar" is waived and beneficiary may pay co-payment on a sliding fee scale)
- Eligible to participate in the PHS Section 340B Drug Pricing Program- Discounts of 51% on medications from AWP
- Access free medical malpractice insurance under the Federal Torts Claims Act (FTCA) and other benefits
- Examples-Flint Hills Community Health Center, Hunter Health Clinic, Inc., and United Methodists Mexican American Ministries, Salina Health Education Foundation.
- A community health center may be a faith based organization subject to governance requirements.

Comprehensive Primary Care Services

- Primary medical care
- Behavioral health care services
- Substance abuse
- Diagnostic lab and X-ray services
- Prenatal and perinatal care
- Cancer and other disease screening
- Eye, ear and dental screening for children
- Well child services
- Immunizations against vaccine-preventable diseases
- Screenings
  - Elevated blood lead levels,
  - communicable diseases
  - cholesterol
- Dental health care
- Family planning

Recommended Enabling Services

- Case management
- Assistance in obtaining financial support for health and social services
- Referrals to other providers of medical and health-related services including substance abuse and mental health services
- Outreach
- Transportation
- Interpreter services
- Education about health services availability and access

Disadvantages of Becoming A Community Health Center

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- Highly competitive, complicated grant process
- Competitive grant application every five years
- Annual Financial Status Report (FSR) required
- Comprehensive data reporting annually, (Uniform Data Set, or UDS)
- Comprehensive Objective Performance Review
- Higher level of staffing is necessary to meet requirements, including clinical and administrative/management
- Must accept governance by a community board and directly employ key professionals, including medical staff
- Clinic site must be located in a federally designated medically underserved area.

Federally Qualified Look-Alikes

- Meet ALL of the Section 330 program requirements
- Advantages
  - Eligible for cost-based reimbursement from Medicaid and Medicare
  - Reimbursement by Medicare of patient deductible ("first dollar" is waived)
  - Eligible to participate in the PHS Section 340B Drug Pricing Program
  - Access to federal Vaccines for Children Program
  - Access to placement of National Health Service Scholars and Loan Repayors
  - No competitive application process
- Disadvantages
  - Do not receive 330 grant support or free malpractice coverage under the Federal Tort Claims Act Coverage

Rural Health Centers

- Created in 1977 as part Public Law 95-210.
- Intent was to increase availability and accessibility of primary health care services in rural areas
- Eligibility Requirements
  - Privately owned, a non-profit organization or a public entity
  - Staffed at least 50% by a mid-level providers
  - Provide outpatient primary care under supervision of a physician (on site every 2 weeks)
  - Not located in an "Urbanized Areas" as designated by U.S. Census Bureau and Secretary of Health and Human Services
  - Located in a Health Professional Service Area or Medically Underserved Area

Rural Health Clinic

- Benefits
  - No competitive application process
  - Ownership can be private, public or non-profit
  - Facility can be certified at any time
  - Medicare and Medicaid services receive cost based reimbursement
- Disadvantages
  - No federal grant money for uninsured patients or operational expenses
  - Medicare Patient is responsible for deductible of 20% or "1st dollar" must be paid by patient
  - RHCs are not required to provide care to uninsured or underinsured persons, i.e. regardless of ability to pay

Comparison of RHC and CHC Program

	Rural Health Clinic	Federally Qualified Health Center
Location	Non-Urban MUA or HPSA	MUA or MUP
Organizational Type	For-profit, nonprofit or public entity	Nonprofit or public entity
Governance Requirement	None	Majority user board of directors
Federal 330 Grant funding for operations	None	Yes
Services Provided	Basic primary care	Comprehensive primary health care, mental health, dental health care
Other services required	Basic lab	Pharmacy, lab (as appropriate), enabling services
Mid-level provider required	Yes, 50%	No
Enhanced Medicaid/Medicare	Yes	Yes
Application process	Certification any time	Competitive grant cycles
Access to free medical malpractice coverage (FTCA)	No	Yes
Program Evaluation	Annually	On-site Objective Performance Review

Faith-based clinics

- Clinics supported by churches and faith-based foundations, such as the Sisters of Charity, United Methodists Health Ministry Fund.
- Provide primary health care services to medically indigent.
- Benefits-
  - Most likely eligible for free malpractice coverage under the Kansas Tort Claim Act.
  - Eligible entity for local aid to communities grant funds.
  - May be eligible as 330 grantee if otherwise meet eligibility requirements and agree to accept Medicare/Medicaid.
  - Facility has the discretion to determine services and benefits, and may have referral relationship with other faith-based providers such as Catholic hospitals resulting in vertical integration of care for patients.
  - No federal reporting requirements.
- Disadvantage-
  - No cost based reimbursement under Medicaid and other federal program benefits such as discount prescription purchases.
- Examples- Marian Clinic, Duchesne Clinic.

Indigent Clinics-

- Defined as outpatient medical clinic that is a not-for-profit that provides care to the medically indigent. (Kansas)
- Medically indigent are defined as uninsured and Medicaid beneficiaries.
- Coordinated services are generally provided in part by volunteering health professionals, as well as donated lab, x-ray and hospital coverage.
- Benefits-
  - Eligible for malpractice coverage under the Kansas Tort Claim Act.
  - Eligible entity for Aid to Local Communities Grant (KDHE).
- Disadvantage-
  - Not eligible for federal grant money because 330 grantees must accept Medicare in addition to uninsured/Medicaid.
  - No cost based reimbursement under Medicaid.
- Example-Health Care Access, Inc.

2004-
Task Team Studies the Primary Care Safety Net

- Task Team Studied Primary Care Safety Net-
  - Key findings
  - Strategic partnerships strengthened
  - Strategies to improve competitiveness of grants developed-
    - Prospective grant review;
    - Grant writing assistance;
    - Community needs assessment including surveys of target population;
      - These strategies where developed by the task team and implemented with the support of the Sunflower Foundation: Health Care for All Kansans and United Methodists Health Ministries Fund.
- Task Team-
  - Members-Barbara Gibson, KDHE; Edie Snethen, Association of Local Health Department; Tony Wellever, KHI; Terri Muchmore, Legislative Research; Karla Finnell, KAMU; Melissa Ness, Facilitator-Connections Unlimited.
  - Objectives were to identify strategies to take advantage of current grant opportunities in the federal system and develop a model for building future expansions. Reported to the larger group of stakeholders including representatives from the House, Senate, and Governor's office as well as foundations on June 7, 2004.

The Task Team on Growing and Strengthening the Safety Net

- Results-
  - Evaluated the areas of greatest need;
  - Evaluated the strengths and weaknesses of the safety net;
  - Developed tools and strategies to assist communities who had the greatest capacity of accessing federal community health center funding in the 2004 grant cycle.

Strengths and Weaknesses of the Safety Net

- **Strengths-**
  - A foundation of primary care safety net clinics exists upon which to grow and strengthen.
  - Communities have strong commitment and take pride in providing access to a basic level of health care services for all residents regardless of ability to pay.
  - Capable and committed partners including the presence of foundations and other private support.
- **Weaknesses-**
  - Resources
    - Operating reserves
    - Financial viability
    - Infrastructure development
  - Technical Expertise
    - Developing grant applications, including developing a sound business plan
    - Human resources
      - Administrators
      - Health professionals
    - Information systems and technology

Resources-

- Operating reserves
  - Several primary care clinics are struggling financially. The demand and cost of care has simply outstretched resources.
- "The strong get stronger"-
  - In a national study by the Centers for Studying Health System Change it was confirmed that applicants with multiple payor sources are able to demonstrate the financial viability to be competitive for grant funding because the federal community health center model is based on leveraging of resources. It is recommended that grants seek no more than $150.00 per user.
  - Financial resources are needed to leverage federal and other grant sources.

Resources-

- Infrastructure-
  - A number of facilities need renovations and those seeking expanding capacity under the 330 program require substantial remodeling, if not larger facilities.
    - 330 community health center funding may not be used for renovations or construction.
    - Obtaining a loan for capital improvement is extremely difficult for non-profit primary care safety net clinics.
  - The lack of access to capital for equipment and appropriate facilities limits the capacity and quality of care at safety net clinics, as well as the ability to recruit and retain staff.

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Human Resources and Technology-

- Human Resources-
  - Administrators
  - Health professionals-including dentists and dental hygienists.
- Technology-
  - Sophisticated practice management software is needed to manage operations of the community health center model as well as comply with data reporting requirements of the Bureau of Primary Health Care.
  - Health centers have evaluated an established network designed to meet compliance with community health centers financial and clinical regulations and developing a business plan to become a member.

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Opportunities-

- Foundation Support-
  - Sunflower Foundation: Health Care for All Kansans has recently provided 5 bridging grants to expand services.
    - The grant must be matched 50:50 and become self-sustaining in one to two years.
  - United Health Ministries Fund is also providing short term funding to increase dental access.
  - Both foundations are supporting community development and capacity building.
  - Other state foundations are investing in the primary care safety net clinics as well such as the Jones Foundation, the REACH foundation.
- "Banding Together" of Resources-
  - Optimal growth can be achieved when federal, state and private resources are banded together.

Highlights of 2004-

- KDHE and KAMU launched a joint web-based data reporting system to improve reporting and accountability of safety net primary care clinics.
- KDHE supported KAMU in assessing the clinics' preparedness for a bioterrorism event and in developing a response plan.
- KAMU in partnership with the University of Kansas launched KAMU Fellowship Program to train health center managers.
- KDHE strengthens the capacity of the safety net by providing a diabetes chronic disease management grant and protocols.
- Several clinics expanded operations.
- A new community health center was established receiving $650,000 in new ongoing federal funding in Salina, Kansas.
- An expanded medical capacity grant was awarded to the Kansas Farmworker Health Program.

Highlights of 2005-Access to Low Cost or Free Prescriptions

- Specific programs supported by the appropriation:
  - Expand 340B Prescription Programs-
    - Community health centers are eligible entities to utilize the 340B program created by Public Health Service Act.
      - Requires drug manufacturers who want to participate in the Medicaid program to sell covered outpatient drugs to 340B eligible entities at the same discounted price given to Medicaid.
      - On average, 340B drugs cost 20-50% less than the average wholesale price.
    - In Kansas, twelve safety net clinics qualify to participate in the 340B drug program. When the legislation was passed, two clinics, United Methodists Mexican American Ministries and Hunter Health Clinic, were participating.
  - Expand access to manufacturer's prescription assistance programs (PAP's) by providing $$ to support the retention of staff to provide enrollment assistance.

Highlights of 2005-Access to Low Cost or Free Prescriptions

- Today 10 clinics are participating in the 340B prescription drug program - achieving the initial goal of 80% participation by eligible clinics.
- Specifically, the following eligible clinics have started or will soon begin to provide access to low-cost prescriptions through the 340B prescription drug program:
  - Community Health Center of Southeast Kansas, Pittsburg
  - Flint Hills Community Health Center, Emporia
  - GraceMed Health Clinic, Inc., Wichita
  - Konza Prairie Community Health Center, Junction City
  - Salina Family Care Clinic, Salina
  - Shawnee County Health Agency, Inc.
  - Swope Health Care Services, Kansas City
  - We Care Clinic, Inc., Great Bend
  - All of these clinics are providing prescription access in partnership with local or regional pharmacies.
- United Methodists Mexican American Ministries, Garden City and surrounding counties, and Hunter Health Clinic, Wichita have expanded or stabilized the formulary and expanded subsidies for patients.

Highlights of 2005-Access to Low Cost or Free Prescriptions

- Expanded access to manufacture's prescription programs:
  - 17 clinics expanded staffing to increase patient's to access manufacturers prescription assistant programs (PAP's)(at least 22 new FTES)
  - Other utilization of funds included a retainer for a pharmacist in charge to oversee clinic pharmacy, computers and software to manage PAP.
- Best practices developed include:
  - Development of new collaborative relationships
    - A local hospital is referring patients without a medical home admitted with a chronic disease to clinic for physician services and prescription assistance
    - Pilot project with a local private physician to provide application assistance for patients without affordable prescription access (PAP program only)
  - Integration of quality measures and chronic disease management into processes when patients apply for PAP refills to ensure compliance with patient visits, monitoring of blood pressure, diabetes, etc.
  - KAMU sponsored an intensive training on software program to expedite and manage PAPs (January 24, 2006).
- It is too early to predict the economic impact; however patients have expressed high satisfaction with the program. The intended goals of program implementation have been achieved.
- Continued funding is critical to maintain the program at its current level.

Highlights of 2005-Increased Access to Oral Health Care Services

- The number of dentists employed at a safety net primary care clinic has increased from 5 in 2003 to 12.5 FTEs in 2005. Dentists volunteer at clinics as well.
- New or expanded dental clinics have opened (8).
  - Community Health Center of Southeast Kansas opened a 12 chair operatory with 3 FTE dentists in partnership with Fort Scott Community College. Location also serves as a training site for dental hygienists. (Pittsburg)
  - Salina Family Care Inc has opened a 6 chair dental operatory and celebrated its grand opening on January 6, 2006. (Salina)
  - Johnson County Health Partnership celebrated the grand opening of its new facility on January 12, 2006.
  - GraceMed Health Clinic, Inc., has moved to a new facility and has 8 operatories.
  - Swope Health Care Services opened its new dental facility, January 23, 2006. (Kansas City)
  - Douglas County Dental Clinic moved to a new larger facility, expanding capacity. (Lawrence)
  - Southwest Boulevard Clinic has retained a part-time dentist. (Kansas City)
  - Marian Clinic expanded its dental staff. (Topeka, Kansas)
- Dental clinics are being planned by primary care safety net clinics in Hutchinson, Newton, Hays, Junction City, Great Bend, Wichita (Healthy Options for Plainview).
- Clinics are utilizing the extended practice dental hygienist act-
  - Marian Clinic,
  - Douglas County Dental Clinic
  - GraceMed Health Clinic, Inc., Flint Hills Community Health, Healthy Options for Plainview are developing programs for implementation.

Highlights of 2005-Increased Access to Oral Health Care Services (continued)

- KAMU is coordinating attendance for Kansas dentists and executive directors at a dental directors training sponsored by the Iowa/Nebraska Primary Care Association and developed specially for community health centers.
  - United Methodists Health Ministries Fund has sponsored attendance by Kansas participants. KDHE has made web-cast trainings available at central locations.
- 6 clinics now have affiliation agreements with UMKC for year round placement of dental students. Dentists in these facilities have adjunct faculty positions. The clinics are: Douglas County Dental Clinic, Flint Hills Community Health Center, GraceMed, Hunter Health Clinic, Marian Clinic, and Salina Family Health Care Center. The agreement was negotiated by Judy Eyerly, Workforce Development Director, KAMU.
- Denice Curtis, DDS, M.P.H., Director of Clinical Services, KAMU, has been selected as member of a national advisory committee established by the Bureau of Primary Health Care to develop national standards for integration of primary health care with oral health services.
- Jason Wesco, Director of Community Development and Operations, KAMU, former director of Douglas County Dental Clinic, has been selected as a Oral Health Kansas Dental Champion and is participating in leadership training and is assisting with teaching seminars on utilization of the extended dental hygienist practice act to serve underserved populations.

Highlights of 2005-Incubator Programs

- Sunflower Foundation: Health for Kansans developing a new program called "Bridging Grants".
  - Bridging grants are incubator programs designed to create access by funding the start up of new projects.
  - The following safety net clinics were funded to start new or expand programs that increase access to primary health care, oral health care services, or behavioral health services:
    - **Community Health Center of Southeast Kansas,** Pittsburg - $100,000 to add a dentist and dental hygienist
    - **Flint Hills Community Health Center,** Emporia - $100,000 to add a family practitioner
    - **GraceMed, Inc.,** Wichita - $100,000 to add medical and dental staff
    - **Health Ministries Clinic,** Newton - $100,000 to add a nurse practitioner (two-year grant)
    - **Marian Clinic,** Topeka - $45,312 to add a dentist, dental hygienist and social worker
    - **Shawnee County Health Agency,** Topeka - $94,332 to add one licensed clinical social worker and one psychologist
- United Methodists Health Ministries Fund and Sunflower Foundation: Health Care for Kansas have supported community development, grant writing, and grant reviews as well.

Highlights of 2005-Other New Projects

- A new safety net clinic opened in Wamego – Community Health Ministries Clinic - which relies upon donated services of health professionals.
- 11 clinics expanded medical capacity by increasing providers, opening satellites, moving to larger facilities, or remodeling existing facilities:
  - Community Health Center of SE Kansas
  - GraceMed Health Clinic, Inc.
  - Flint Hills Community Health Center
  - Health Care Access
  - Health Ministries Clinic
  - Hunter Health Clinic
  - Prairie Star Health Center
  - Marian Clinic
  - Salina Family Health Care Clinic
  - Southwest Boulevard Clinic
  - Swope Healthcare Services

Highlights of 2005-Other New Projects

- Three Community Health Centers submitted expanded medical capacity grants for new consolidated community health center funding-
  - Community Health Center of Southeast Kansas (Pittsburg)
  - Hunter Health Clinic (Wichita)
  - Konza Prairie Community Health Center (Junction City);
- Rural Outreach Grants pending-
  - Health Ministries Clinic (Newton)
  - Prairie Star Community Health Center (Hutchinson)
- Prairie Star Health Center has a Federally Qualified Health Center Look-Alike Application (FQHC Look-Alike) pending.
- Two communities are developing the infrastructure for an FQHC Look Alike: Hays and Newton.
- If and when a new cycle of new start community health center funding is announced, GraceMed Health Clinic, Wichita, and Prairie Star Health Center have expressed an intent to apply
  - (The December, 2005 cycle was cancelled due to other priorities for funding such as hurricane relief. Initiatives are underway in Congress, supported by President Bush, for new consolidated community health center funding in the next fiscal year.)

- No story on health access would be complete without an update on quality-
  - 11 Clinics participated in a diabetes chronic disease management project in partnership with KDHE. 5 others participate in the National Health Disparities Collaborative.
  - KDHE and KAMU launched a joint web-based data reporting system to improve reporting and accountability of primary care safety net clinics.
    - Data was collected for the year ending 2004 for the first time using the new system.
    - When fully operational, clinics will be able to benchmark performance against peers.
  - KDHE supported KAMU in assessing the clinics' preparedness for a bioterrorism event and in developing a response plan, and is now providing some basic protective equipment and will assess technology readiness for an emergency.

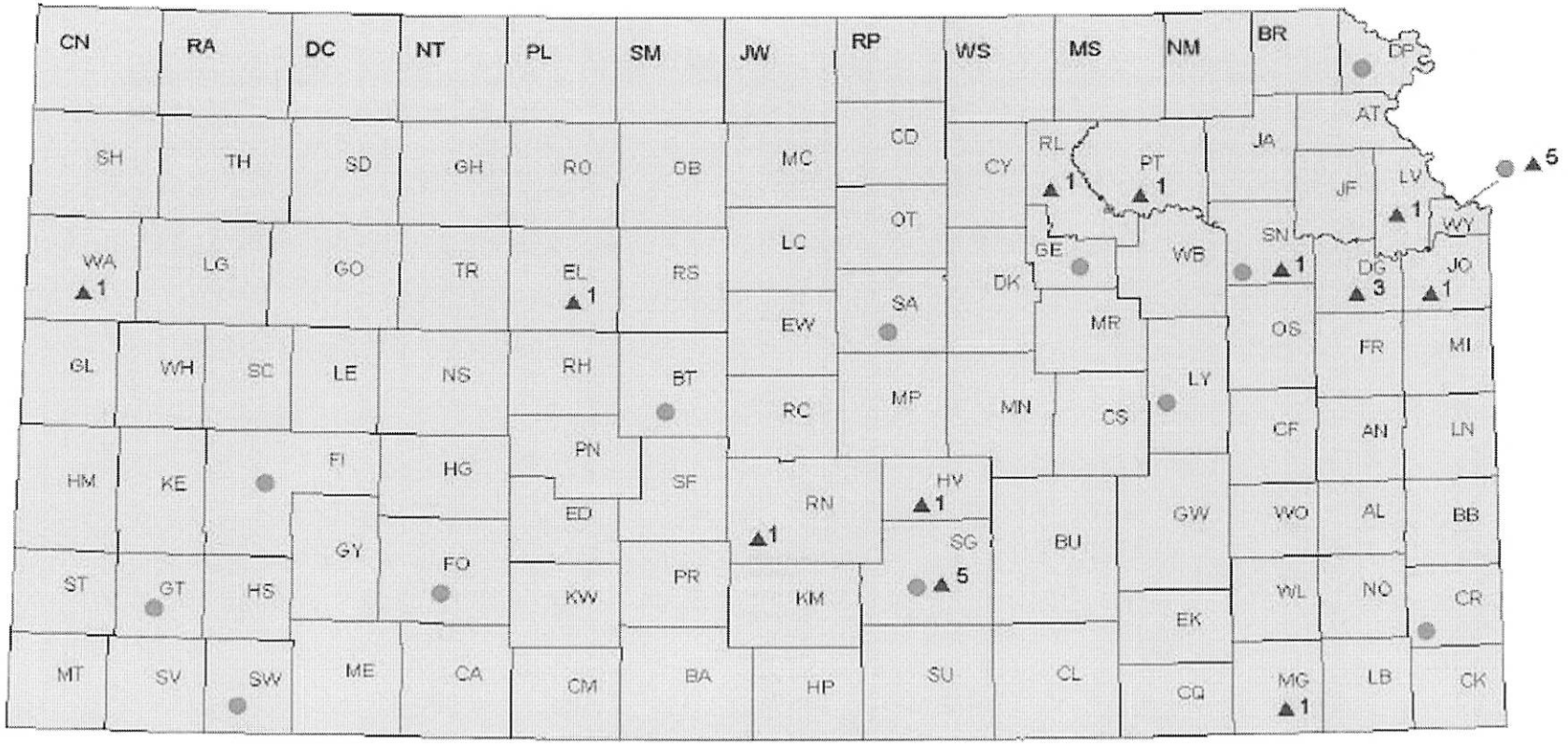
Growing the primary care safety net clinics?

- Without considering pharmacy projects, over 36 projects increased access to basic primary health care services for the underserved.
- Kansas primary care safety net clinics have been successful in expansion efforts-
  - Communities have a strong commitment and take pride in providing access to a basic level of health care services for all residents regardless of ability to pay.
  - Clinics are cost effective and reduce more expensive forms of accessing health care, such as emergency room visits.
    - According to the BPHC 2004 Report on Kansas community health centers (FQHCs), the average cost for a medical user was $249; oral health services $115 per user. The average number of medical visits per user was 2.35 and the average number of dental visits per user was 2.12.
  - A foundation of primary care safety net clinics exists upon which to grow and strengthen.
- There remains critical shortages of services particularly in the area of oral health care, primary care services, obstetric care, and geographic access is limited in key areas.
- Health Care Provider Assessment legislation passed in 2004 would have resulted in needed assistance that would have both stabilized and grown the safety net clinic system. The waiver implementing Part A of the legislation increasing hospital and physician reimbursement has been approved by the Centers for Medicare and Medicaid Services as a result of Part B. However Part B can no longer be approved due to changes in the Congressional Budget reconciliation.
- A number of the projects that have been implemented or are in development require additional funding. Any state investment will be leveraged with both private and other resources.

Legislative 2006 Session

- KAMU is *leading* key initiatives to sustain and increase access to basic health care services-
  - An increase of $1 million in operating support for community based primary care safety net clinics.
  - Development of a capital loan guarantee to support the renovation, construction, acquisition, modernization, leasehold improvements and equipping of Community Health Centers, FQHC-Look Alikes, and indigent clinics.
- KAMU is supporting the development of the advanced education in general dentistry residency.

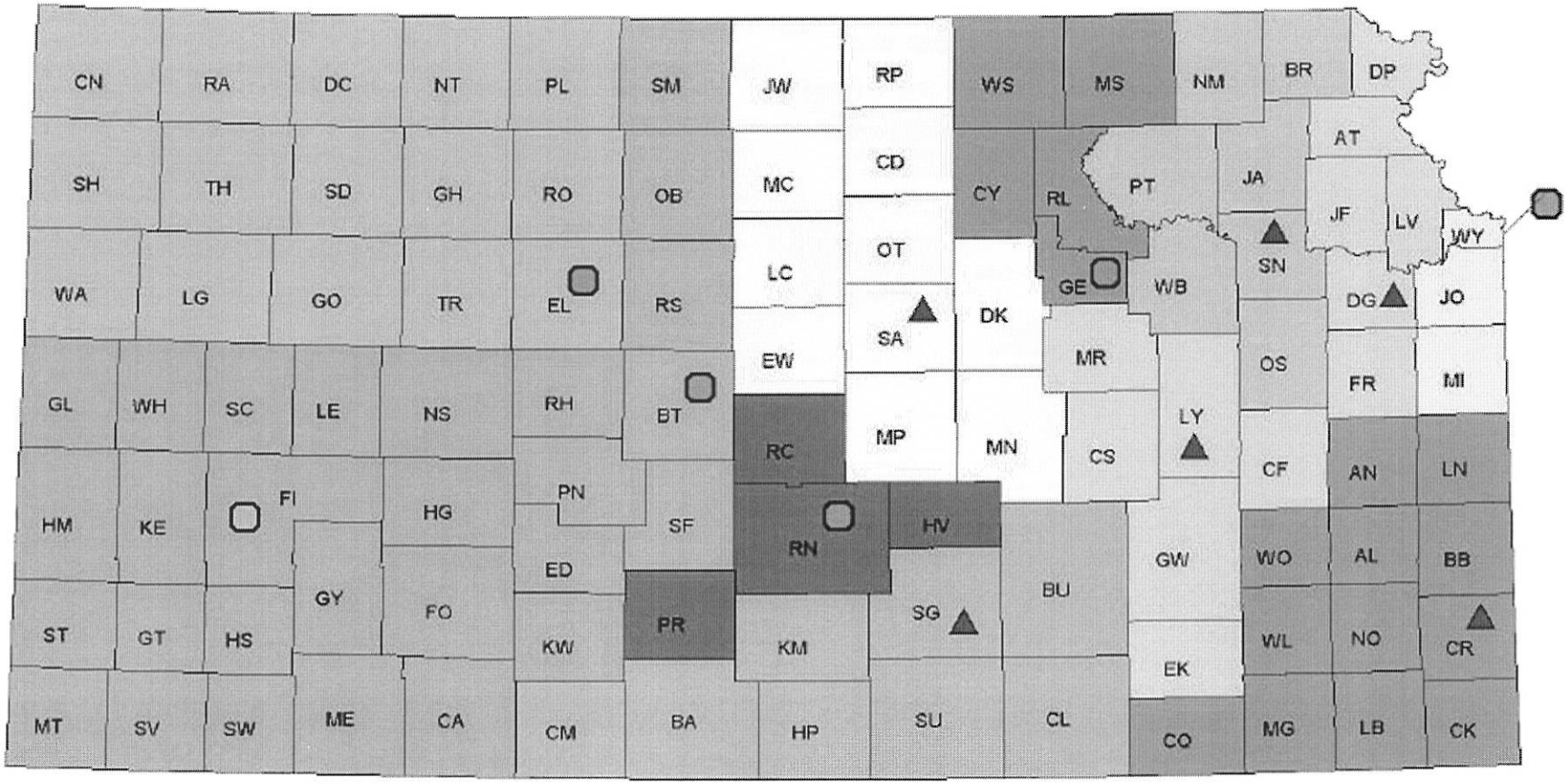
Primary Care Safety Net Clinics



● Community Health Centers or Satellite

▲# Primary Care Clinics

Proposed Regional Dental Hubs



- Proposed Dental Clinic Site
- Existing Dental Clinic Site
- Under Consideration

Thank you.

Kansas Association for the Medically Underserved and all of the Safety Net Clinics.

Attachment 2
HHS 2-15-06

Primary Care Safety Net Clinics and Partners

Agency Name	CHC	Primary Care Clinic	Partners, Affililations	KDHE Operating Support	KDHE Prescription Support
Center for Health & Wellness		x	Wichita Black Nurses Association; Kansas Minority Health Advocacy Network; Project Access	Yes	No
Cherryvale Rural Health Clinic			Mercy Hospitals of Kansas Inc	No	No
Children's Mercy		x	Wyandotte Safety Net Coalition	No	No
Community Health Center of Southeast Kansas	x		Fort Scott Community College, Dental Hygeine Program; Bureau of Primary Health Care; Delta Dental Foundation of Kansas	No	Yes
Community Health Ministry Clinic (Wamego)		x	Robert Wood Johnson Foundation	No	Yes
Douglas County Dental Clinic		x	Delta Dental Foundation of Kansas; UMHMF, United Way, Sunflower Foundation, Douglas County Community Foundation	No	No
Duchesne Clinic		x	Sisters of Charity of Leavenworth; Wyandotte Safety Net Coalition	Yes	No
First Care Clinic of Hays		x	Hays Medical Center	No	No
Flint Hills Community Health Center	x		Lyon County Health Department; Bureau of Primary Health Care; Jones Foundation	Yes	Yes
Good Samaritan Clinic		x	World Impact Church; The Urban Ministry Institute; Project Access	No	Yes
GraceMed Health Center, Inc.		x	United Methodist Church; Delta Dental Foundation of Kansas; Project Access	Yes	Yes
Guadalupe Clinic		x	Catholic Diocese of Wichita; University of Kansas School of Medicine (Wichita); Project Access	No	Yes
Health Care Access, Inc		x	Lawrence Memorial Hospital; Bert Nash	Yes	No
Health Ministries Clinic		x	Newton Medical Center; Prairie View Mental Inc.; Harvey County; United Way	Yes	Yes

Note: Most Clinics Partner with Sunflower Foundation: Health Care for Kansans and United Methodist Health Ministry Fund

Primary Care Safety Net Clinics and Partners

Agency Name	CHC	Primary Care Clinic	Partners, Affililations	KDHE Operating Support	KDHE Prescription Support
Health Partnership Clinic of Johnson County		x	United Way; Reach Foundation	Yes	Yes
Heartland Medical Clinic Inc.		x	Heartland Community Church	No	No
Hunter Health Clinic	x		Urban Indian Health Program; Bureau of Primary Health Care; Project Access	Yes	Yes
KDHE, Local and Rural Health	x		health departments; Bureau of Primary Health Care	No	No
Konza Prairie Community Health Center	x		Bureau of Primary Health Care	No	Yes
Marian Clinic		x	Sisters of Charity of Leavenworth; St. Francis Health Center; Stormont-Vail HealthCare;	Yes	Yes
PrairieStar Health Center		x	Hutchinson Hospital	Yes	Yes
Riley County Community Health Clinic		x	Riley County Health Department	Yes	No
Saint Vincent Clinic		x	Sisters of Charity of Leavenworth;	Yes	No
Salina Family Health Care Center	x		Smoky Hills Residency Program; The University of Kansas School of Medicine - Wichita; Salina Regional Health Center; Bureau of Primary Health Care	No	Yes
Sedgwick County Health Department		x	Project Access	Yes	No
Shawnee County Health Agency	x		Shawnee County Health Department; Bureau of Primary Health Care; Access Project	No	Yes
Silver City Health Center		x	University of Kansas School of Medicine; Wyandotte Safety Net Coalition	No	
Southwest Boulevard Family Health Care		x	Delta Dental Foundation of Kansas; Reach Foundation; Wyandotte Safety Net Coalition	No	Yes
Swope Health Wyandotte & Quindaro	x		Bureau of Primary Health Care; Swope Community Enterprises; Wyandotte Safety Net Coalition	Yes	No
Turner House Clinic for Children		x	Kansas Health Foundation; Wyandotte Safety Net Coalition	No	No

Note: Most Clinics Partner with Sunflower Foundation: Health Care for Kansans and United Methodist Health Ministry Fund

2-2

Primary Care Safety Net Clinics and Partners

Agency Name	CHC	Primary Care Clinic	Partners, Affililations	KDHE Operating Support	KDHE Prescription Support
United Methodist Mexican-American Ministries	x		Bureau of Primary Health Care; United Methodist Church; Robert Wood Johnson Foundation; United Way	Yes	Yes
Wallace Co. Family Practice Clinic			Greeley County Health Services	No	No
Wathena Medical Center	x		Bureau of Primary Health Care	No	No
We Care Project, Inc.	x		Bureau of Primary Health Care; Dominican Sister of Great Bend; United Way	Yes	Yes

Note: Most Clinics Partner with Sunflower Foundation: Health Care for Kansans and United Methodist Health Ministry Fund

Testimony before the House Committee on Health and Human Services
By Barbara Atkinson, M.D.
Executive Vice Chancellor, University of Kansas Medical Center
Executive Dean, University of Kansas School of Medicine

Wednesday, February 15, 2006

Chairman Morrison and Members of the Committee:

I am Barbara Atkinson, Executive Vice Chancellor of the University of Kansas Medical Center and Executive Dean of the University of Kansas School of Medicine. It is my pleasure to appear before you today and provide you with an update on the remarkable things happening at the University of Kansas Medical Center. Our School of Medicine celebrated its centennial in 2005 and our School of Nursing celebrates that same milestone this year.

While our campus hugs the Kansas-Missouri state line in Kansas City, in fulfilling our mission of research, education and service we take seriously our obligation to serve the needs of all Kansans. We train doctors, nurses and other health care professionals for Kansas and through our presence at outreach clinics, our Area Health Education Centers, our preceptor sites, our continuing education, rural health and telemedicine outreach—we touch the lives of Kansans in every part of our state.

We have 4000 KU doctors, 3000 KU nurses, and 3300 KU allied health professionals living in Kansas. This is a significant number if you consider we have graduated just under 10,000 graduates total in our School of Medicine's history and have graduated a total of 5,000 nurses during that school's 100 year history.

We work diligently to be good stewards of the state funds you invest with us. It is estimated that the $106 million we receive in state general funds creates an economic impact of over $1.5 billion. We leverage the state's investment with funds we generate from tuition, competitive grants, clinical income and private donations.

We currently have 1413 students in our School of Medicine. This includes 14 MD/PhD students, 717 medical students on our campuses in Kansas City and Wichita, and 682 Residents and Fellows. The School of Medicine's Class of 2005 had a mean undergraduate GPA of 3.66.

We have 529 students in our School of Nursing. Three hundred ten of them are undergraduates, 181 are graduate students and 38 are pursuing PhDs. This year for the first time our School of Nursing will offer a PhD in nursing degree through distance education. The School of Nursing Class of 2005 had undergraduate GPA mean of 3.70

Our School of Allied Health enrolls 503 students. One hundred seventy-three of these students are undergraduates, 271 are graduate students and 59 are PhD students.

Attachment 3
HHS 2-15-06

In addition to these students we also enroll a number of graduate students in programs including Masters in Health Policy and Management and Public Health, and a Ph.D in biomedical research.

Last year our researchers successfully competed for over $75 million dollars in external grants and awards. $38.4 million was awarded in National Institutes of Health grants.

These dollars have significantly enhanced the ability of the Medical Center to hire additional faculty in both our basic science and clinical departments. These faculty members have come from some of the most distinguished universities in the United States including Tufts, Duke, Emory and UCLA.

In the last four fiscal years we have successfully recruited 122 new faculty to the School of Medicine. Thirty-six of these faculty have been in basic science, 29 in clinical research, and 57 in clinical positions. The expansion of our clinical faculty has allowed us to serve more patients and to generate more clinical revenue. We are currently in the preliminary stages of planning a new center for advanced medicine that would house our clinical practices in a unified space—enhancing patient care and greatly improving the efficiency with which care is delivered.

The work our faculty does to earn clinical income and successfully compete for grants helps leverage the investment of state dollars. In our School of Medicine's basic science departments, state appropriations and tuition dollars make up less than half of faculty salaries. In our clinical departments state funds and tuition make up less than a third of faculty salaries. Clearly, my colleagues work hard to create a solid return on your investment.

There is an excitement at the KU Medical Center as we plan for the next generation of advances in health care and health education. We have designed and will begin deploying a new curriculum in our School of Medicine next year. As medicine advances we must adapt and change the ways we prepare health care professionals. Our School of Nursing recently began training its students using an electronic medical record platform and we will begin using this technology to educate our medical students beginning with the incoming class this fall. These innovations will allow our schools to remain on the leading edge of health education and prepare our students to be successful their careers as healers and caregivers.

We are also very excited about the initiative now underway to obtain National Cancer Institute designation for our KU Cancer Center. This effort builds on a rich history of cancer research at the Medical Center. KU's commitment to cancer research was strengthened ten years ago when we created the Kansas Cancer Institute under the direction of Dr. William Jewell. In 2003 the Institute was renamed the Kansas Masonic Cancer Research Institute in recognition of a $15 million commitment from the Kansas Masonic Foundation.

When I was appointed Dean of the KU School of Medicine developing a world-class cancer center became a very high priority for our school. As many of you know, Chancellor Hemenway has declared this effort now to be our university's top priority.

As a pathologist much of my work has been in the field of cancer diagnosis. I am pleased to be joined today by Dr. Roy Jensen, also a cancer pathologist, who I recruited to serve as the first full time director of the University of Kansas Cancer Center.

Dr. Jensen is a native Kansan who grew up in Gardner and attended Neosho County Community College and graduated from Pittsburg State University. He attended Vanderbilt University for his medical education and assisted them as a faculty member in obtaining NCI designation for their cancer center. Mr. Chairman, with your permission I will turn this briefing over to Dr. Jensen who is prepared to discuss the KU Cancer Center initiative and I will be happy to respond to your questions at the conclusion of his remarks.

Respectfully submitted,

Barbara Atkinson, M.D.

Testimony Before the House Committee on Health and Human Services
Presentation by Roy Jensen, M.D.
Director, KU Cancer Center

Wednesday, February 15, 2006

Mr. Chairman and Members of the Committee:

My name is Roy Jensen and it is my privilege to serve as the Director of KU Cancer Center and the Kansas Masonic Cancer Research Institute at the University of Kansas Medical.

The KU Cancer Center and our partners are dedicated to ending suffering and death from cancer. Each day we work to understand how cancer develops and what we can do to prevent it. We work to improve the lives of those living with this disease and to support them and their families as they battle this terrible plague on humanity.

Our Chancellor, Dr. Robert Hemenway, has declared our work to be the university's top priority. In doing so he affirmed the value of basic research, developing therapies, of preventing and controlling cancer and of providing access to the best possible cancer care.

Cancer research is a tremendous intellectual challenge. But we pursue this work because like all of you we have lost friends and loved ones to cancer. Yes, cancer research is about genes and proteins and cells in a Petri dish, but when it is all said and done—our work is really about people. This work is vitally important because it gives us the chance to find new treatments, therapies and cures and in doing so allows us to extend, enrich and save people's lives. It is that aspect of the work in which we find our greatest satisfaction.

The design of our cancer center is not intended to create a fortress in Kansas City. Instead the heart of our center is designed around an alliance of health care providers from Johnson City to Johnson County, from Sharon Springs to Baxter Springs—and everywhere in between. We want Kansans, no matter where they live, to have access to world-class cancer care. Our center will provide patients with access to clinical trials through the Midwest Cancer Alliance. We will invite hospitals and other health care providers throughout the state to join as a member of this important component of our cancer center.

We also believe that the KU Cancer Center will lead in bioscience innovation. Teaming up with the nationally recognized excellence of the KU School of Pharmacy we are designing a powerhouse for drug discovery and development. These discoveries will seek to enhance treatments and help prevent disease but they will also have significant commercial benefits for the Kansas economy.

Attachment 4
HHS 2-15-06

If our quest to achieve National Cancer Institute designation for our cancer center is to be successful we will need significant additional resources. The Governor's budget for the next fiscal year includes a $5 million appropriation which, if approved, will provide some of the resources we will need to recruit top talent to crucial leadership posts within the center and to attract the best cancer doctors, scientists and researchers to our center. These funds will also be used to help design and deploy our statewide cancer alliance. This annual appropriation is the single most important step this legislature can take in support of the fight against cancer in Kansas. I hope I can count on your support for this appropriation.

A legislative briefing book is attached to this testimony which details the need for a comprehensive cancer center and the benefits to be obtained by investing in one. I would encourage you to review this publication if you wish to know more about our plans.

In addition to state appropriations we will aggressively be seeking support from federal government sources and investments from private donors. Obtaining National Cancer Institute designation is no easy task and the resources required to achieve this goal will be significant.

I am proud of my decision to return to Kansas. I have been welcomed warmly by my colleagues and made many new and valued friends. As I have shared our vision for a cancer center I have been enthusiastically received by legislators from throughout the state. I am impressed by your commitment to the greater good and your interest in helping us achieve something great for the Kansans we serve. I look forward to working with you during this legislative session as we advance the future of cancer care in Kansas and our region.

I encourage any effort you as legislators can take to support the KU Cancer Center and our work to end suffering and death from cancer in Kansas.

Thank you for this opportunity to be with you today and I would be pleased to stand for any questions.

Respectfully submitted,

Roy Jensen, M.D.
Director, Kansas Masonic Cancer Research Institute
and The University of Kansas Cancer Center

KANSAS

RODERICK L. BREMBY, SECRETARY

KATHLEEN SEBELIUS, GOVERNOR

DEPARTMENT OF HEALTH AND ENVIRONMENT

Testimony on House Bill 2752

To:
House Health and Human Services Committee

By:
Presented by Dr. Howard Rodenberg, MD, MPH
Director, Division of Health

Kansas Department of Health and Environment

Date: February 15, 2006

Chairman Morrison and Members of the Committee, I am Dr. Howard Rodenberg. I serve as Director of the Division of Health within the Kansas Department of Health and Environment, and as Kansas State Health Officer. I am pleased to appear before you today to support HB 2752.

Last year, over 1,100 Kansans died from unintentional injuries suffered on the road, the farm, or in the home. Many of these victims are young people. Unintentional injury is the leading cause of death in Kansans less than 34 years of age. Kansas ranks in the top twenty states in death rates from injuries in general, and 16th in death rates from motor vehicle crashes (Health Care State Rankings, Morgan Quitno, 2005). The rural nature of our state, and the absence of comprehensive health care facilities in those rural areas, means that Kansans living in rural areas have a higher death rate from trauma than urban residents. Approximately two-thirds of all fatal motor vehicle crashes occur in rural areas.

In 1999, the Kansas legislature recognized that injuries were a significant public health issue in Kansas and established the Kansas Trauma Program. The Secretary of Health and Environment was directed to develop and implement a statewide trauma system, including a Kansas Trauma System plan, to include system components such as hospital designation, regional trauma councils, quality improvement programs, and a statewide trauma data collection system. The legislation established an Advisory Committee on Trauma (ACT) to provide input to KDHE on the development of the statewide trauma system.

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CURTIS STATE OFFICE BUILDING, 1000 SW JACKSON ST., STE. 300, TOPEKA, KS 66612-1368
Voice 785-296-1086 Fax 785-296-1562 http://www.kdhe.state.ks.us/

Attachment 5
HHS 2-15-06

As one of the key steps in developing a comprehensive trauma system, the ACT recommended that hospitals in the state be categorized according to the level of trauma care resources they are able to provide. However, while the original legislative intent may have been to include statutory authority for hospital designation, interpretation by KDHE program and legal staff is that the language in the statute did not give clear authority to the agency to perform such designations.

Kansas has three level one trauma centers located in Wichita and Kansas City respectively. While most Americans believe that specialized trauma centers encompass the entirety of a trauma system, it is truly but one component of a well-coordinated system. In rural states such as Kansas, the trauma system extends well beyond the walls of the large, urban center. Three hospitals in the State (two in Wichita and one in Kansas City) have sought and received national recognition as trauma centers under the auspices of the American College of Surgeons (ACS) Trauma Center Verification Program. This bill will allow the Kansas Trauma Program to recognize ACS verification for Level I and Level II facilities (Level I being the highest level of care), and to undertake a state-directed hospital designation process for Level III facilities. A checklist of required facility resources and a verification process has already been identified for Level III trauma facilities. Due to the rural nature of our state, where just over half the population can currently reach a trauma center within the "golden hour" of mortality, the establishment of additional Trauma Centers throughout the state will increase the number of Kansans with access to trauma expertise in their time of need.

There is strong evidence that outcomes for injured patients are better if they are treated at a trauma center (MacKenzie *et al.*, 2006). Numerous states have already adopted trauma systems that have legal authority to designate hospitals (Nathens *et al.,* 2000). These systems have been shown repeatedly to improve patient outcomes such as survival and disability (for example, see Mullins *et al.*, 1996, for analysis of the Oregon Trauma system).

Trauma centers do more than look good on paper. In my career as an emergency physician, I've worked at hospitals with equivalent levels of resources, one that assumed the role of a Trauma Center and one that did not. The differences in attitudes towards both trauma patients, and emergency care in general, were astounding. A heightened awareness of the time-critical nature of trauma meant that patients were assessed sooner, treated faster, and had more clinician expertise available to them as they reached the door of the ED. There was a drive to provide continuing education to staff at all levels, and focused reviews of what went right and what went wrong with individual cases, lessons we could then apply to later cases. And while the focus of the effort was on trauma care, we found that our abilities to care for all kinds of emergent patients expanded as we become more confident in our critical care skills and more used to working as a multidisciplinary team.

While individual facility designation is an important step, evaluation of statewide trauma system effectiveness, accessibility, cost, and quality of care is essential. It is the role of the state trauma program to assure consistency in the strategies used for process improvement statewide, and to monitor, analyze and report improvements in the system along with deficiencies needing to be addressed. However, a statutory barrier exists to the use of system data for quality management and performance improvement. While the regional trauma plans already contain recommendations for quality improvement processes, use of the trauma registry data for quality improvement process is not occurring at this time because existing statute does not include peer

review protections in the use of this data for quality purposes. Patient records are essential to analyzing performance and identification of opportunities for improvement. These medical records must be accessible for these purposes, while being protected from inappropriate disclosure. The contents of this bill will accomplish this purpose.

The trauma system should provide optimal care given available resources, for all trauma patients no matter where they are injured or treated. Trauma is truly a matter of life or death.

We ask that you support HB 2752. I'll be happy to answer any additional question you might have.

Attachment 6
HHS 2-15-06

Testimony HB 2752

Paul B. Harrison, MD, FACS
Chair, Advisory Committee on Trauma

Background

- 1999 Legislation was passed
- Authorized KDHE as the lead agency
- Appointed Advisory Committee on Trauma
- Required a State Trauma Plan
- Established a fee fund

Requested statute changes

- Authority to designate hospitals
- Provision of fees for designation of hospitals
- Authority to link quality improvement with existing peer review

What is a trauma system?

- An organized & coordinated response to care for the injured
- Regionalized, making efficient use of resources
- Based on the needs of the population
- Emphasizes prevention
- Ability to expand to meet the medical needs of the community during disaster

Goals of the KS Trauma System

- Prevent death & disability due to trauma
- Improve delivery of trauma services
- Encourage provider preparation & response to trauma
- Increase public awareness & prevention
- Design an inclusive & comprehensive system

Kansas Milestones in Trauma

- 1997: Kansas EMS/Trauma Plan written
- 1999: Legislation passed
- 2000: Members appointed to Advisory Committee
- 2001: Kansas Trauma Plan presented to legislature
- 2002: Statewide data collection efforts begin

Milestones cont….

- 2003: 6 Regional trauma councils established
- 2004: Trauma training provided
- 2005: Regional Plans written
- 2005: Recommendations made for hospital designation
- 2005: 9,135 serious trauma cases reported
- 2006: Data Benchmark reports developed

Trauma Plan Components

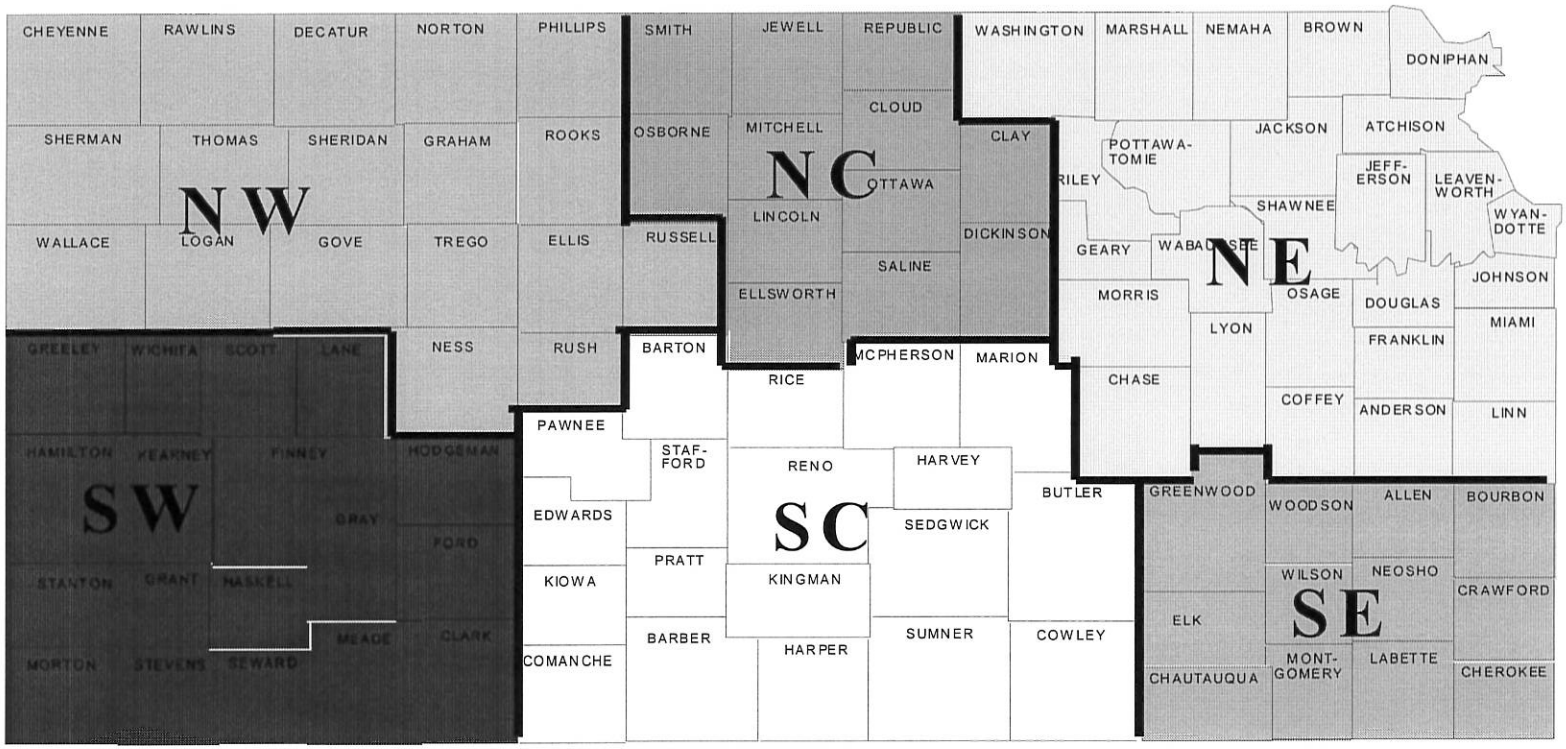
- State wide data collection system
- Regional Trauma councils
- Hospital Verification
- Training and Education
- Prehospital/EMS
- Injury Prevention
- Rehabilitation

Regional Trauma Councils

Population: 101,005
Staffed Beds : 582
Hospitals : 18 Counties: 18

Population: 133.843
Staffed Beds : 581
Hospitals : 13 Counties: 12

Population: 1,299,832
Staffed Beds : 3,200
Hospitals : 34 Counties: 26



Population: 152,623
Staffed Beds : 556
Hospitals : 18 Counties: 18

Population: 800,507
Staffed Beds : 2,503
Hospitals : 30 Counties: 19

Population: 196,108
Staffed Beds : 735
Hospitals : 15 Counties: 12

Regional Trauma Councils Accomplishments

- Regional Trauma Plans written
- Support for EMD training & education
- Supported injury prevention activities based on data
- Supported regional trauma education
- Annual meeting of Executive Committee members

Hospital Designation Criteria

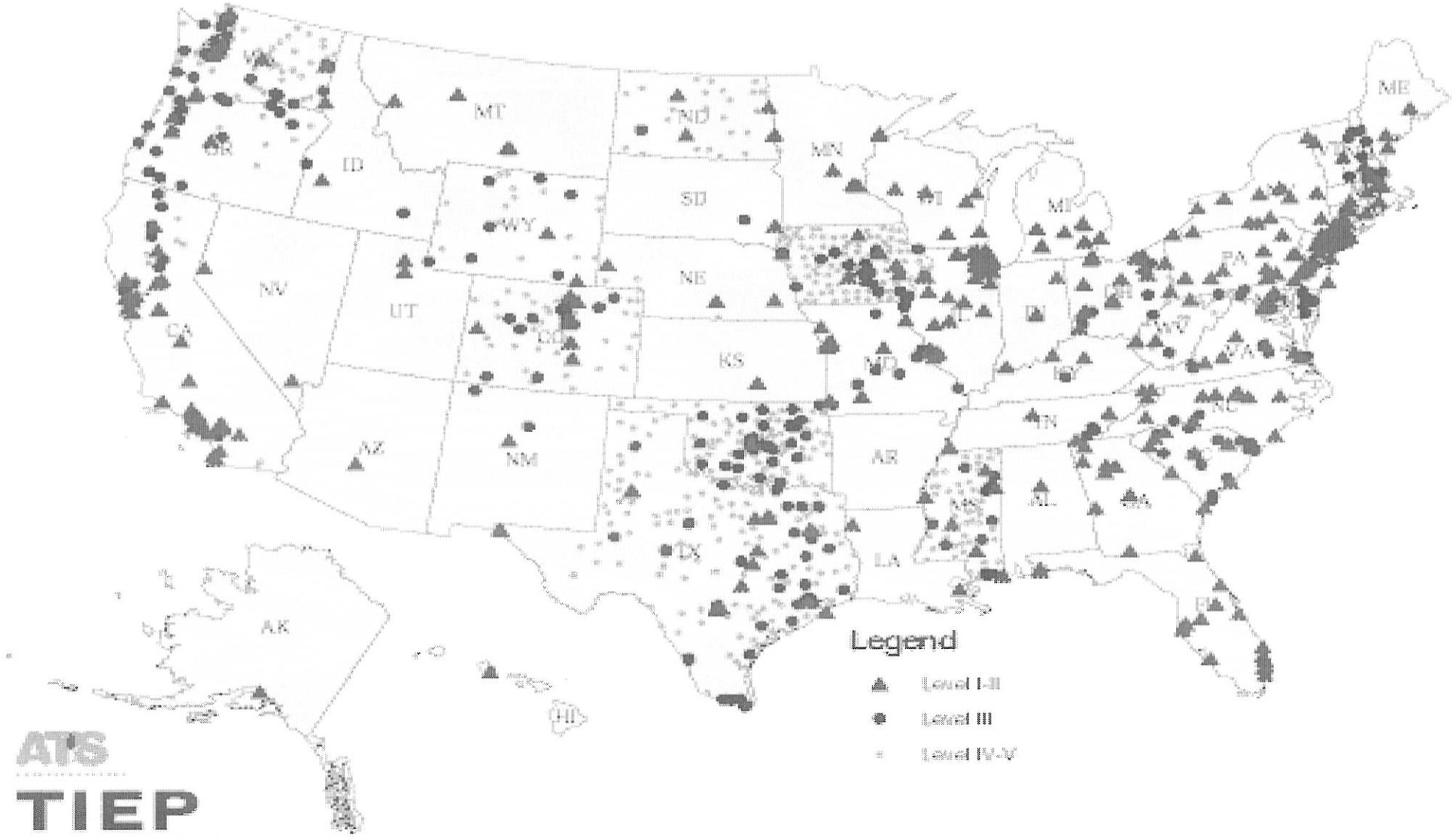
- Hospitals are classified based on level of resources
- Kansas has 3 level 1 trauma centers voluntary verified
- No level 3 or 4 facilities: backbone of the system
- Rural hospitals are the port of entry

Levels of Designation

- Level 1: Provide full range of services & research responsibility
- Level 2: Similar level of clinical service & community based
- Level 3: Emergency & surgical capability. Commonly stabilize the most severe and transfer to a higher level trauma center

All Levels of Trauma Centers
January 2005

6-13



ATS

TIEP

TRAUMA INFORMATION EXCHANGE PROGRAM

Access to Level I or II Trauma Centers Within 60 min

http://jama.ama-assn.org/cgi/content/full/293/21/2565

How Does Your State Compare?

This ranking is based on the percentage of the state's population within 50 miles, regardless of state borders, of a Level I or II Trauma Center.

1	CT	100		OH	88		OR	74		WV	50
	DC	100	15	SC	86	28	TN	73	41	AK	49
	NJ	100		WA	86	29	HI	72	42	NM	46
4	NY	97	17	FL	85	30	DE	71	43	AL	41
5	PA	96	18	UT	83		MN	71	44	LA	40
	RI	96	19	MI	82		TX	71	45	MT	39
7	NH	94	20	GA	78	33	IA	68	46	NE	34
8	IL	93		MO	78	34	MS	67		OK	34
9	CA	92	22	ME	77	35	IN	64	48	WY	33
10	MA	91	23	VA	76	36	KY	60	49	SD	29
11	NV	90		VT	76	37	ND	58	50	AR	9
12	MD	89		WI	76	38	KS	57	51	AZ	0
13	CO	88	26	NC	74	39	ID	50			

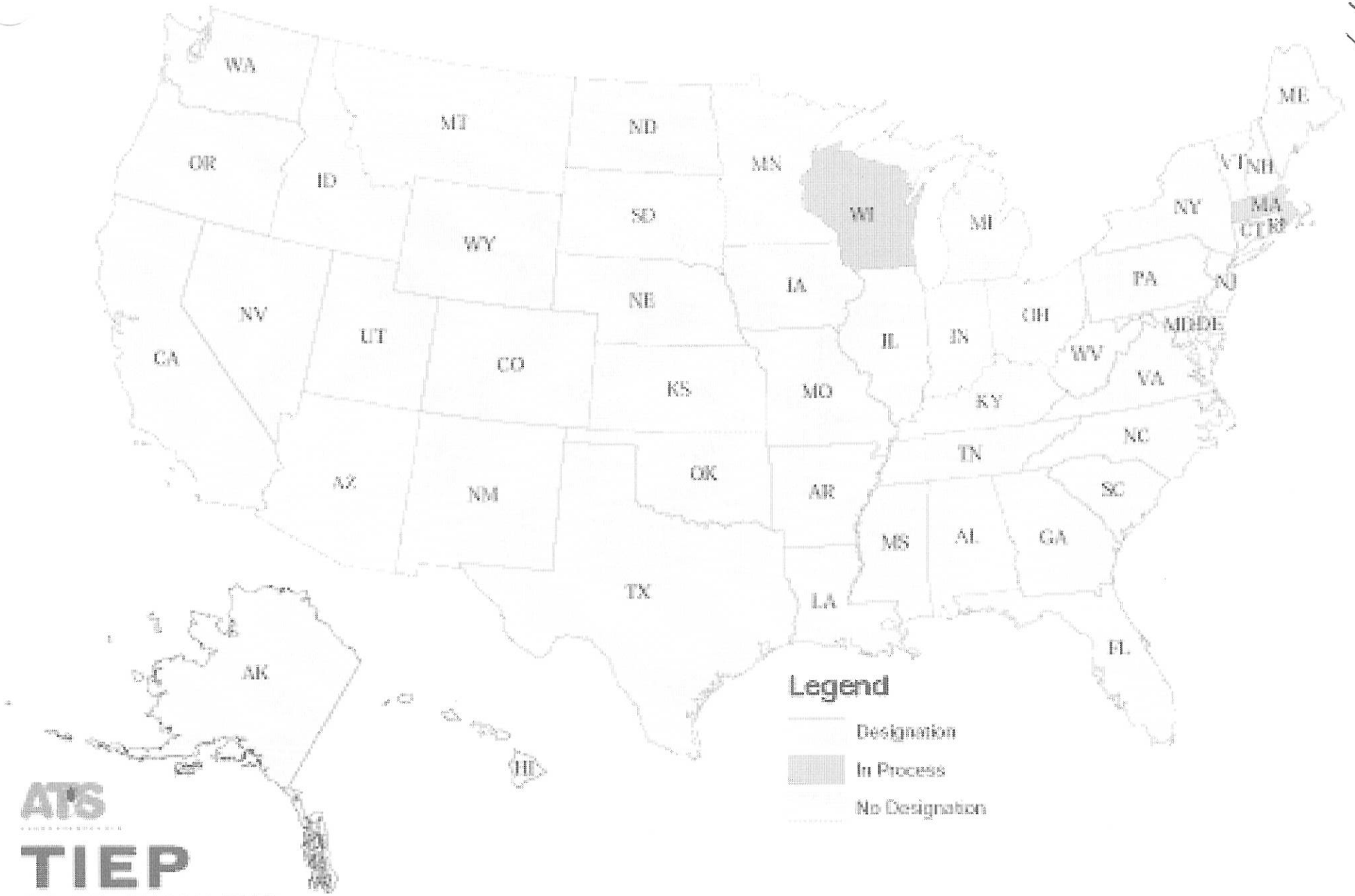
Source: Trauma Information Exchange Program 4/02

ATS

TIEP

TRAUMA INFORMATION EXCHANGE PROGRAM

6-5-9



ATS

TIEP

TRAUMA INFORMATION EXCHANGE PROGRAM

Is the Trauma System Worth it?

- Documented studies show the benefit of a organized trauma system can:
  - Reduce the risk of death by greater than 50% among severely injured
  - Survivors have shorter hospital stays
  - More efficient use of resources
  - Reduced costs

81-9

We appreciate your support of HB 2752

Thank
you

Kansas Hospital Association
Testimony on HB 2752
Committee on Health and Human Services
Presented by Leanne Irsik
St. Catherine Hospital, Garden City, Kansas

Mr. Chairman and members of the Committee, my name is Leanne Irsik, and I am here representing the Kansas Hospital Association. I have been a nurse at a rural hospital for many years and now serve as the Sr. Vice President for St. Catherine Hospital in Garden City. I am also a member of the Kansas Advisory Committee on Trauma (ACT) in one of the three positions representing hospitals on that Committee. Thank you for giving me the opportunity to provide testimony in favor of HB 2752. As you are all aware, HB 2752 makes two important changes to the statutes governing our trauma planning process.

First, HB 2752 clarifies the authority of KDHE to implement the Kansas Trauma System plan by designating trauma centers in Kansas. While we have come a long way toward developing a trauma system that meets the diverse nature of Kansas, we have been in planning stages – encouraging hospitals to work with the American College of Surgeons (ACS) criteria and its "verification" process. Until we bring the process into the state auspices, it will be very difficult for hospitals like St. Catherine and other smaller rural hospitals to participate.

- This amendment allows KDHE, with guidance from ACS and the Kansas Advisory Committee on Trauma, to deepen and broaden the improvements that trauma center standards or criteria provide to our rural areas.

- It does this by allowing the state through KDHE to set standards, which have been developed by the ACT through a collaborative process, that raise the bar for Kansas hospitals and then recognizes, through designation, those hospitals that choose to implement the standards at a cost more reasonably borne by the hospital.

- In addition, it allows KDHE to work with and recognize our small, critical access hospitals (Kansas now has 84) to encourage improvement and participation in the trauma system though things like increased education, field protocols and other critical roles that our small rural hospitals must provide in a large state like Kansas.

Attachment 7
HHS 2-15-06

- St. Catherine Hospital will endeavor to become designated as a Level III trauma center. It is very important that the criteria used as the basis for this designation be customized to meet the needs and resources specific to Kansas and, at the same time, enhance the trauma services in the manner envisioned by the ACS.

The second amendment allows us to move the trauma registry to the next level.

- Hospitals have been reporting data to the registry, but there has been little use of the data primarily due to concern about how the data will be distributed. The amendment protects the data under the Kansas peer review statutes to assure that it can be used fully for system and patient care improvement.

- This protection will provide the appropriate environment to both encourage full reporting and actual use of the data in critical areas of patient transport and treatment.

The collection of data is only the first step to improving a process. At St. Catherine Hospital, we use data collection as part of our overall Performance Improvement Process and our Peer Review Process. To have the best system possible and to provide the best individual provider performance possible, data has to be available for analysis. The tort reform laws of the 1980's have proven in Kansas that having a peer review framework within which to review specific data can improve outcomes and reduce risk.

Thank you, Mr. Chairman, for the opportunity to testify. I'd be happy to try to answer questions.

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H.B. 2752 KANSAS TRAUMA SYSTEM

February 15, 2006

Chairman Morrison and members of the House Health and Human Services Committee, my name is Carolyn Middendorf, M.N., R.N., and I am here to support H.B. 2752 on behalf of the KANSAS STATE NURSES ASSOCIATION and the KANSAS EMERGENCY NURSES ASSOCIATION. A majority of the members of the Advisory Committee on Trauma are registered nurses, and they strongly support the development of a state trauma plan. The additional provisions and revisions in this bill strengthen the already standing legislation.

It is hoped that this proposed legislation would result in a decrease in both incidence and severity of injury through strengthened quality-improvement activities. These activities could include things such as identifying common causes of injury in Kansas, so prevention efforts can be more specific. It will also allow honest evaluation of care through protected peer review. This activity is vital to improve existing care through multidiscipline evaluation and discussion, without fear of litigation. Currently, trauma-care providers are not able to easily compare their outcomes to those of their peers around the state.

A foundational component of the *Kansas Trauma Plan* has always been to classify hospitals according to their resources to care for the most critically injured. The vast majority of trauma patients can be cared for in their local communities, but a few will require resources available only in more urban areas. Verification by the American College of Surgeons is planned for Level I and Level II Trauma Centers, but the majority of Kansas hospitals are more community-based and rural in nature. This bill will permit all hospitals to be a part of the Trauma System, yet be fairly evaluated by an outside agency to assure capabilities.

Finally, registered nurses all across this state care for injured patients on a daily basis. They see the human toll of pain and suffering. The most critically ill and injured will benefit from strengthening the current Kansas Trauma Plan. We strongly support HB 2752.

Thank You.

Attachment 8
HHS 2-15-06

KANSAS

DENNIS ALLIN, M.D., CHAIR
ROBERT WALLER, ADMINISTRATOR

KATHLEEN SEBELIUS, GOVERNOR

BOARD OF EMERGENCY MEDICAL SERVICES

February 14, 2006

The Honorable Jim F. Morrison, Chair
2006 Legislature
House Committee on Health and Human Services
Room 526-S, Statehouse
Topeka Kansas

Re: HB 2752, as introduced by the House Committee on Health and Human Services

Dear Representative Morrison:

The Kansas Board of Emergency Medical Services would like to support the passage of HB 2752.

The Kansas Board of Emergency Medical Services is introducing Legislation this session (SB 546) that would create a data collection system to collect pre-hospital data similar to what is collected by the Kansas Department of Health and Environment (KDHE) within the Trauma Registry. The legislation, supported by the Board, is very similar to this Legislation and will also allow us the opportunity for improvement of quality pre-hospital care to Kansas citizens in addition to the Traffic Records System operated by the Kansas Department of Transportation's (KDOT). The value of HB 2752 cannot be underestimated and the Board of Emergency Medical Services would ask the Committee to pass the bill favorably. If you have any further questions, please call the Board Office at (785) 296-7296.

Sincerely,

Mary E. Mulryan

Mary E. Mulryan
Administrative/Fiscal Officer

Attachment 9
HHS 2-15-06

LANDON STATE OFFICE BUILDING, 900 SW JACKSON STREET, ROOM 1031, TOPEKA, KANSAS 66612-1228
Voice 785-296-7296 Fax 785-296-6212 www.ksbems.org

February 15, 2006

The Honorable Jim Morrison, Chairperson
House Committee on Health and Human Services
Statehouse, Room 143-N
Topeka, Kansas 66612

Dear Representative Morrison:

SUBJECT: Fiscal Note for HB 2752 by House Committee on Health and Human Services

In accordance with KSA 75-3715a, the following fiscal note concerning HB 2752 is respectfully submitted to your committee.

HB 2752 would amend legislation passed in 1999 that established the statewide Kansas Trauma Program. The bill would provide the authority for and clarify language in the current trauma statutes regarding the following three items:

1. The collection of fees to support the process of hospital designation;
2. The designation of trauma facilities by level of trauma care capabilities; and
3. The linking of trauma quality improvements to existing statutes supporting hospital peer review.

Estimated State Fiscal Effect				
	FY 2006 SGF	FY 2006 All Funds	FY 2007 SGF	FY 2007 All Funds
Revenue	--	--	--	--
Expenditure	--	--	--	$85,000
FTE Pos.	--	--	--	--

Attachment 10
HHS 2-15-06

The Department of Health and Environment indicates that the primary expense related to hospital designation is the on-site survey team review process. The Advisory Committee on Trauma (ACT) recommends that the agency use survey teams from out of state to avoid any conflict of interest. The agency estimates that ten surveys could be completed in FY 2007 at an average cost of $8,500 per survey for a total cost of $85,000 from the agency's Trauma Fund. Any fiscal effect resulting from the passage of this bill would be in addition to amounts recommended in *The FY 2007 Governor's Budget Report.*

Sincerely,

Duane A. Goossen
Director of the Budget

cc: Aaron Dunkel, KDHE
Dan Roehler, DHPF

Representative Kirk 1st
Balloon Amendment
February 15, 2006

Attachment 11
HHS 2-15-06

Session of 2006

HOUSE BILL No. 2829

By Committee on Health and Human Services

2-6

AN ACT concerning the secretary of health and environment; providing for regulation of clinics and facilities where office-based surgeries and special procedures are performed.

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

Section 1. As used in this act:

(a) "Board" means the state board of healing arts.

(b) "Local anesthesia" means the administration of an anesthetic agent into a localized part of the human body by topical application or local infiltration in close proximity to a nerve, which produces a transient and reversible loss of sensation.

(c) "Minimal sedation" means the administration of oral sedative or oral analgesic drugs in doses appropriate for the unsupervised treatment of insomnia, anxiety or pain.

(d) "Minor surgery" means surgery which can be safely and comfortably performed on a patient who has received local or topical anesthesia, without more than minimal sedation and where the likelihood of complications requiring hospitalization ~~is remote~~ not reasonably foreseen.

(e) "Office-based surgery" means any surgery or other special procedure requiring anesthesia, analgesia or sedation which is performed by a physician in a clinical location other than a medical facility licensed pursuant to K.S.A. 65-425, and amendments thereto, and which results in a patient stay of less than 24 hours. The term does not include minor surgery.

(f) "Physician" means a person licensed to practice medicine and surgery in the state of Kansas.

(g) "Secretary" means the secretary of health and environment.

(h) "Special procedure" means a patient care service which requires contact with the human body with or without instruments in a potentially painful manner, for a diagnostic or therapeutic procedure requiring anesthesia services. The term does not include minor surgery.

(i) "Surgery" means a manual or operative procedure which involves the excision or resection, partial or complete, destruction, incision or other structural alteration of human tissue by any means, including the use of lasers, performed upon the human body for the purpose of pre-

serving health, diagnosing or treating disease, repairing injury, correcting deformity or defects, prolonging life or relieving suffering, or for aesthetic, reconstructive or cosmetic purposes. Surgery includes, but is not limited to, incision or curettage of tissue or an organ, suture or other repair of tissue or an organ, a closed or open reduction of a fracture, extraction of tissue from the uterus and insertion of natural or artificial implants.

(j) "Topical anesthesia" means an anesthetic agent applied directly or by spray to the skin or mucous membranes, intended to produce a transient and reversible loss of sensation to a circumscribed area.

Sec. 2. (a) The secretary, by rules and regulations, shall establish standards for clinics and other facilities, in consultation with the state board of healing arts, where office-based surgery or special procedures, or both, are performed. Such standards shall promote the safety of patients, including, but not limited to, standards addressing:

(1) Qualifications and supervision of nonphysician personnel;

(2) facility safety and sanitation;

(3) equipment requirements, sanitation, testing and maintenance;

(4) patient screening, assessment and monitoring;

(5) selection of procedures to be performed;

(6) anesthesia services;

(7) peri-operative care;

(8) emergencies and patient transfers; and

(9) quality assurance and peer review.

(b) In adopting standards pursuant to this section, the secretary, in consultation with the state board of healing arts, shall give consideration to standards adopted for the purposes of regulating ambulatory surgical centers licensed pursuant to K.S.A. 65-425 et seq. and amendments thereto and shall give consideration to the guidelines for office-based surgery and special procedures approved by the Kansas medical society house of delegates on May 5, 2002, and any subsequently approved guidelines, and to guidelines for office-based surgery and special procedures approved by the state board of healing arts.

(c) Any rules and regulations adopted by the secretary pursuant to this act shall provide for protection of the identities of patients and health care providers. ~~Rules and regulations adopted under this section shall allow a reasonable time for compliance as specified by the rule and regulation.~~

Sec. 3. (a) A correction order may be issued by the secretary or the secretary's designee to a clinic or facility which performs office-based surgery or special procedures, or both, whenever a duly authorized representative of the secretary inspects or investigates such clinic or facility and determines that the clinic or facility is not in compliance with the

terminating a pregnancy,

excluding licensed nurses and registered nurse anesthetists

(d) Rules and regulations required by this section shall be adopted as temporary regulations within 60 days of the effective date of this act with corresponding permanent rules and regulations adopted on or before January 1, 2007.

11-2

standards adopted by the secretary by rule and regulation pursuant to section 2 and amendments thereto. The correction order shall be served upon the clinic or facility either personally or by certified mail, return receipt requested. The correction order shall be in writing, shall state the specific deficiency and shall specify a time of 30 days for correction of the deficiency, unless the deficiency is of such an extreme hazard to the health and safety of a patient that immediate correction is required. In such an extreme case correction of the deficiency in less than 30 days may be ordered by the secretary or the secretary's designee.

(b) When the time period set forth in the correction order has passed, the clinic or facility shall be reinspected for compliance. If the clinic or facility is still in noncompliance, the secretary or the secretary's designee may restrict the performance of any office-based surgeries or special procedures, or both, at the noncompliant clinic or facility until compliance is found and may level a civil penalty against such clinic or other facility pursuant to section 4, and amendments thereto. If the secretary determines that the continued performance of office-based surgeries and special procedures at the noncompliant clinic or facility poses a threat of potential harm to patients, the secretary may exercise injunctive authority until such time as a hearing may be conducted in accordance with the provisions of the Kansas administrative procedure act.

Sec. 4. (a) Any clinic or facility which remains noncompliant to the correction order and continues to violate any provision of the rules and regulations adopted under this act may incur a civil penalty in an amount not more than $5,000 for every such violation. In the case of a continuing violation, every day such violation continues shall be deemed a separate violation.

(b) The secretary, upon a finding that a clinic or facility has violated any provision of rules and regulations adopted under this act may impose a penalty within the limits provided in this section. In determining the amount of the civil penalty, the secretary shall take into consideration all relevant circumstances, including, but not limited to, the extent of harm caused by the violation, the nature and persistence of the violation, the length of time over which the violation occurs and any corrective actions taken.

(c) No penalty shall be imposed under this section until written notice and an opportunity for hearing have been provided to the clinic or facility alleged to have committed the violation. Such notice shall state the violation, the penalty to be imposed and the right of the clinic or facility to a hearing on the matter. Such clinic or facility, within 15 days after service of the order, may make written request to the secretary for a hearing thereon. The hearing shall be conducted in accordance with the provisions of the Kansas administrative procedure act.

the correction order will become an open record at this time and

11-3

(d) Any action of the secretary pursuant to this section is subject to review in accordance with the act for judicial review and civil enforcement of agency actions.

Sec. 5. Any clinic or facility where office-based surgery or special procedures, or both, are performed at the time rules and regulations adopted under this act take effect shall be given reasonable time, as determined by the secretary under the particular circumstances, but not to exceed 30 days from the effective date of such rules and regulations, within which to comply with such rules and regulations.

Sec. 6. (a) The secretary shall conduct unannounced inspections of any clinic or facility where office-based surgery or special procedures are performed at least every five years on a routine basis. As soon as possible after the effective date of this act, the secretary shall conduct unannounced inspections of any clinic or facility in which abortions are performed. Upon receipt of a complaint, the secretary shall conduct an inspection in a timely manner. ~~The secretary shall certify to the board of healing arts the cost of inspections under this act, and the board of healing arts shall pay to the department of health and environment from the healing arts fee fund the amount of such certified costs.~~

(b) The board of healing arts shall forward all complaints it receives regarding clinics or facilities where office-based surgery or special procedures are performed to the secretary.

(c) The secretary shall forward the results of all inspections to the board of healing arts or the state board of nursing, or both, as appropriate, when such clinic or facility is out of compliance.

Sec. 7. This act shall take effect and be in force from and after its publication in the statute book.

and after the effective dates of the adoption of the new rules and regulations under this act

(b) The secretary shall assess a fee for the inspection of any clinic or facility where office-based surgery or special procedures are performed. The fee shall cover part of the cost of the inspection and be paid by the clinic or facility being inspected to the department of health and environment. The secretary shall adopt rules and regulations establishing the fees to be charged for such inspections.

(c) The secretary shall certify to the board of healing arts the costs of inspections under this act and the amount of the costs outstanding after payment of the fees charged to inspected clinics or facilities. The board of healing arts shall pay to the department of health and environment from the healing arts fee fund the amount certified as outstanding for the inspections.

And relettering the remaining subsections

11-4

February 14, 2006

The Honorable Jim Morrison, Chairperson
House Committee on Health and Human Services
Statehouse, Room 143-N
Topeka, Kansas 66612

Dear Representative Morrison:

SUBJECT: Fiscal Note for HB 2829 by House Committee on Health and Human Services

In accordance with KSA 75-3715a, the following fiscal note concerning HB 2829 is respectfully submitted to your committee.

HB 2829 would establish standards for medical procedures at any health care facility in the state, including clinics and other locations where office-based surgery or special procedures are performed. The Secretary of the Department of Health and Environment (KDHE) would consider guidelines adopted by the Kansas Medical Society when establishing the standards. HB 2829 would define "office-based surgery" as surgery performed by a physician in a setting other than a medical care facility and a "special procedure" as a medical procedure that is not necessarily performed by a physician. The bill would also give KDHE the authority to issue correction and non-compliance orders as well as prohibit further medical procedures for clinics or facilities with non-compliance issues.

The bill would also require that the Secretary conduct unannounced inspections of any clinic or facility in which abortions are performed. Upon receiving a complaint, the Secretary would conduct an inspection in a timely manner. The Secretary would be required to certify to the Board of Healing Arts the cost of these inspections, and the Board would pay for the inspections from the Healing Arts Fee Fund. The Board of Healing Arts and the Board of Nursing would be required to forward the results of all inspections to the Secretary of Health and Environment.

Attachment 12
HHS 2-15-06

Estimated State Fiscal Effect				
	FY 2006 SGF	FY 2006 All Funds	FY 2007 SGF	FY 2007 All Funds
Revenue	--	--	--	--
Expenditure	--	--	$2,009,155	$2,009,155
FTE Pos.	--	--	--	18.00

The Board of Healing Arts indicates that the bill could be implemented within current staffing levels; however, the agency could not absorb the cost of surveys and inspections that the bill would require.

KDHE indicates that the passage of HB 2829 would increase expenditures by $2.0 million from the State General Fund and add 18.00 FTE positions to the Department. The bill would apply to approximately 2,300 physician offices. Since the bill authorizes a five-year survey cycle, 20.0 percent, or 460, of the physician offices would be surveyed each year. The Department assumes that 25.0 percent, or 115, of the inspections would require a second visit within the same year, and that 25.0 percent of all facilities would have a complaint filed against them.

In the first year, the Department estimates $980,151 in salaries that are detailed in the table below, as well as a six-month contract with a full-time surgical physician to establish standards and interact with the Board of Healing Arts. The first year cost of the contract would be $156,000, and out-year costs would be $14,400 per year for consultation fees at eight hours per month. Although the bill requires the Board of Healing Arts to reimburse KDHE from the Healing Arts Fee Fund for expenses, the State General Fund needs to be identified as the source of funding for this bill, because it is unlikely the Healing Arts Fee Fund would be able to finance an additional $2.0 million in expenditures.

The amount of survey time needed to comply with the bill was calculated on the basis of the time it takes to perform a survey at an ambulatory surgical center. Survey staff would perform the inspections and investigate complaints.

A Public Service Administrator, with the help of a Senior Administrative Assistant would write regulations, track locations covered by the law, and maintain basic office functions. The Department would also need 1.00 Attorney II, 1.00 Legal Assistant, and 1.00 Senior Administrative Assistant to interpret legal issues, 1.00 Database Administrator III, 11.00 Health Facility Surveyor I positions, and 1.00 Health Facility Surveyor II. Office space and operating expenditures of $705,574 and a 10.0 percent contingency amount of $167,430 are also included in the cost estimate.

Salaries and Wages	Amount
Health Surveyor II (1)	64,158
Health Surveyor I (11)	620,312
Public Service Administrator III (1)	64,158
Attorney II (1)	62,828
Legal Assistant (1)	38,079
Database Administrator III (1)	62,828
Sr. Administrative Assistant (2)	67,788
Subtotal Salaries and Wages	$980,151
Communications	42,120
Printing	6,300
Overhead, including Rent	167,430
Travel	309,396
Contingency	167,430
Physician Contract	156,000
Office and Other Supplies	86,328
Capital Outlay	94,000
Total Expenditures	$2,009,155

Sincerely,

Duane A. Goossen

Duane A. Goossen
Director of the Budget

cc: Aaron Dunkel, KDHE
Cathy Brown, Healing Arts

Proposed Substitute for HB NO. 2829

AN ACT concerning abortion clinics; providing for regulation, licensing and standards for the operation thereof; providing penalties for violations and authorizing injunctive actions.

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

Section 1. (a) As used in this section:

(1) "Secretary" means the secretary of health and environment.

(2) "Abortion clinic" means a facility, other than an accredited hospital, in which five or more first trimester surgical abortions in any month or any second or third trimester abortions are performed.

(3) "Department" means the department of health and environment.

(4) "Physician" means a person licensed to practice medicine and surgery in this state.

(5) "Gestational age" shall have the meaning ascribed to such term under K.S.A. 65-6701 and amendments thereto.

(6) "Viable" shall have the meaning ascribed to such term under K.S.A. 65-6701 and amendments thereto.

(b) The secretary shall adopt rules and regulations for an abortion clinic's physical facilities. At a minimum these rules and regulations shall prescribe standards for:

(1) Adequate private space that is specifically designated for interviewing, counseling and medical evaluations.

(2) Dressing rooms for staff and patients.

Attachment 13
HHS 2-15-06

(3) Appropriate lavatory areas.

(4) Areas for preprocedure hand washing.

(5) Private procedure rooms.

(6) Adequate lighting and ventilation for abortion procedures.

(7) Surgical or gynecologic examination tables and other fixed equipment.

(8) Postprocedure recovery rooms that are supervised, staffed and equipped to meet the patients' needs.

(9) Emergency exits to accommodate a stretcher or gurney.

(10) Areas for cleaning and sterilizing instruments.

(11) Adequate areas for the secure storage of medical records and necessary equipment and supplies.

(12) The display in the abortion clinic, in a place that is conspicuous to all patients, of the clinic's current license issued by the department.

(c) The secretary shall adopt rules and regulations to prescribe abortion clinic supplies and equipment standards, including supplies and equipment that are required to be immediately available for use or in an emergency. At a minimum these rules and regulations shall:

(1) Prescribe required equipment and supplies, including medications, required for the conduct, in an appropriate fashion, of any abortion procedure that the medical staff of the clinic anticipates performing and for monitoring the progress of each patient throughout the procedure and recovery period.

(2) Require that the number or amount of equipment and supplies at the clinic is adequate at all times to assure sufficient quantities of clean and sterilized durable equipment and supplies to meet the needs of each patient.

(3) Prescribe required equipment, supplies and medications that shall be available and ready for immediate use in an emergency and requirements for written protocols and procedures to be followed by staff in an emergency, such as the loss of electrical power.

(4) Prescribe required equipment and supplies for required laboratory tests and requirements for protocols to calibrate and maintain laboratory equipment at the abortion clinic or operated by clinic staff.

(5) Require ultrasound equipment in those facilities that provide abortions after 12 weeks gestational age of the fetus.

(6) Require that all equipment is safe for the patient and the staff, meets applicable federal standards and is checked annually to ensure safety and appropriate calibration.

(d) The secretary shall adopt rules and regulations relating to abortion clinic personnel. At a minimum these rules and regulations shall require that:

(1) The abortion clinic designate a medical director of the abortion clinic who is licensed to practice medicine and surgery in Kansas.

(2) Physicians performing surgery in an abortion clinic are licensed to practice medicine and surgery in Kansas, demonstrate

competence in the procedure involved and are acceptable to the medical director of the abortion clinic.

(3) A physician with admitting privileges at an accredited hospital in this state is available.

(4) Another individual is present in the room during a pelvic examination or during the abortion procedure and if the physician is male then the other individual shall be female.

(5) A registered nurse, nurse practitioner, licensed practical nurse or physician assistant is present and remains at the clinic when abortions are performed to provide postoperative monitoring and care until each patient who had an abortion that day is discharged.

(6) Surgical assistants receive training in the specific responsibilities of the services the surgical assistants provide.

(7) Volunteers receive training in the specific responsibilities of the services the volunteers provide, including counseling and patient advocacy as provided in the rules and regulations adopted by the director for different types of volunteers based on their responsibilities.

(e) The secretary shall adopt rules and regulations relating to the medical screening and evaluation of each abortion clinic patient. At a minimum these rules and regulations shall require:

(1) A medical history including the following:

(A) Reported allergies to medications, antiseptic solutions or latex.

(B) Obstetric and gynecologic history.

(C) Past surgeries.

(2) A physical examination including a bimanual examination estimating uterine size and palpation of the adnexa.

(3) The appropriate laboratory tests including:

(A) For an abortion in which an ultrasound examination is not performed before the abortion procedure, urine or blood tests for pregnancy performed before the abortion procedure.

(B) A test for anemia as indicated.

(C) Rh typing, unless reliable written documentation of blood type is available.

(D) Other tests as indicated from the physical examination.

(4) An ultrasound evaluation for all patients who elect to have an abortion after 12 weeks gestational age of the fetus. The rules shall require that if a person who is not a physician performs an ultrasound examination, that person shall have documented evidence that the person completed a course in the operation of ultrasound equipment as prescribed in rules and regulations. The physician or other health care professional shall review, at the request of the patient, the ultrasound evaluation results with the patient before the abortion procedure is performed, including the probable gestational age of the fetus.

(5) That the physician is responsible for estimating the gestational age of the fetus based on the ultrasound examination and obstetric standards in keeping with established standards of care regarding the estimation of fetal age as defined in rules

and regulations and shall verify the estimate in the patient's medical history. The physician shall keep original prints of each ultrasound examination of a patient in the patient's medical history file.

(f) The secretary shall adopt rules and regulations relating to the abortion procedure. At a minimum these rules and regulations shall require:

(1) That medical personnel is available to all patients throughout the abortion procedure.

(2) Standards for the safe conduct of abortion procedures that conform to obstetric standards in keeping with established standards of care regarding the estimation of fetal age as defined in rules and regulations.

(3) Appropriate use of local anesthesia, analgesia and sedation if ordered by the physician.

(4) The use of appropriate precautions, such as the establishment of intravenous access at least for patients undergoing second or third trimester abortions.

(5) The use of appropriate monitoring of the vital signs and other defined signs and markers of the patient's status throughout the abortion procedure and during the recovery period until the patient's condition is deemed to be stable in the recovery room.

(g) The secretary shall adopt rules and regulations that prescribe minimum recovery room standards. At a minimum these rules and regulations shall require that:

(1) Immediate postprocedure care consists of observation in a supervised recovery room for as long as the patient's condition warrants.

(2) The clinic arrange hospitalization if any complication beyond the management capability of the staff occurs or is suspected.

(3) A licensed health professional who is trained in the management of the recovery area and is capable of providing basic cardiopulmonary resuscitation and related emergency procedures remains on the premises of the abortion clinic until all patients are discharged.

(4) A physician or a nurse who is advanced cardiovascular life support certified shall remain on the premises of the abortion clinic until all patients are discharged and to facilitate the transfer of emergency cases if hospitalization of the patient or viable fetus is necessary. A physician or nurse shall be readily accessible and available until the last patient is discharged.

(5) A physician or trained staff member discusses Rho(d) immune globulin with each patient for whom it is indicated and assures it is offered to the patient in the immediate postoperative period or that it will be available to her within 72 hours after completion of the abortion procedure. If the patient refuses, a refusal form approved by the department shall be signed by the patient and a witness and included in the medical record.

(6) Written instructions with regard to postabortion coitus, signs of possible problems and general aftercare are given to each patient. Each patient shall have specific instructions regarding access to medical care for complications, including a telephone number to call for medical emergencies.

(7) There is a specified minimum length of time that a patient remains in the recovery room by type of abortion procedure and gestational age of the fetus.

(8) The physician assures that a licensed health professional from the abortion clinic makes a good faith effort to contact the patient by telephone, with the patient's consent, within 24 hours after surgery to assess the patient's recovery.

(9) Equipment and services are located in the recovery room to provide appropriate emergency resuscitative and life support procedures pending the transfer of the patient or viable fetus to the hospital.

(h) The secretary shall adopt rules and regulations that prescribe standards for follow-up visits. At a minimum these rules and regulations shall require that:

(1) A postabortion medical visit is offered and, if requested, scheduled within four weeks after the abortion, including a medical examination and a review of the results of all laboratory tests.

(2) A urine pregnancy test is obtained at the time of the follow-up visit to rule out continuing pregnancy. If a continuing pregnancy is suspected, the patient shall be evaluated and a

physician who performs abortions shall be consulted.

(i) The secretary shall adopt rules and regulations to prescribe minimum abortion clinic incident reporting. At a minimum these rules and regulations shall require that:

(1) The abortion clinic records each incident resulting in a patient's or viable fetus' serious injury occurring at an abortion clinic and shall report them in writing to the department within 10 days after the incident. For the purposes of this paragraph, "serious injury" means an injury that occurs at an abortion clinic and that creates a serious risk of substantial impairment of a major body organ.

(2) If a patient's death occurs, other than a fetal death properly reported pursuant to law, the abortion clinic shall report such death to the department of health and environment not later than the next department business day.

(3) Incident reports are filed with the department of health and environment and appropriate professional regulatory boards.

(j) (1) The secretary shall adopt rules and regulations requiring each abortion clinic to establish and maintain an internal risk management program which, at a minimum, shall consist of: (A) A system for investigation and analysis of the frequency and causes of reportable incidents within the clinic; (B) measures to minimize the occurrence of reportable incidents and the resulting injuries within the clinic; and (C) a reporting system based upon the duty of all health care providers staffing the clinic and all agents and employees of the clinic directly

involved in the delivery of health care services to report reportable incidents to the chief of the medical staff, chief administrative officer or risk manager of the clinic.

(2) As used in this subsection (j), "reportable incident" means an act by a health care provider which: (A) Is or may be below the applicable standard of care and has a reasonable probability of causing injury to a patient; or (B) may be grounds for disciplinary action by the appropriate licensing agency.

(k) The secretary shall make or cause to be made such inspections and investigations of abortion clinics at such intervals as the secretary determines necessary to protect the public health and safety and to implement and enforce the provisions of this act and rules and regulations adopted hereunder. For that purpose, authorized agents of the secretary shall have access to an abortion clinic during reasonable business hours.

(l) Information received by the secretary through filed reports, inspections or as otherwise authorized under this act shall not be disclosed publicly in such manner as to identify individuals. Under no circumstances shall patient medical or other identifying information be made available to the public, and such information shall always be treated by the department as confidential.

(m) (1) No person shall operate an abortion clinic in this state unless such clinic holds a currently valid license as an abortion clinic under this act. Each such clinic shall be

required annually to obtain a license from the department. The secretary shall adopt rules and regulations providing for the issuance of such licenses. At a minimum such rules and regulations shall require compliance with the standards adopted pursuant to this act. The secretary shall establish by rules and regulations the fee for such licenses in the amount required to cover costs of implementation and enforcement of this act.

(2) The department shall deny, suspend or revoke a license in any case in which it finds that there has been a substantial failure to comply with the requirements established under this act and rules and regulations adopted pursuant thereto, a failure to report any information required to be reported under subsections (i) and (j) or a failure to maintain a risk management program as required under subsection (j), after notice and an opportunity for hearing to the applicant or licensee in accordance with the provisions of the Kansas administrative procedure act.

(n) The rules and regulations adopted by the secretary pursuant to this section do not limit the ability of a physician or other health care professional to advise a patient on any health issue. The secretary periodically shall review and update current practice and technology standards under this act and based on current practice or technology adopt by rules and regulations alternative practice or technology standards found by the secretary to be as effective as those enumerated in this act.

(o) The provisions of this act and the rules and regulations

adopted pursuant thereto shall be in addition to any other laws and rules and regulations which are applicable to facilities defined as abortion clinics under this section.

(p) In addition to any other penalty provided by law, whenever in the judgment of the secretary of health and environment any person has engaged, or is about to engage, in any acts or practices which constitute, or will constitute, a violation of this section, or any rules and regulations adopted under the provisions of this section, the secretary shall make application to any court of competent jurisdiction for an order enjoining such acts or practices, and upon a showing by the secretary that such person has engaged, or is about to engage, in any such acts or practices, an injunction, restraining order or such other order as may be appropriate shall be granted by such court without bond.

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