Approved: March 21, 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 March 20, 2006, in Room 526-S of the Capitol.

All members were present except Representatives Landwehr, Watkins, Bethell, and Miller, all of whom were excused.

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

Conferees appearing before the committee:
Jan Buckman, Fetal Alcohol Symdrome Clinic, Emporia
Ed Olson, President, Lyme Association of Greater Kansas City
Jeanne Gawdun, Senior Lobbyist, Kansas for Life
Rocky Nichols, Executive Director, Disability Rights Center of Kansas
Shannon Jones, Executive Director, Statewide Independent Living Council of Kansas
Senator David Haley

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

Jan Buckman, former Chief of Rehabilitation Services, Kansas Social and Rehabilitation Services (SRS) who presently works with the Fetal Alcohol Syndrome Clinic in Emporia, reviewed the effects of fetal alcohol syndrome, which may include memory deficits, limited abstract thinking, confused receptive language, poor social skills, erratic problem-solving skills, and explosive emotional episodes. (Attachment 1) She said becoming aware of the source of such behavior and working to change the environment, not the conduct, provide the best strategies for stability and a more productive life.

Ed Olson, President, Lyme Association of Greater Kansas City, presented information about Lyme disease. (Attachment 2) He reviewed information about Lyme disease and the work of the Kansas City Lyme Association, noting that its most important function is the hotline to answer questions from concerned citizens. He commented that Lyme disease is often misdiagnosed because it displays symptoms similar to many other ailments. He emphasized the need for education and prompt treatment, stating that four Kansans have died from the disease. He cited legislation in Rhode Island that addresses some of the needs associated with Lyme disease.

The Chair opened the hearing on **SB 528.**

Jeanne Gawdun, Senior Lobbyist, Kansas for Life, spoke as a proponent. (Attachment 3) She said the bill expands some statistical information about post-22-week abortion reporting and reporting of infants born

alive during an abortion procedure, commenting that the bill clarifies reasons reported for abortion of viable babies and noting that more specific information regarding mental health and fetal anomalies will provide more nearly accurate statistics regarding abortions. She cited several instances where information was vague, referenced a chart regarding abortion statistics, (Attachment 4), and provided a sample termination of pregnancy report, (Attachment 5) and a sample birth certificate. (Attachment 6)

Judy Smith, State Director, Concerned Women for America of Kansas, provided written testimony as a proponent. (Attachment 7)

Rocky Nichols, Executive Director, Disability Rights Center of Kansas, testified as a neutral party, commenting that the disability community had concerns about the potential discriminatory effects of the bill. (Attachment 8) He urged the committee to consider two questions before making judgments about the bill: (1) Why does the bill only require data regarding specific disabilities, which, if the bill were to become law, would be the only Kansas statute referencing disabilities? and, (2) Can the Kansas Department of Health and Environment (KDHE) provide assurances that the privacy of those listed will be absolutely protected? He commented that he could not find such assurances in the bill, noting that cross-tabulation of data could identify individuals even if no names were used. He recommended that the bill specify the use of raw data collected in the aggregate statewide.

Senator David Haley spoke as an opponent of the bill. (Attachment 9) He said the bill is intended primarily for use as an election issue, commenting that the bill is duplicitous, confusing, and is merely a tool to harass abortion providers. He complained about the perceived surreptitious introduction of the bill in the Senate committee and urged members to follow time-tested procedures in dealing with the bill. Answering questions, he said the estimated additional cost of $25 per late-term abortion might be a burden on some low-income women and serves only to chip away at a women's right to choose. Regarding the Kansas Attorney General's attempt to investigate health records of abortion providers, he replied he was unaware of what effect this bill would have.

Shannon Jones, Executive Director, Statewide Independent Living Council of Kansas, said her organization seeks to promote the civil rights of disabled individuals. (Attachment 10) She said her primary concern focused on lines 33-42 of page 1, which singles out women with disabilities, unaccountably placing in statute a certain class of individuals. She recommended striking the offensive language.

The following provided written testimony in opposition to the bill: Ami Hyten, Assistant Executive Director, Topeka Independent Living Resource Center, (Attachment 11); Anne-Marie Hughey, Legislative and Policy Advocate, Southeast Kansas Independent Living Resource Center, (Attachment 12); Kathy Lobb, Legislative Liaison, Self-Advocate Coalition of Kansas, (Attachment 13); Elizabeth Hatcher, Psychiatrist, Topeka, (Attachment 14); Robbin Palmer, Ph.D, Genetic Counselor, Reno, NV, (Attachment 15); and Kerrie Bacon, Kansas Commission on Disability Concerns. (Attachment 16)

Members posed several questions to conferees. Ms. Jones said if the designated lines were struck, she would not object to the bill. Responding to another question, she added another line (page 3, line 19) she said should be struck. Dr. Lorne Phillips, Director, Bureau of Vital Statistics, Division of Health, KDHE, answered that the bill refers to two different forms already in use—the termination of pregnancy report and the (live) birth certificate. A member commented that the present forms are adequate without

requiring the proposed additions. To another question, he said there is no concept in current law about an attempted abortion resulting in a live birth. Mr. Nichols, responding to a question that if the bill identifies a disparate number of those with disabilities as having abortions and thus offers protection for them rather than discriminating against them, said his only purpose was to raise the question regarding discrimination. When a member cited a statistic that those mentally deficient are more likely to be abused (25% more boys, 40% more girls), Mr. Nichols said that if the bill is used as a basis for collecting data, the committee should first answer the two questions he posed. Ms. Gawdun replied that the intent of the bill was to create parity on the reporting forms and to assure that the federal born-alive law is being followed, the latter which is not clear at present because the reporting is incomplete. Ms. Jones said she had no knowledge whether the disabled have more or fewer abortions than the general populace.

A fiscal note was included for members. (Attachment 17)

The hearing on **SB 528** was closed.

The meeting was adjourned at 3:31 p.m. The next meeting is scheduled for Tuesday, March 21, 2006.

HOUSE HEALTH AND HUMAN SERVICES COMMITTEE
GUEST LIST

DATE: MARCH 20 2006

NAME	REPRESENTING
Josie Torrez	SILCK
[illegible]	[illegible]
[illegible]	KDHE
Jennifer Lyon	Pinegar, Smith, & Assoc.
Greg Crawford	KDHE
Roy Schmitz	Lyme Disease
Ed Olson	Lyme Association
Jan Buchman	FAS
Shannon Jones	SILCK
Sky Westerlund	KNASW
Dan Murray	Federico Consulting
Debra Billingsley	Board of Pharmacy
Tanya Dorf	KACIL
Sharon Johnson	DHPF
Alan & Eileen Angleton	
Jeanne Gawdun	KFL
Dan Morin	Kansas Medical Society
Kathleen T. Ostrowski	KFL

What Is FAS/FAE And Is There Help Out There?

By Jan Buckman M.S, C.R.C.

In the last decade research into the cause and severity of drinking while pregnant has increased exponentially with new imaging techniques in the medical field, and with the realization of how serious and wide-spread this disability is among all of the population. I takes very little alcohol to cause serious brain damage. Even a single dose, at the wrong time, can cause a varying intensity in loss of I.Q., ADD/ADHD, memory deficits, tremors, asthma, developmental delay, autistic traits, auditory processing delay, depression, heart defects, and a wide variety of common behavior diagnoses. There are approximately 50,000 toxic substances that can cause prenatal damage to the fetus, and alcohol exposure is the number 1 toxin that causes damage. The severity of the damage depends on the amount of alcohol drank, timing during pregnancy, peak alcohol levels, genetic make-up of the fetus, and environmental factors. Most researchers are adamant that there is no safe level of drinking while pregnant. Unfortunately, fetuses can be unknowingly damaged during the time a woman does not even know that she is pregnant if she has a social drink, or by drinking a glass of wine to celebrate her pregnancy.

Although Fetal Alcohol Syndrome is the most widely known alcohol-related disability, Fetal Alcohol Effects can be the most damaging to society and to the individual. FAE is also referred to as Alcohol-Related Neurodevelopmental Disorders (ARND). Although FAE individuals may not have the physical appearance associated with full-blown FAS, damage to the brain and internal organs can be just as devastating. Remember, timing is crucial in producing various fetal brain damage. And since these children and adults with undiagnosed FAE look "normal", they are expected to develop and behave along the usual timelines. But if left undiagnosed, these individuals can develop secondary traits that can often lead to school drop-out, trouble with the law, unplanned pregnancy, homelessness, mental illness, drug and alcohol addiction, and inappropriate sexual behavior, with 82% unable to live independently.

Some of the common problems resulting in brain damage and the way they are characterized, noted by Morse, Rathbun, and Malbin, and based on theoretical construct are:

Memory deficits which can create a slow awareness that causes a time lag from input to understanding the action, the need for constant reminders and repetition, inconsistent memory, and problems with vision and auditory processing.

Abstract thinking can cause many independent living problems with adults, as well as with children. They have no concept of the value of money, their abilities in math are very poor, their concept of time may be decreased, and they may have problems associating new information with past information.

Receptive language may prevent the individual from comprehending what is being said. That is why it is important to not "talk too much" and create confusion, and to express information in many different ways.

Attachment 1
AHS 3-20-06

Difficulty generalizing may prevent the individual from seeing the cause and effect of their behavior. They can have poor social skills, be impulsive, cannot utilize traditional problem-solving skills, or associate their behaviors from one day to the next.
Difficulty seeing similarities and differences can cause distractibility, over-stimulation creating hyperactivity, difficulty sequencing and seeing patterns.
Perseveration can be seen as not wanting to stop an activity such as a project, teasing, interrupting, or a resistance to change.
Shut down is manifested by chronic frustration from having these neurological problems, and society expecting them to develop and understand their surroundings at the "normal" pace. They may appear as withdrawn but have explosive episodes with little provocation. They may show a higher degree of defiance than your typical teenager.

So, is there help out there to deal with this hidden disability? Help from professionals is growing every day as they learn how to deal with this population. But for some very quick ideas on what might help, Deb Evensen and Jan Lutke, educators and leaders in Alaska with this mission, developed a very general outline for successful interventions called **Eight Magic Keys :**

1. **Concrete** – don't use words that have double-meaning, idioms, etc., because their social and emotional understanding is far below their age level. Think younger.
2. **Consistency** – since learning from one situation to another is difficult, have few changes in their environment, including language use.
3. **Repetition** – for learning to make it to long-term memory, it needs repetition.
4. **Routine** – stable routines will decreased anxiety and increase learning.
5. **Simplicity** – "Keep it short and sweet". People with FAS/FAE are easily over-stimulated, leading to "shut-down", a wall for learning.
6. **Specific** – say exactly what you mean since they have problems generalizing, abstracting, and not being able to "fill in the blanks" when given instructions. Give step-by-step directions.
7. **Structure** – it creates the foundation to be successful in their environment.
8. **Supervision** – because of brain damage supervision is needed as if the person were much younger. This will develop habit patterns of appropriate behavior and maturity.

When an intervention is not working, then:
Stop Action!
Observe
Listen carefully to find out where he/she is stuck

Although FAS/FAE is not curable, if we can view this disability, and its resulting behaviors, as being beyond their control, then better understanding can be gained into the difficulties that they are going through. If attitudes and environments can be changed to reflect the concept that poor behavior is not willful, then there will be fewer legal problems, unwanted pregnancies, alcohol and drug addictions, school problems and early drop-outs, mental health problems, and other immeasureable societal successes. That does not even count the success of living a happy and productive life.

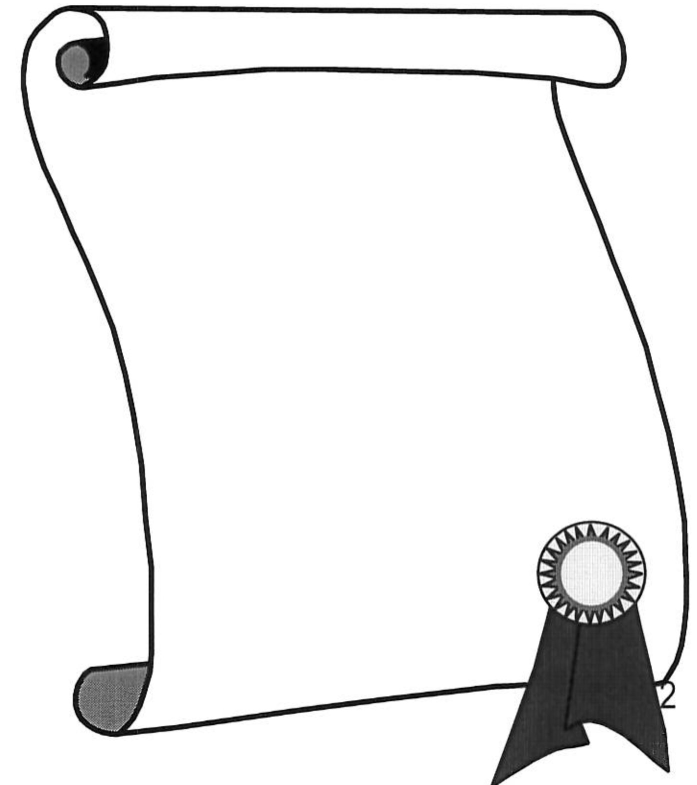
The Lyme Association of Greater Kansas City, Inc.

Attachment 2
HHS 3-20-06

- Ed Olson, President
- Evelyn Steeley, 1st Vice President
- Karen Welch, 2nd Vice President
- Kathy White, Secretary
- Ray Schmitz, Treasurer
- Welcome to our Presentation

Lyme Association of Greater Kansas City, Inc.

- A non-profit, {501 (c) (3)} all-volunteer, patient support group serving both Kansas and Missouri



Goals of the Lyme Association

- **To** provide information and support to victims of Lyme Disease and their families
- **To** promote cooperation with the medical community
- **To** increase public awareness of tick-borne diseases and their prevention

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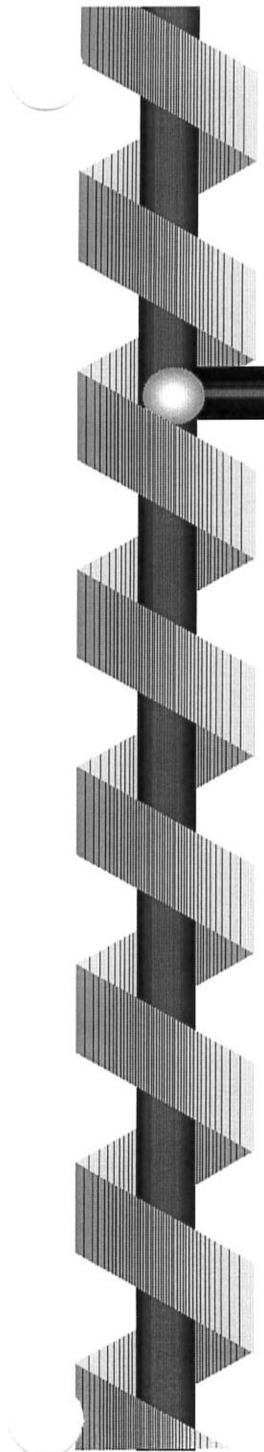
Activities of the Lyme Association

- Maintains a website http://community.Lawrence.com/orgs/Lymeassociation
- Provides monthly meetings with guest speakers for victims of Lyme disease
- Operates a hotline (913) 438-LYME and E-mail address Lymefight@aol.com



Activities (continued)

- Publishes a monthly newsletter, Prime Time Lyme
- Produces a brochure about Lyme disease
- Distributes brochures to libraries and physician's and chiropractic offices

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Lyme Association Display Table

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Activities (continued)

- Mails information packets about Lyme disease upon request
- Participates in health fairs in schools and community
- Makes presentations to schools, youth and community groups
- Provides free education packets and tick removal kits to schools

Lyme Disease Education Packet Content

- Handbook - Lyme disease information and symptom descriptions. Also includes:
- LDF brochure, Tick-Spread Diseases,16 pages of colored pictures
- LDA brochure , Lyme {R} Primer, 8 pages
- LDA brochure, The ABC's of Lyme disease, 10 pages
- CD containing four 15 minute presentations, one each for K-4 and 5-6, plus 2 presentations for 7-12 grades

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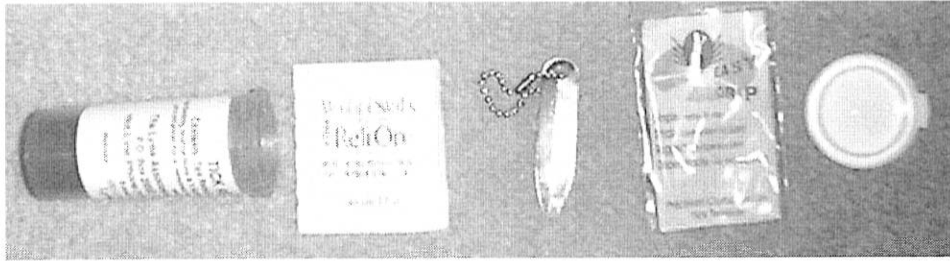
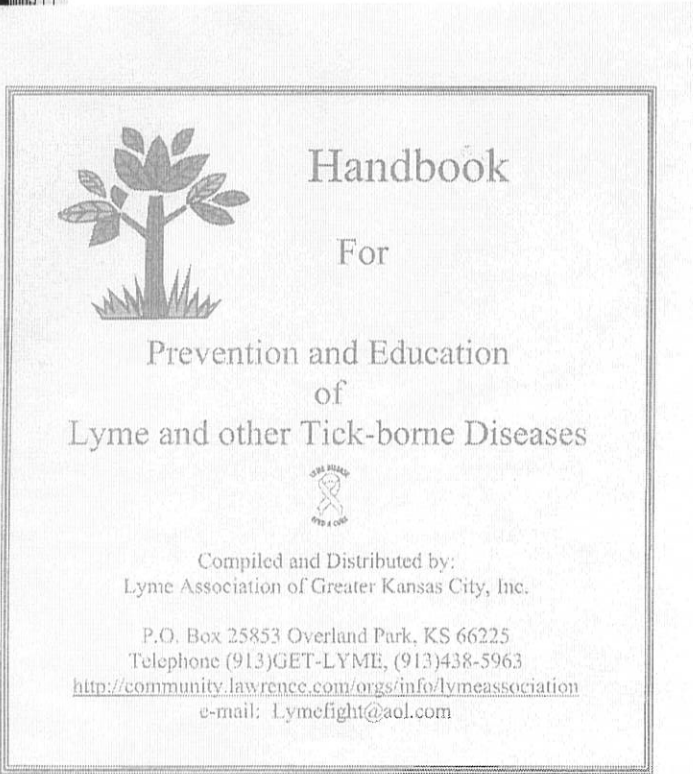
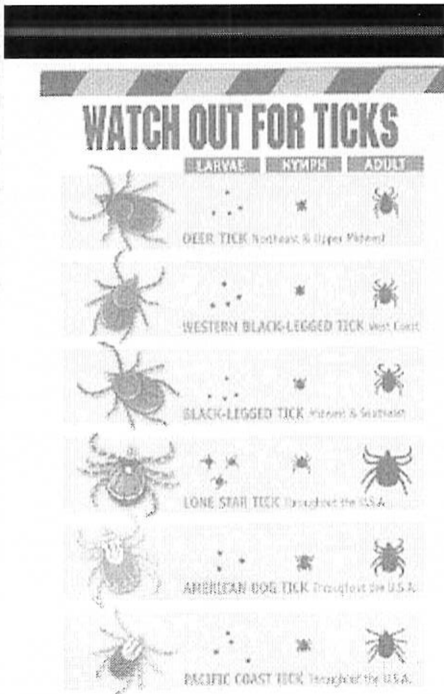
Lyme Disease Education Packet Contents (continued)

- Tick removal kit in a plastic vial, includes:
- Tick removal tool with instructions
- Alcohol swabs
- Zip-lock bag for a removed tick



The Handbook, Tick Card and Brochure

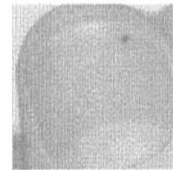


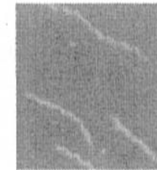


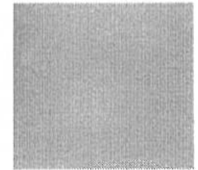
Lyme Disease On the *RISE*

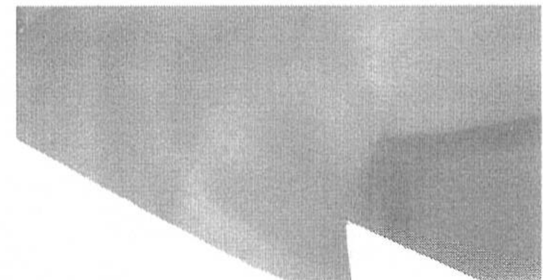
Protect Your Family

Lyme disease® causes a variety of Symptoms and can become disabling if not treated promptly with antibiotics. It is caused by the bite of a tick infected with Lyme bacteria. The disease has spread throughout the U.S.


Ixodes tick on thumb


Lyme Bacteria (spirochetes) (magnified)


EM rash



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Education Makes a Difference

- Tick bites, the usual cause of Lyme disease, can often be prevented if people know what measures to take

Education Makes a Difference

- Prompt treatment can often prevent the disease from becoming chronic and disabling

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Education Makes a Difference

- Knowledge of early symptoms and the importance of prompt treatment will motivate people to seek prompt medical care

Education Makes a Difference

- Funding is needed by the Lyme Association to reach their goal of an Education packet in every school in Kansas

Education Packets Create Awareness

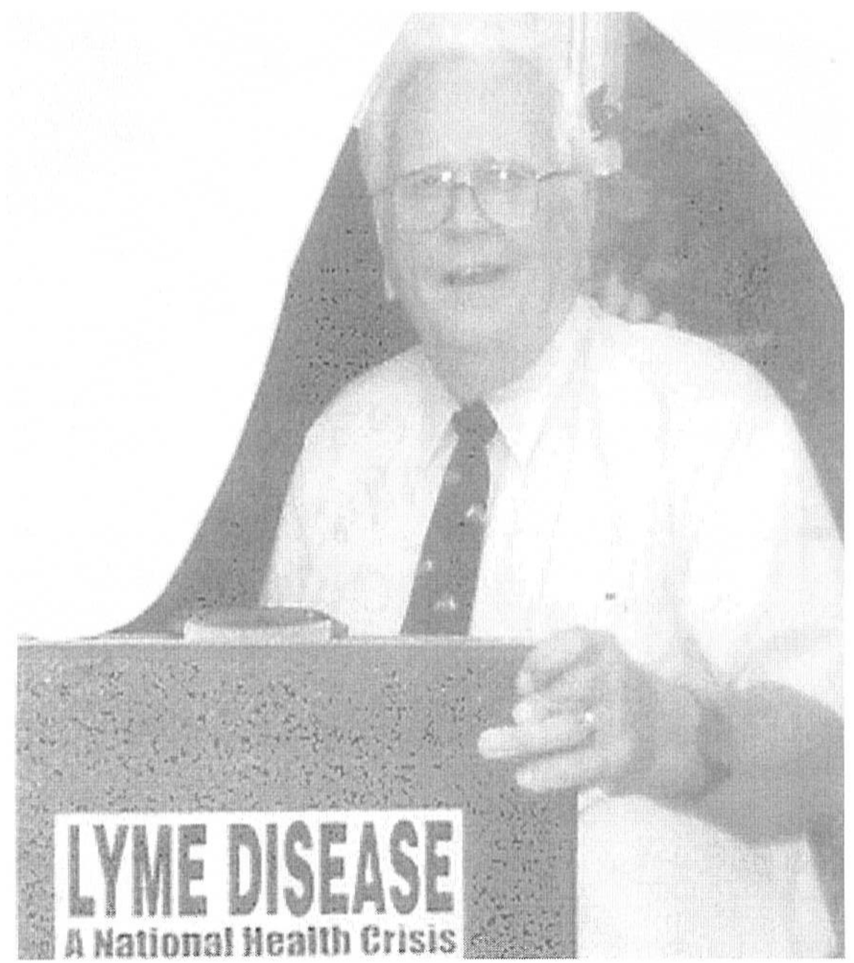
- The Lyme Association has given 220 packets to schools in Kansas.
- Kansas has approximately 2,003 schools.
- There are about 1,783 schools without packets.
- The Lyme Association can equip the remaining schools with education packets with a grant of $12,000.00 - $15,000.00.

Legislation Recommended

- Protect doctors from having their licenses threatened by medical review boards for treating chronic Lyme disease with antibiotics
- Require Insurance Companies to pay for IV antibiotics and other Lyme disease treatment as needed

The Lyme Association of Greater Kansas City, Inc.

- **PART TWO**
- Ed Olson, President



3/21/2006

- Lyme disease is present and the number of incidents is increasing in Kansas. The large herds of white tail deer are carriers after they have been bitten by an infected tick.
- We have many hot-line calls from people whose doctor denies that Lyme disease is present and want to treat them for other conditions. (arthritis, etc)

The Lyme Association of Greater Kansas City, Inc.

- Lyme patients in Kansas are routinely denied adequate treatment by their insurance companies, resulting in debilitating chronic illness, and sometimes death

- If the disease becomes chronic, longer antibiotic treatment is necessary. Doctors in other states have had their licenses threatened or suspended by medical review boards for treating Lyme disease with antibiotics for more than four weeks

- It is important that Kansas take action promptly to prevent our situation from deteriorating to the level cited in the Rhode Island "Lyme Diagnosis and treatment Act" (The following slides will display this law)

ŽThe Lyme Association of Greater Kansas City, Inc.

- ž We present the Rhode Island law as an example of how a state has made an effort to solve the growing problem of Lyme Disease.
- ℌ We, the Lyme Association of Greater Kansas City, Inc. suggest, encourage, and recommend that this type of legislation be passed for the state of Kansas ASAP. The concerns outlined in the Preamble are almost identical to the situation in Kansas.

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Rhode Island Lyme Disease Law CHAPTER 5-37.5

- Lyme Disease Diagnosis and Treatment
  - Index Of Sections
  - § 5-37.5-1 Short title
  - .§ 5-37.5-2 Preamble
  - .§ 5-37.5-3 Definitions.
  - § 5-37.5-4 Long-term antibiotic treatment.
  - § 5-37.5-5 Mandatory coverage for certain Lyme Disease treatments
  - Effective until December 31, 2004.

Rhode Island Lyme Disease Law TITLE **5**

- **Businesses and Professions**
  - **CHAPTER *5-37.5***
  - **Lyme Disease Diagnosis and Treatment**
    - **SECTION 5-37.5-1**

§ 5-37.5-1 Short title.

- — This chapter shall be known and may be cited as the "Lyme Disease Diagnosis and Treatment Act."

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- **TITLE** 5
- **Businesses and Professions**
  - **CHAPTER *5-3* 7.5**
    - –SECTION 5-37.5-2

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§ 5-37.5-2 Preamble. — WHEREAS,

- The Governors Commission on Lyme Disease and Other Tick-Borne Diseases (the "Commission") was formed by executive order in 2002; and,

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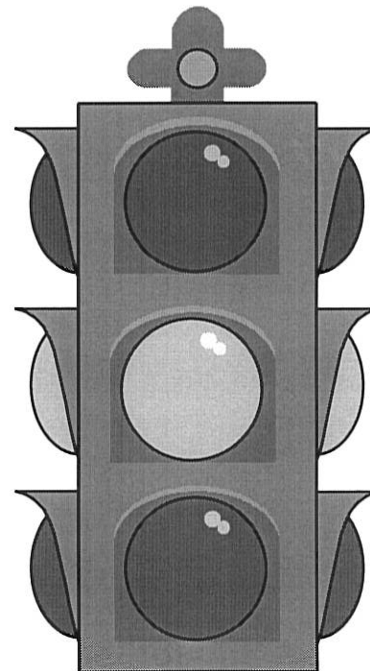
WHEREAS,

- The General Assembly recognizes the negative impact of Lyme disease on Rhode Islanders; and,



WHEREAS,

- Rhode Island has the second highest number of reported Lyme disease cases as a percentage of population in the United States; and,

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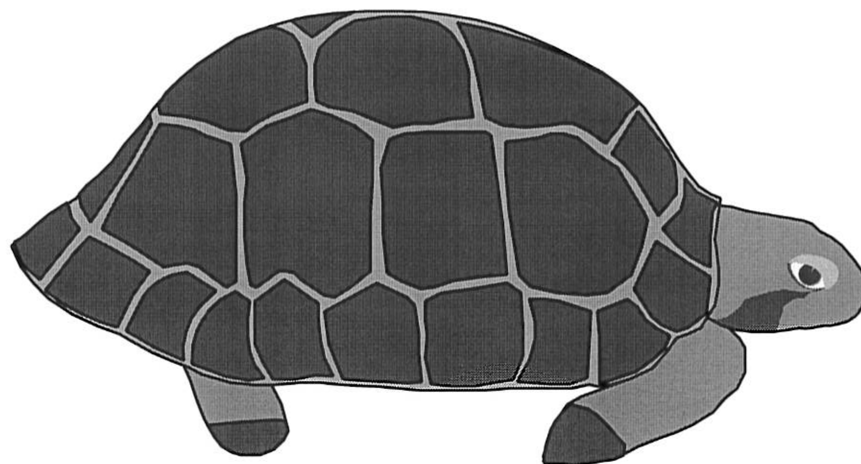
WHEREAS,

- The Commission and the General Assembly held hearings and reviewed the medical literature to gain an understanding of the concerns of citizens and the medical community about Lyme disease diagnosis, treatment and prevention; and,

WHEREAS,

- Citizens of Rhode Island diagnosed with chronic Lyme disease experience great difficulty in being diagnosed and treated thereby impairing their access to medical care; and,



WHEREAS,

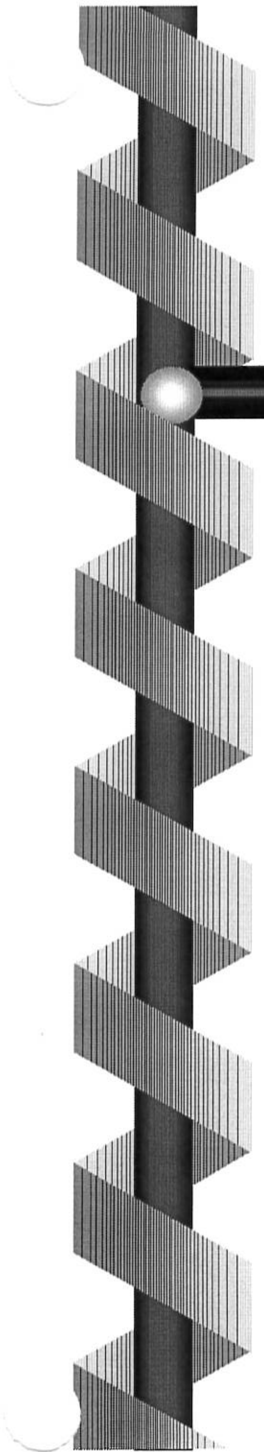
- The lack of insurance coverage for diagnosis and long-term antibiotic therapies is a major barrier to access to medical care for persons with symptoms compatible with chronic Lyme disease; and,

WHEREAS,

- Physicians whose practices are devoted to treating chronic Lyme disease patients, and who continue to provide treatment if they feel such treatment is medically necessary, have noted significant improvement in the condition of their patients; and,

WHEREAS,

- There is substantial evidence that considerable scientific controversy surrounds the diagnosis and treatment of Lyme disease and other tick-borne illnesses; and,



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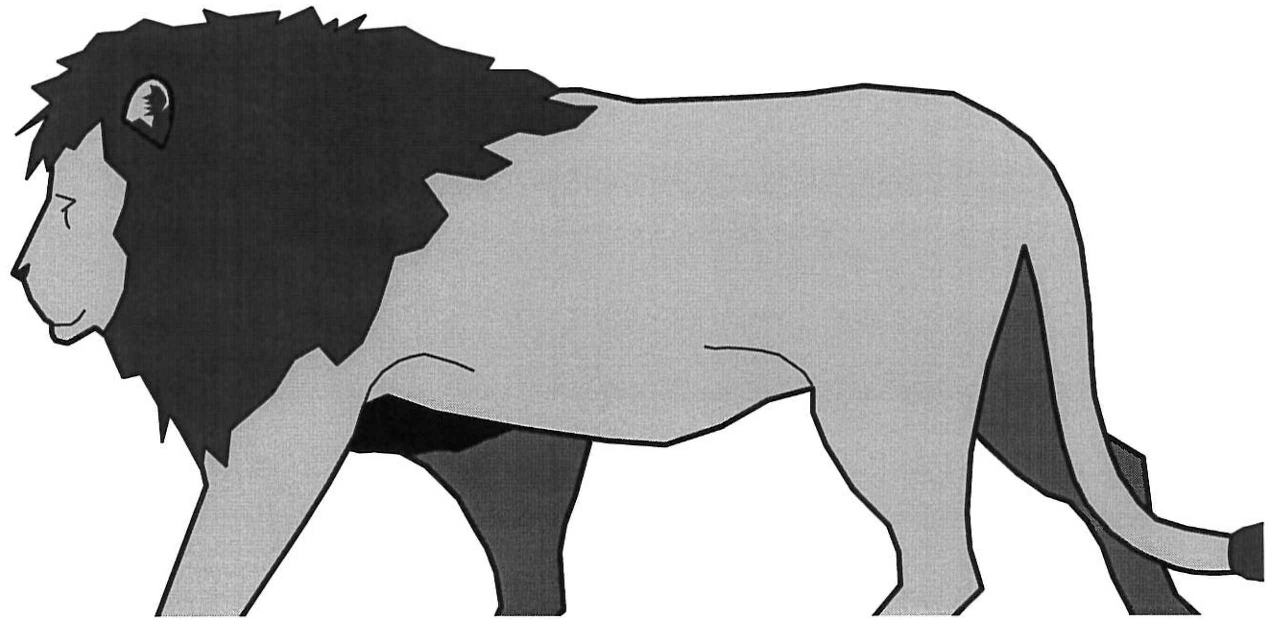
WHEREAS,

- Some physicians feel threatened by insurers and licensing boards for their choices among possible therapies for their patients; and,



WHEREAS,

- The Commission and this General Assembly recommend that legislation be adopted that promotes access to medical care for persons with chronic Lyme disease in Rhode Island; and,
- **Now, therefore**, it is enacted by the General Assembly as follows:

SECTION 5-373-3

- **§ 5-37.5-3 Definitions. — For purposes of the chapter,**
  - **(1) “Board” means the Rhode Island board of medical licensure and discipline;**

Definitions

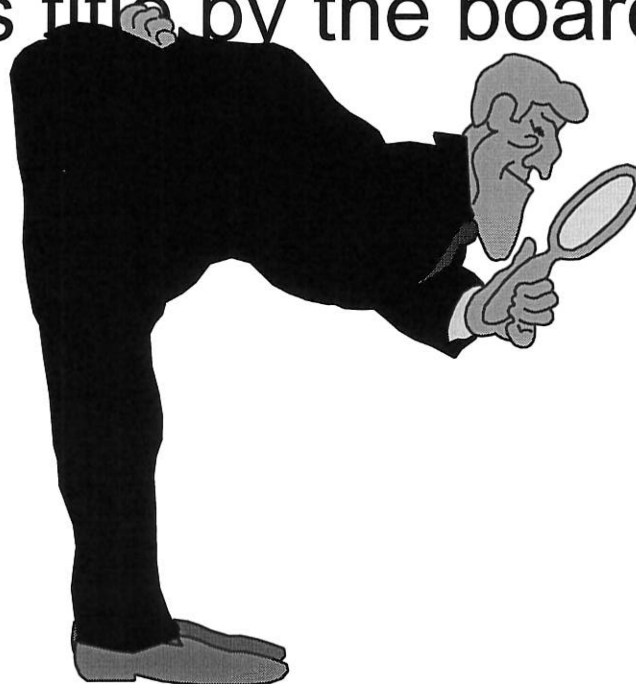
- (2) "Lyme disease" means the clinical diagnosis by a physician of the presence in a patient of signs and symptoms compatible with acute infection with Borrelia burgdorferi, or with late stage or chronic infection with Borrelia burgdorferi, or with complications related to such an infection.

Definition

- "Lyme disease" includes infection which meets the surveillance criteria set forth by the US Centers for Disease Control and Prevention (CDC), but also includes other acute and chronic manifestations of such an infection as determined by the physician;

Definition

– (3) "Physician" means persons licensed pursuant to chapter 37 of this title by the board;



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Definition

- (4) "Therapeutic purpose" means the use of antibiotics to control a patient's symptoms determined by the physician as reasonably related to Lyme disease and its sequelae;

Definition

- (5) “Long term antibiotic therapy” means administration of oral, intramuscular or intravenous antibiotics, singly or in combination, for periods of greater than four (4) weeks.

SECTION 5-37.5-4

- **§ 5-37.5-4 Long-term antibiotic treatment. — (a)**
- A physician may prescribe, administer, or dispense antibiotic therapy for therapeutic purpose to a person diagnosed with and having symptoms of Lyme disease if this diagnosis and treatment plan has been documented in the physician's medical record for that patient.

Long-term antibiotic treatment. — (a) (continued)

- No physician is subject to disciplinary action by the board solely for prescribing, administering or dispensing long-term antibiotic therapy for a therapeutic purpose for a patient clinically diagnosed with Lyme disease, if this diagnosis and treatment plan has been documented in the physician's medical record for that patient.

Long-term antibiotic treatment - (b)

- (b) Nothing in this section denies the right of the board to deny, revoke, or suspend the license of any physician or discipline any physician who prescribes, administers, or dispenses long-term antibiotic therapy for a non-therapeutic purpose,

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Long-term antibiotic treatment – (b) (continued)

- or who fails to monitor the ongoing care of a patient receiving long-term antibiotic therapy, or who fails to keep complete and accurate ongoing records of the diagnosis and treatment of a patient receiving long-term antibiotic therapy.

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SECTION *5-37.5-5*

- § 5-37.5-5 Mandatory coverage for certain Lyme disease treatments. [Effective until December 31, 2004.]

Mandatory coverage -- (continued)

- — Every individual or group hospital or medical expense insurance policy or individual or group hospital or medical services plan contract delivered, issued for delivery, or renewed in this state on or after January 1, 2004, shall provide for Lyme disease treatment as provided in chapters 27-18, 27-19, 27-20, and 27-41 of the general laws.

A copy of this law can be obtained by clicking on the following url.

http://www.rilin.state.ri.us/statutes/title5/5-37.5/index.htm

3/21/2006

LYME DISEASE CASE REPORT FORM

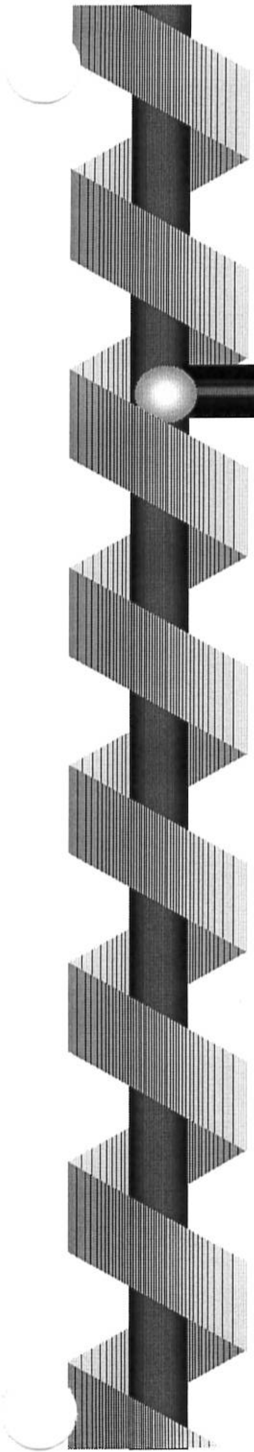
- We believe that the current report form which doctors are required to submit to the health department does not meet the requirements of the current conditions.

LYME DISEASE CASE REPORT FORM

- It is generally accepted that only 1 to 10 percent of Lyme cases are reported because they do not meet the CDC surveillance requirements.

LYME DISEASE CASE REPORT FORM

- We therefore recommend that the current form be updated or modified so that adequate data is collected to maintain a tracking of Lyme disease cases in the state of Kansas



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END of PRESENTATION

- The Lyme Association of Greater Kansas City, Inc wishes to thank the Kansas State House Health Committee for this opportunity to share our concerns about the growing need to inform and support Lyme disease patients.
- Lymefight@aol.com

3/21/2006

Kansans for Life

Proponent SB 528

March 17, 2006
House Health and Human Services Committee
Chairman Jim Morrison,

Good Afternoon Chairman Morrison and committee members, I am Jeanne Gawdun, senior lobbyist for Kansans for Life, an affiliate of the National Right to Life Committee. I am here to testify in support of SB 528, a bill addressing post-22-week abortion reporting and infants born alive during abortion.

SB 528 expands some statistical information already being collected about post-22-week abortion in Kansas. State law requires an abortion of a viable baby be based on a referral from a physician in addition to the abortionist. **The bill will require the vital statistics department to verify the second physician,** in a way similar to the protected manner that identification of the abortionists is kept.

SB 528 **will clarify the reason reported for abortions of viable babies.** The state abortion reporting form already specifically asks whether a post-22-week Partial Birth abortion was done for the mental or physical health of the mother, but neglected to ask that explicit question for other post-22-week abortion methods.

Kansas passed a conjoined late-term and partial birth abortion law in 1998 narrowing the legal reason for obtaining an abortion, and requiring state reports to be filed. Post 22-week abortions would be allowed in Kansas to preserve the mother's life or to prevent "substantial and irreversible impairment of a major bodily function". Incidentally, since such reporting began in 1997, no abortions in Kansas have ever been reported to save the mother's life.

The 1998 law stated that the partial birth method of destroying a viable baby would be permitted to protect a mother's 'mental health'. As soon as this new law went into effect, partial birth abortions for 'mental health' reasons began to be reported in Kansas. *(see KFL chart below)*

Immediately after passage of the law, it was highly debated whether other methods of post-22-week abortion done for reason of "substantial and irreversible impairment of a major bodily function of the pregnant woman" also could utilize "mental health." However, within one year, it was determined that other methods of destroying a viable baby would also be permitted to protect a mother's 'mental health.' From that point in time onward, partial birth abortions ceased to be reported as occurring in Kansas.

But the **abortion reporting form was not changed after the year-long controversy of** whether all late-term abortions included 'mental health' exceptions. SB 528 will correct this by requiring that abortionists clearly report whether late-term abortion is done for the 'mental health' exception.
→ *(see questions 15 and 18 on the KDHE abortion reporting form)*

The question is raised **whether Kansas law is being violated** in regards to post-22-week abortions. Fetal anomalies, which are diseases or disabilities diagnosed as present in the unborn, were removed in 1998 as a reason for a Kansas abortion. However, last May, a series in the Los Angeles Times featured women who admitted they obtained late-term abortions because their unborn child was diagnosed with a fetal anomaly, including Down Syndrome. The abortions were obtained at George Tiller's late -term abortion business in Wichita.

Recent figures cite that up to 90% of infants **diagnosed in utero as having Down syndrome** are aborted. Federal bill S 609, co-sponsored by Senators Sam Brownback and Ted Kennedy,

Attachment 3
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would provide improved support information be given to pregnant women with in utero diagnoses of abnormalities, including Down syndrome. SB 528 would contribute data whether there are a disproportionate number of disabled children aborted in Kansas.

Another question that SB 528 can answer is **whether disabled women are targeted for abortion.** SB 528 responds to cultural trends to consider mothers with disabilities as unworthy of parenthood and babies with disabilities as unworthy of being born. SB 528 will add a few questions to the state's statistical profile of the mother and baby, including whether the mother seeking abortion, and the baby escaping abortion, are physically and/or mentally disabled.

This is dis-identified, aggregate information. Similar information about fetal anomalies and the mother's birth history is already collected on birth certificates and for other health policy purposes. All data is private, and protected under threat of criminal prosecution.

There is currently no data on how many women with cognitive disabilities are receiving abortions, although a healthy teen with Down syndrome *(pictured right)* died Jan. 13, 2005 after her 28-week-gestation abortion form George Tiller. The criminality of her pregnancy is still under investigation.

Late-term abortion facilities are places where infants may be born alive. In 2002, President Bush signed into law an act proclaiming that any infant escaping an abortion death should receive appropriate medical care. SB 528 will secure that all physicians and abortionists are aware of this instruction, and will collect records to see if such births are occurring in Kansas. *(see attachments about national trends)*

All provisions of data derived from SB 528 are confidential, as are all abortion reports, unless criminal investigations warrant otherwise. Thank you, Mr. Chairman, I stand for questions.

Attachments include an excerpt of the pertinent abortion statute, information about late term survival and national trends, a chart showing numbers of late term Kansas abortions, a sample KDHE abortion reporting form, and a sample KDHE birth certificate.

Kansas ABORTION LAW relevant to SB 528.

65-6703 (a)If the physician who is to perform the abortion determines the gestational age of a fetus is 22 or more weeks, and determines that the fetus is viable, both physicians under subsection (a) determine in accordance with the provisions of subsection (a) that an abortion is necessary to preserve the life of the pregnant woman or that a continuation of the pregnancy will cause a substantial and irreversible impairment of a major bodily function of the pregnant woman and the physician performs an abortion on the woman, the physician who performs the abortion shall report such determinations, the reasons for such determinations and the basis for the determination that an abortion is necessary to preserve the life of the pregnant woman or that a continuation of the pregnancy will cause a substantial and irreversible impairment of a major bodily function of the pregnant woman in writing to the medical care facility in which the abortion is performed for inclusion in the report of the medical care facility to the secretary of health and environment under K.S.A. 65-445

65-6721(a)No person shall perform or induce a partial birth abortion on a viable fetus unless such person is a physician and has a documented referral from another physician not legally or financially affiliated with the physician performing or inducing the abortion and both physicians determine: (1) The abortion is necessary to preserve the life of the pregnant woman; or (2) a continuation of the pregnancy will cause a substantial and irreversible impairment of a major physical or mental function of the pregnant woman.

Evidence of procedures resulting in Born Alive Infants

Nurse Jill Stanek, formerly employed by Christ Hospital in a Chicago suburb, testified to Congress in July 2002 about that hospital's practice of "live-birth abortion." Instead of performing a grisly, mid-trimester abortion, doctors at Christ Hospital simply induced labor, delivered premature infants, and allowed them to die from respiratory distress due to immature lungs. Inductions were scheduled in the weeks just prior to expected "viability" so that children could not survive very long without medical attention. These newborns were simply abandoned to die in a back room or, in one case, accidentally dumped in a hamper with soiled linens. Nurse Stanek was reprimanded for comforting one little victim until he died in her arms 45 minutes later.

Nurses at an Ohio hospital have described caring for babies born alive to patients of partial-birth abortion practitioner Dr. Martin Haskell. Their mothers unexpectedly gave birth outside clinic hours, in a motel or emergency room beyond the reach of Dr. Haskell's scissors. Although some of these children died in the arms of a nurse who took time to cuddle and rock them and sing to them for their few remaining hours, at least one survived and was later adopted.

LIVE BIRTH INDUCTIONS

In September 2003, it was reported nationally that Loyola Health System in Chicago, and Providence Health System on the West Coast and Alaska, both commit live-birth abortion. But they don't like the word, "abortion." So they call what they do, "early induction of labor" for fetuses at 23-26 weeks gestation with certain anomalies. Investigations were proceeding as to whether these hospitals were violated the Born Alive Infant Protection Act.

INFANTS BORN ALIVE AT ABORTION BUSINESSES?

In June 2005, a document obtained by WORLD magazine indicated that some babies at Tiller's Wichita facility are dying after abortions instead of during them. The document, entitled, "Your Stay at Women's Healthcare Services: Step-by-Step What to Expect, Intrauterine Induction Abortion," states that "live birth of the fetus" is among the possible complications. It states that responsibility for the medical care and transport of a live-born infant rests on the mother. But the Born Alive Infants Protection Act requires that medical workers offer life-saving aid when a baby survives an abortion

Joann Armentrout, an administrator with the Wichita facility, claims the abortion center is not violating the law. Armentrout was quoted in WORLD magazine saying, "We've never had a live birth here." However, Armentrout failed to mention the case of Sarah Brown, a girl with severe disabilities who was adopted and lived for five years after surviving an abortion at the Wichita facility in July 13,1993. Sarah had been aborted at 36 weeks gestation,.at seven-pounds five-ounces and bore visible puncture wounds above her left eyebrow and at the base of her skull

Armentrout's statement also contradicts statements made by abortionist LeRoy Carhart last year. Carhart told the Associated Press that during dilation-and-evacuation abortions, "The fetuses are alive at the time of delivery" at least once a month.

The Wichita abortion center is not the only one suspected of violating the Born Alive Infants Protection Act. A 34-year-old woman said her child, known as Baby Rowan, curled up as if he were cold and grabbed her finger with his hand after she delivered him in a toilet at an abortion center in Orlando. Shortly after, the baby died. In deposition testimony, abortionist Randall B. Whitney has said that born-alive abortions do take place at the Florida facility and staff members make no effort to resuscitate the babies.

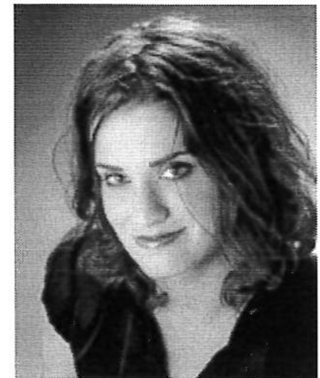
Medical care can rescue premature babies .

The New England Journal of Medicine reported that the smallest known surviving preemie just celebrated her 15th birthday. In 1989, Madeline Mann was born at Loyola Hospital at 27 weeks, weighing **9.9 ounces**. She is now a violin playing, roller-blading, high-school honor student.

25 % of babies born at 22 weeks can survive. Survival rates of premature babies between **23-26 weeks are reaching the 90%** mark according to a major US retrospective study published in 2004. At **28 weeks, the survival rate is 95%.**

Wichita's Wesley Medical Center prides itself on its neonatal care, saving babies born as early as 20 weeks gestation. Ironically, Wesley is just a few blocks from the Tiller late term abortion business.

A Near-Death Experience - Gianna Jensen



Jessen is an abortion survivor who now spends her life speaking up for the speechless. She was invited to meet the president on August 5, 2002, as a result of her standing before Congress and testifying on behalf of the Born-Alive Infants Protection Act that Bush signed into law that day.

As described by National Right to Life, "The law guarantees that every infant born alive enjoys full legal rights under federal law, regardless of his or her stage of development or whether the live birth occurred during an abortion."

The law came 25 years too late for Jessen but not a minute too soon for the countless number of babies that are yet to be born. However, Jessen knows that it was because of the sheer power of Jesus Christ that she survived a saline abortion in 1977 after her biological mother went to a Planned Parenthood clinic in southern California.

"I was that baby she aborted," Jessen said, or at least attempted to abort by allowing an abortionist to inject a saline salt solution into her womb. The plan is for the baby to gulp the solution which burns the child both inside and out before she is delivered dead within 24 hours. After being burned alive in her mother's womb for 18 hours, Jessen was delivered alive in the abortion clinic.

"The abortionist ... was not on duty the moment I came into this world," Jessen added. "Had he been there, he would have ended my life with strangulation, suffocation or [by] leaving me there to die, which was considered perfectly legal up until ... President Bush signed ... the Born-Alive Infant Protection Act to prevent that from happening any further. Now a child who goes through something like that must receive proper medical care."

God's plan for Jessen was unfolding as evident from the medical care she received after a nurse at the abortion clinic called an ambulance and had this two-pound life transported to a hospital where Jessen refused to die.

"The abortionist had to sign my birth certificate," Jessen said. "A few hours before, he was trying to take my life, and then a few hours later he had to acknowledge it."

Prepared by Kansans for Life from Statistics from the Kansas Department of Health and Enviror

SEE: www.kdhe.state.ks.us/hci/absumm.html (See abortion summaries for particular year, page

Year	Abortions Total	Abort. Ks. Res.	Abort. Non-Kansan	Chemical #1 RU-486	Chem.#2 Methotrx.	No Prior Abortion	1 Prior Abortion	2 Prior Abort.	3 Prior Abort.	4 Prior Abort.
1998	11624	6440	5184	0	125	7410	2910	920	255	126
1999	12421	6392	6029	0	289	7864	3089	988	326	152
2000	12323	6352	5971	1	403	7721	3106	980	354	162
2001	12404	6401	6003	187	314	7645	3123	1105	339	191
2002	11844	6298	5546	667	310	7071	3105	1136	344	187
TOTAL	**60616**	**31883**	**28733**	**855**	**1441**	**37711**	**15333**	**5129**	**1618**	**818**

Year	Post-22 Total	Post-22 Viable	% Viable*	Post-22 To Prevent Death	Post-22 Phys.	Post-22 Mental
1998	**227**	**91**	40%	**0**	No statistics are kept	
1999	**574**	**302**	53%	**0**	detailing reasons	
2000	639	380	59%	**0**	for post-22 week	
2001	635	395	62%	**0**	abortions. Only re:	
2002	564	356	63%	**0**	to prevent death (left)	
TOTAL	**2639**	**1524**	**58%**	**0**	& on PBA (below).	

*These are rounded percentages

Year	PBA Total	PBA Viable	% Viable	PBA To Prevent Death	PBA Physical	PBA Mental
1998	**58**	**58**	**100%**	**0**	**0**	**58**
1999	**182**	**182**	**100%**	**0**	**0**	**182**
2000	-	-	-	-	-	-
2001	-	-	-	-	-	-
2002	-	-	-	-	-	
TOTAL	**240**	**240**	**100%**	**0**	**0**	**240**

ABORTIONS BY RESIDENCE OF WOMEN

Year	KS county Douglas	KScounty Johnson	KS county Sedgwick	KS county Wyandotte	KS county all other	OutState Missouri	OutState all other
1998	434	1183	1424	762	2637	4408	776
1999	390	1195	1411	827	2569	5242	787
2000	378	1187	1409	807	2571	5124	847
2001	371	1308	1340	877	2505	5136	867
2002	360	1306	1310	863	2459	4784	762
TOTAL	**1933**	**6179**	**6894**	**4136**	**12741**	**24694**	**4039**

The law requiring these kinds of statistics passed in 1998 and went into effect after July 1998. Thus the 1998 statistics are not complete as regards post-22 week ar post-22 week and PBA (partial birth abortions.)

The post-22 ban only has an exception for life of the mother and when the pregnancy will "cause a "substantial and irreversible impairment of a major bodily function." (Which the former AG defined to include mental & physical health.)

The Partial Birth Abortion "Ban" has express exceptions for "substantial and irreversible" mental or physical health.

The determination for mental health is made by abortionist and one other doctor who is not financially or legall affiliated with him. However, that doctor can be any kind, need have no mental health training and can be utilized over and over again.

Attachment 4
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Unspecifed Prior Abort.
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KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

Office of Health Care Information
Curtis State Office Building, Suite 130
1000 SW Jackson
Topeka, Kansas 66612-1354
785-296-8627

Report of Induced Termination of Pregnancy

State File Number

INSTRUCTIONS SEE HANDBOOK

1. Provider Identification Number 00000

2. Patient ID Number

3. Age on Last Birthday

4. Married ☐ Yes ☐ No

5. Date of Pregnancy Termination — Month / Day / Year

6a. Residence *US State or Country*

6b. County

6c. City or Town

6d. Inside City Limits ☐ Yes ☐ No

7a. Hispanic Origin
(Check the box or boxes that best describes whether the individual is Spanish, Hispanic, or Latina, or not Spanish, Hispanic, or Latina)

- ☐ Not Spanish, Hispanic, or Latina
- ☐ Mexican, Mexican American, or Chicana
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Central American
- ☐ South American
- ☐ Other Spanish, Hispanic, or Latina (specify) ____________
- ☐ Unknown

7b. Ancestry
(Enter the name of the country that best describes the heritage or origin of the individual)

8. Race
(Check one or more races to indicate what the individual considers herself to be

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native

Principal Tribe(s)____________

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian (specify) ____________
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander (specify) ______
- ☐ Other (specify) ____________
- ☐ Unknown

9. Education
(specify only highest grade completed)

- ☐ 8th grade or less
- ☐ 9th-12th grade no diploma
- ☐ High school graduate/GED
- ☐ Some College - no degree
- ☐ Associate degree
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Doctorate
- ☐ Unknown

10. Date Last Normal Menses Began — Month / Day / Year

11. Clinical Estimate of Gestation *(Weeks) (1)*

12. Previous Pregnancies *(Enter number or zero in every section)*

Live Births		12c. Previous Induced Abortions	12d. Spontaneous Terminations (Miscarriages, Fetal Deaths)
12a. Now Living	12b. Now Dead		

SAMPLE

13 TERMINATION PROCEDURES

13a Procedure that terminated pregnancy

(Check only one)

- ☐ Suction Curettage
- ☐ Sharp Curettage
- ☐ Dilation & Evacuation
- ☐ Medical Procedure I (Mifepristone)
- ☐ Medical Procedure II (Methotrexate)
- ☐ Intra-Uterine Prostaglandin Instillation
- ☐ Hysterotomy
- ☐ Hysterectomy
- ☐ Digoxin/Induction
- ☐ Partial Birth (2)
- ☐ Other (Specify) ____________

13b Additional procedures used for this termination, if any

(Check all that apply)

- ☐ Suction Curettage
- ☐ Sharp Curettage
- ☐ Dilation & Evacuation
- ☐ Medical Procedure I (Mifepristone)
- ☐ Medical Procedure II (Methotrexate)
- ☐ Intra-Uterine Prostaglandin Instillation
- ☐ Hysterotomy
- ☐ Hysterectomy
- ☐ Digoxin/Induction
- ☐ Partial Birth (2)
- ☐ Other (Specify) ____________

1 If clinical estimate of gestational age is 22 weeks or more, complete reverse side of form
2 If Partial Birth Procedure as defined by KSA 65-6721 is used, complete reverse side of form

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Complete the following items only if the clinical estimate of gestational age is 22 weeks or more

14. Reasons for determining gestational age 22 weeks or more

15a Was fetus viable?

☐ YES ☐ NO

15b Reasons for the determination

Complete 16a-c only if 15a is yes

16a Was this abortion necessary to
(Check all that apply)

☐ Prevent patient's death

☐ Prevent substantial and irreversible impairment of a major bodily function

16b Reasons for determination

16c Basis for determination

SAMPLE

Complete the following items only if a partial birth procedure was performed

17a Was fetus viable?

☐ YES ☐ NO

17b Reasons for determination

Complete 18a-b only if 17a is yes

18a Was this abortion necessary to
(Check all that apply)

☐ Prevent patient's death

☐ Prevent substantial and irreversible impairment of a major bodily function

If so, was the impairment

☐ Physical

☐ Mental

18b Reasons for determination

Kansas Department of Health and Environment
Office of Vital Statistics

CERTIFICATE OF LIVE BIRTH

115-
State File Number

1. CHILD'S NAME (First, Middle, Last, Suffix)
2. DATE OF BIRTH (Month, Day, Year)
3. TIME OF BIRTH M
4. SEX
5. BIRTH WEIGHT (Grams)
6. CITY, TOWN, OR LOCATION OF BIRTH
7. COUNTY OF BIRTH
8. PLACE OF BIRTH
   - ☐ Hospital ☐ Freestanding Birthing Center ☐ Home Birth
   - ☐ Clinic/Doctor's Office ☐ Other (Specify) ____________
9. FACILITY NAME (If not institution, give street and number)
10. I CERTIFY THAT THE STATED INFORMATION CONCERNING THIS CHILD IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.
    Certifier's Signature ➢ ____________
11. DATE SIGNED (Month, Day, Year)
12. ATTENDANT'S NAME AND TITLE (Type)
    Name ____________
    ☐ M.D. ☐ D.O. ☐ C.N.M. ☐ Other Midwife
    ☐ Other (Specify) ____________
13. Certifier's Name and Title (Type)
    Name ____________
    ☐ M.D. ☐ D.O. ☐ Hosp Adm. ☐ C.N.M. ☐ Other Midwife
    ☐ Other (Specify) ____________
14. ATTENDANT'S MAILING ADDRESS (Street and Number or Rural Route, City, or Town, State, Zip Code)
15. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)
16. MOTHER'S LAST NAME PRIOR TO FIRST MARRIAGE
17. DATE OF BIRTH (Month, Day, Year)
18. BIRTHPLACE (State, Territory, or Foreign Country)
19. PRESENT RESIDENCE-STATE
20. COUNTY
21. CITY, TOWN, OR LOCATION
22. STREET AND NUMBER OF PRESENT RESIDENCE
23. ZIP CODE
24. INSIDE CITY LIMITS? ☐ YES ☐ NO
25. MOTHER'S MAILING ADDRESS (If same as residence, leave blank)
26. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)
27. DATE OF BIRTH (Month, Day, Year)
28. BIRTHPLACE (State, Territory, or Foreign Country)
29. PARENTS REQUEST SOCIAL SECURITY NUMBER ISSUANCE? ☐ YES ☐ NO
30. IMMUNIZATION REGISTRY
    I wish to enroll my child in the Immunization Registry ☐ YES ☐ NO
31. I CERTIFY THAT THE PERSONAL INFORMATION PROVIDED ON THE CERTIFICATE IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.
    Signature of Parent (or Other Informant) ➢ ____________
32. DATE SIGNED (Month, Day, Year)
33. DATE FILED BY STATE REGISTRAR (Month, Day, Year) (Vital Statistics only)

SAMPLE

Form VS240 Rev. 07/23/2004

Attachment 6
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CONFIDENTIAL INFORMATION FOR INTERNAL USE ONLY

34. IF HOME BIRTH, WAS DELIVERY PLANNED AT HOME? ☐ Yes ☐ No ☐ Unknown

35. MOTHER'S SOCIAL SECURITY NUMBER

36. FATHER'S SOCIAL SECURITY NUMBER

37a. WAS MOTHER EVER MARRIED? ☐ Yes ☐ No ☐ Unknown

37b. MOTHER MARRIED? (At birth, conception or any time between) ☐ Yes ☐ No ☐ Unknown

37c. IF NO, HAS PATERNITY ACKNOWLEDGMENT BEEN SIGNED? ☐ Yes ☐ No

37d. MOTHER REFUSES TO GIVE HUSBAND'S INFORMATION ☐ Yes ☐ No

38. WHAT IS THE PRIMARY LANGUAGE SPOKEN IN THE HOME? ☐ English ☐ Spanish ☐ Vietnamese ☐ German ☐ French ☐ Russian ☐ Ukrainian ☐ Mandarin ☐ Cantonese ☐ Sign Language ☐ Other *(Specify)* ________________

39. PARENT'S HISPANIC ORIGIN (Check the box or boxes that best describes whether the parent is Spanish, Hispanic, or Latino. Check the "No" box if the parent is not Spanish, Hispanic, or Latino.)

39a. MOTHER
- ☐ No, not Spanish/ Hispanic/Latina
- ☐ Yes, Mexican/Mexican American/Chicana
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, Central American
- ☐ Yes, South American
- ☐ Yes, other Spanish/ Hispanic/Latina (Specify)________________
- ☐ Unknown

39b. FATHER
- ☐ No, not Spanish/ Hispanic/Latino
- ☐ Yes, Mexican/Mexican American/Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, Central American
- ☐ Yes, South American
- ☐ Yes, other Spanish/ Hispanic/Latino (Specify)________________
- ☐ Unknown

40. PARENT'S RACE (Check one or more races to indicate what you consider yourself to be.)

40a. MOTHER
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native (Name of the enrolled or principal tribes) ______________
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian (Specify) ______________
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander (Specify) ______________
- ☐ Other (Specify) ______________
- ☐ Unknown

40b. FATHER
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native (Name of the enrolled or principal tribes) ______________
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian (Specify) ______________
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander (Specify) ______________
- ☐ Other (Specify) ______________
- ☐ Unknown

41. ANCESTRY - What is the parents' ancestry or ethnic origin?- Italian, German, Dominican, Vietnamese, Hmong, French Canadian, etc. (Specify below)

41a. MOTHER

41b. FATHER

42. OCCUPATION AND BUSINESS/INDUSTRY

Occupation	Business/Industry (Do not give name of company.)
42a. MOTHER (Most recent)	42c. MOTHER
42b. FATHER (Usual)	42d. FATHER

43. EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery.)

43a. MOTHER'S EDUCATION ☐ 8th grade or less ☐ 9th - 12th grade; no diploma ☐ High school graduate or GED ☐ Some College credit, but no degree ☐ Associate degree (e.g., AA,AS) ☐ Bachelor's degree (e.g., BA, AB, BS) ☐ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA) ☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD) ☐ Unknown

43b. FATHER'S EDUCATION ☐ 8th grade or less ☐ 9th - 12th grade; no diploma ☐ High school graduate or GED ☐ Some College credit, but no degree ☐ Associate degree (e.g., AA,AS) ☐ Bachelor's degree (e.g., BA, AB, BS) ☐ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA) ☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD) ☐ Unknown

44. PREVIOUS LIVE BIRTHS (Do not include this child.)

44a. Now living Number _______ ☐ None

44b. Now dead Number _______ ☐ None

44c. DATE OF LAST LIVE BIRTH (Month, Year)

45. NUMBER OF OTHER OUTCOMES (Spontaneous or induced losses or ectopic or stillbirth pregnancies)

45a. Before 20 weeks Number _______ ☐ None

45b. 20 weeks & over Number _______ ☐ None

45c. DATE OF LAST OTHER PREGNANCY OUTCOME (Month, Year)

46. PRENATAL CARE? ☐ Yes ☐ No

47. DATE OF FIRST PRENATAL CARE VISIT (Month, Day, Year)

48. DATE OF LAST PRENATAL CARE VISIT (Month, Day, Year)

49. PRENATAL VISITS-Total Number (If none, enter "0")

50. DATE LAST NORMAL MENSES BEGAN (Month, Day, Year)

51. OBSTETRIC ESTIMATE OF GESTATION (Completed Weeks)

52. PLURALITY-Single, Twin, Triplet, etc. (Specify)

53. IF NOT A SINGLE BIRTH – Born First, Second, Third, etc. (Specify)

54. TOTAL LIVE BIRTHS AT THIS DELIVERY

55. IS INFANT ALIVE AT THE TIME OF THIS REPORT? ☐ Yes ☐ No ☐ Unknown

56. IS INFANT BEING BREAST-FED AT DISCHARGE? ☐ Yes ☐ No ☐ Unknown

57. CIGARETTE SMOKING BEFORE & DURING PREGNANCY: Did mother smoke 3 mos. before or during pregnancy? ☐ Yes ☐ No ☐ Unknown

For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked. If none, enter "0".

Average number of cigarettes or packs of cigarettes smoked per day:

	No.		No.	
Three months before pregnancy:	______	cigarettes or	________	packs
First three months of pregnancy:	______	cigarettes or	________	packs
Second three months of pregnancy:	______	cigarettes or	________	packs
Third Trimester of pregnancy:	______	cigarettes or	________	packs

58. PRINCIPAL SOURCE OF PAYMENT FOR THIS DELIVERY
☐ Medicaid ☐ Private/Employer Ins. ☐ Self-pay ☐ Indian Health Service ☐ CHAMPUS/TRICARE ☐ Other government ☐ Other (Specify) ______________ ☐ Unknown

59. MOTHER'S MEDICAL RECORD NO.

60. NEWBORN'S MEDICAL RECORD NO.

61. MOTHER TRANSFERRED IN FOR DELIVERY DUE TO MATERNAL, MEDICAL, OR FETAL INDICATIONS? ☐ Yes ☐ No (If yes, enter facility name)

FACILITY TRANSFERRED FROM:

62. INFANT TRANSFERRED (Within 24 hours of delivery) ☐ Yes ☐ No (If yes, enter facility name)

FACILITY TRANSFERRED TO:

SAMPLE

CHILD'S NAME ______________________ MOTHER'S NAME ______________________

PRENATAL (Birth)

63. NUTRITION OF MOTHER

1. Height _____
2. Prepregnancy Weight _____
3. Weight at delivery _____
4. Did mother get WIC food for herself?
   Yes _____ No _____
   Unknown _____

64. MEDICAL RISK FACTORS
(Check all that apply.)

1. ☐ Diabetes, prepregnancy
2. ☐ Diabetes, gestational
3. Hypertension
   - ☐ Prepregnancy (Chronic)
   - ☐ Gestational (PIH, preeclampsia)
   - ☐ Eclampsia
4. ☐ Previous preterm birth
5. ☐ Other previous poor pregnancy outcome (SGA, perinatal death, etc.)
6. ☐ Vaginal bleeding during this pregnancy prior to labor
7. ☐ Pregnancy resulted from infertility treatment (If yes, check all that apply.)
   - ☐ Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination
   - ☐ Assisted reproductive technology (e.g. in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT))
8. ☐ Mother had a previous cesarean delivery, if yes, how many? Number: _______
9. ☐ Alcohol use
   No. of drinks per week: _____
10. ☐ None of the above

65. METHOD OF DELIVERY

1. Forceps attempted? Yes ____ No____
   Successful Yes ______ No______
2. Vacuum extraction attempted?
   Yes ______ No______
   Successful Yes ______ No ______
3. Fetal presentation at delivery
   - ☐ Cephalic
   - ☐ Breech
   - ☐ Other
4. Final route and method of delivery (check one)
   - ☐ Vaginal/spontaneous
   - ☐ Vaginal/forceps
   - ☐ Vaginal/vacuum
   - ☐ Cesarean, if cesarean was a trial of labor attempted?
     Yes _______ No_______

LABOR-DELIVERY/NEWBORN

66. OBSTETRICAL PROCEDURES
(Check all that apply.)

1. ☐ Cervical cerclage
2. ☐ Tocolysis
3. External cephalic version:
   - ☐ Successful
   - ☐ Failed
4. ☐ None of the above

67. ONSET OF LABOR (Check all that apply.)

1. ☐ Premature Rupture of the Membranes (prolonged, ≥ 12 hours)
2. ☐ Precipitous Labor (< 3 hrs)
3. ☐ Prolonged Labor (≥ 20 hrs)
4. ☐ None of the above

68. CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply.)

1. ☐ Induction of labor
2. ☐ Augmentation of labor
3. ☐ Non-vertex presentation
4. ☐ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
5. ☐ Antibiotics received by the mother during labor
6. ☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥ 38 C (100.4 F)
7. ☐ Moderate/heavy meconium staining of the amniotic fluid
8. ☐ Fetal intolerance of labor: (examples: in-utero resuscitative measures, further fetal assessment, or operative delivery)
9. ☐ Epidural or spinal anesthesia during labor
10. ☐ None of the above

69. MATERNAL MORBIDITY
(Check all that apply.)
(These are complications associated with labor and delivery.)

1. ☐ Maternal transfusion
2. ☐ Third or fourth degree perineal laceration
3. ☐ Ruptured uterus
4. ☐ Unplanned hysterectomy
5. ☐ Admission to intensive care unit
6. ☐ Unplanned operating room procedure following delivery
7. ☐ None of the above

70. INFECTIONS PRESENT AND/OR TREATED
(During this pregnancy, check all that apply.)

1. ☐ Gonorrhea
2. ☐ Syphilis
3. ☐ Herpes Simplex Virus (HSV)
4. ☐ Chlamydia
5. ☐ Hepatitis B
6. ☐ Hepatitis C
7. ☐ AIDS or HIV antibody
8. ☐ None of the above

71. ABNORMAL CONDITIONS OF NEWBORN (Check all that apply)

1. ☐ Assisted ventilation required immediately following delivery
2. ☐ Assisted ventilation required for more than six hours
3. ☐ NICU admission
4. ☐ Newborn given surfactant replacement therapy
5. ☐ Antibiotics received by the newborn for suspected neonatal sepsis
6. ☐ Seizure or serious neurologic dysfunction
7. ☐ Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention
8. ☐ None of the above

72. VACCINES ADMINISTERED TO NEWBORN

1. ☐ Hepatitis B Date Given: ___________
2. ☐ Other* Specify: ______________________
   Date Given: ______________________

73. APGAR SCORE

1 min	5 min	10 min

74. CONGENITAL ANOMALIES OF THE NEWBORN (Check all that apply.)

1. ☐ Anencephaly
2. ☐ Meningomyelocele/Spina bifida
3. ☐ Cyanotic congenital heart disease
4. ☐ Congenital diaphragmatic hernia
5. ☐ Omphalocele
6. ☐ Gastroschisis
7. ☐ Limb reduction defect (excluding congenital amputation and dwarfing syndromes)
8. ☐ Cleft Lip with or without Cleft Palate
9. ☐ Cleft Palate alone
10. ☐ Down Syndrome
    - ☐ Karyotype confirmed
    - ☐ Karyotype pending
11. ☐ Suspected chromosomal disorder
    - ☐ Karyotype confirmed
    - ☐ Karyotype pending
12. ☐ Hypospadias
13. ☐ Fetal alcohol syndrome
14. ☐ Other congenital anomalies *(Specify)* ____________________
15. ☐ None of the above

SAMPLE

CHILD'S NAME ______________________________ MOTHER'S NAME ______________________________

Test required by K.S.A. 65-153f 153G Serological Test Made: ______ 1st ______ 2nd ______ 3rd (Trimester) ______ At Delivery ______ Not Performed If no test made, state reason:	Test required by K.S.A. 65-180 Infant Neonatal Screening specimen taken: ______ Yes ______ No If no test made, state reason:	Test required by K.S.A. 65-1157A Newborn Hearing Screening Accomplished: ______ Yes ______ No

Infant's patient number:

Infant's Primary Care Physician

First	Middle	Last	Title (MD, DO, etc.)

If screening accomplished, Date hearing screened ____/____/____ Month Day Year	The results of the hearing screening ✓: Right ear: ______ Pass ______ Refer for further testing Left ear: ______ Pass ______ Refer for further testing

Physiologic equipment used ✓: ______ OAE ______ AABR ______ ABR

If screening not accomplished, ✓ one reason:

______ b – missed appointment
______ c – could not test
______ d – deceased
______ i – Incomplete test
______ m – Infant discharged before screening
______ n – transferred to NICU
______ o – other
______ r – did not consent
______ s – scheduled but not completed
______ t – transferred to another hospital
______ u – no information
______ x – invalid results

SAMPLE

March 13, 2006

Chairman Morrison and members of the House Health and Human Services Committee:

We support S 528, a bill that provides statistical information about abortion. In an information-based society, it is imperative that those who provide policy decisions on such routinely-performed procedures such as abortion, know exactly upon whom the abortion is performed, why it is performed and the medical condition of the fetus.

Recent scientific findings are showing that the abortion procedure itself poses significant risks to the woman. Obviously the risk posed to a fetus at 22 weeks gestation is moot, but the state has a vested interest in knowing the reasons for terminating a pregnancy at this point of gestation. At 22 weeks, some children have lived outside the womb. Fetal anomaly and injury to the mother are the general reasons given; however, it would be helpful for future policy decisions to know what those conditions are. The mother's mental and physical state should be a matter of concern to policy-makers, particularly since the U.S. Supreme Court's *Doe v. Bolton* decision that gives the mother's "health" as license to perform an abortion at any stage of viability. The recent death of a young woman with Down's syndrome at the Tiller clinic shows that the mental state and physical state should be known for the mother's protection as well as for statistical reasons.

Recent reports have shown that Down's Syndrome babies are being aborted at alarming rates; causing some to raise concerns about the screening of fetuses for elimination if they don't pass the genetic test. Studies have also shown that some people would like to screen babies for gender preferences. In a world that is developing the capabilities of doing more and more prenatal testing, it is even more important that state policy makers be aware of the ethical ramifications of couples who have access to genetic information who might use it in a deleterious way. All of these things make it imperative that the state know exactly for what reason these late term abortions are being performed. Merely stating "health" or "fetal anomaly" is not enough; too many abuses are already occurring from eliminating a child with a cleft palate to a mother who has trepidations about her pregnancy qualifying as mental health.

We urge you to pass this legislation that would make sure that you have enough information with which to make good public policy decisions concerning abortion.

Judy Smith, State Director
Concerned Women for America of Kansas

CWA of Kansas
PO Box 11233
Shawnee Mission, KS 66207
913-491-1380
director@ks.cwfa.org

Attachment 7
HHS 3-20-06

Disability Rights Center of Kansas
Rocky Nichols, Executive Director
635 SW Harrison, Ste 100 ♦ Topeka, KS 66603
785.273.9661 ♦ 877.776.1541 (Voice)
877.335.3725 (TDD) ♦ 785.273.9414 FAX
rocky@drckansas.org ♦ *Telephone Ext. #106*

House Committee on Health and Human Services

Informational Testimony that is Neutral SB 528
February 16, 2006

Chairman Morrison and the honorable members of the committee, my name is Rocky Nichols. I am the Executive Director of the Disability Rights Center of Kansas, formerly Kansas Advocacy and Protective Services (KAPS). The Disability Rights Center of Kansas (DRC) is a public interest legal advocacy agency, part of a national network of federally mandated and funded organizations legally empowered to advocate for Kansans with disabilities. As the state designated protection and advocacy system for Kansans with disabilities our task is to advocate for the legal and civil rights of persons with disabilities as promised by federal, state and local laws, including protecting them from potential discrimination.

DRC became interested with SB 528 because some in the disability community began voicing concerns and questions regarding potential discriminatory affects of the bill. Any time people with disabilities are specifically tracked or singled out in legislation, regulations or state programs the disability community will raise appropriate questions as to why this is occurring.

With that back drop, DRC is compelled to ask two very important questions regarding SB 528. We believe the Committee needs to answer and address these questions as you work SB 528.

1. Why does SB 528 only require data involving the specific disabilities of women to be collected regarding termination of a pregnancy? If SB 528 were passed into law, the only demographic information that would be specifically spelled out to be collected in the statute would be disability information. Why is this the case? People with disabilities are a "protected class" under the law, and as such if information is collected in a discriminatory manner then it could have the affect of separating them.

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HHS 3-20-06

2. Can the Kansas Department of Health and Environment assure women who have disabilities that collection of additional information about their disabilities will not infringe on their right to privacy, or in any way allow any person viewing the information to identify them? Even if the Department can offer these assurances, will the committee put protections in this bill to statutorily require and ensure these privacy protections? For example, if you are the only woman in Palco Kansas who is 30, African American and has cerebral palsy, would you be identifiable as the result of the data collection and reporting? Or is the data collected ONLY statewide, aggregate data? DRC would like assurances placed into statute that clearly states that the raw data and individually answered forms collected is protected information and neither available to the public or available by discovery in any judicial proceeding. A further protection would be defining via the state law in SB 528 that the only information that is available publicly is the statewide data report, and that cross-tabulation of smaller data sets is not public. Without those specific prohibitions, while collecting disability specific information as one characteristic of the women tracked under K.S.A. 65-445, the state may inadvertently narrow the data to the degree that the individual in small town Kansas becomes identifiable. That would be unacceptable to the disability community.

As you debate SB 528, DRC asks the Committee to consider these two questions, the consequences of each issue, and develop statutory protections in the bill to address these two issues.

Thank you.

OPPOSED
SB 528
The Reporting of Statistical Data Regarding Termination of Pregnancies

Mr. Chairman and Members of the House Health and Human Services Committee:

It is with some nostalgia that I return to this Committee on which I was honored to serve for six years.
Thank you for giving me this opportunity to express to you my concerns regarding SB 528.
I will be brief.

SB 528 reminds me that, sometimes, the more things stay the same, the more they change !

The Kansas Legislature, at least during my twelve years here and *especially* in an election year, has ALWAYS had at least one "feel good" bill designed for no other reason than to tell the folks back home " Look what we're doing to erode the decision women make to have an abortion." SB 528 (as well as the now defunct SB 529 and 530) is simply circa 2006 in this ever perpetuated charade which really, ultimately, is not in our hands. (In my opinion, this entire issue will soon be affirmed or denied by the U.S. Supreme Court. For an era.) SB 528 would require additional, and arguably duplicitous and unnecessary, reporting requirements. The bill would create ambiguities that no one, for or against abortion, has seemingly been able to decipher thereby potentially enacting yet another tool for anti-choice law enforcement to harass medical providers. One example of these required reportings would be for the provider to assess the "disability status" of the pregnant woman. Another would require disclosure of "specific anomalies of the fetus" ... as if anyone could indeed know all of them.

This bill, nor any of its' ilk, should never be allowed to grace the well reasoned and hallowed pages of the Kansas Statutes.

But, Mr.Chair and Members of the Committee, please allow me to detail for you how I *really* feel about this bill ! Specifically, the *change* that this bill represents in what is ordinarily a routine election year "sameness" when it comes to the introduction and promotion of election year "feel good...I'm fighting for you" measures.

In my twelve years of service - 6 in house and 6 in senate - I have yet to experience any matter until now, when longstanding and accustomed practices were not followed in such a blatant matter. As the Ranking member of the Committee, I was not even allowed to listen to and review the tape recording of the Committee hearing during this alleged bill's introduction in order to ascertain whether proper introduction of this bill was followed. In fact, several of the members of the Committee and in the audience that were in attendance (self described as either "Pro Choice" and "Pro Life") did not remember the introduction.

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I am appalled that this bill has made it to this point. My point is, over this unsettling twist to an otherwise familiar theme: If this bill is addressing a legitimate need; if this bill is supporting a truly noble cause, then why not proceed based on that proposition and follow proper introduction ? Why create and perpetuate a manner of suspicion if your cause is just...?

The reality is that SB 528 is (1) not necessary, and (2) inherently unequal. It is flimsy, weak, maybe unconstitutional. SB 528 creates just another hurdle and burden for a poor woman. Why should a poor woman have to scrounge up an extra $25 - that may mean the question between paying her electricity or feeding her family - in order to pay for an emergency pregnancy when on the other side of town a wealthy woman can receive her abortion, with the additional costs of SB 528, without a second thought? It seems to me that our goal should be ensuring equal access for all, despite socioeconomic levels, not widening the gap of inequities.
But that is David Haley's *philosophical basis* for being "Pro Choice..."

But LARGER STILL, I would sincerely hope Mr.Chair, and Members of the Committee, that no matter what you think about abortion or any other controversial issue, that as a Kansas legislator, that you would affirm time tested procedures which bring respect and honor to our legislative process.

I am pleased to stand for questions.

MARCH 20, 2006

Testimony to
House Health & Human Services Committee
on SB 528

March 16, 2006

My name is Shannon Jones. I am the executive director of the Statewide Independent Living Council of Kansas (SILCK).

Throughout the 12 year history of the SILCK and as mandated by the federal Rehabilitation Act of 1973 our purpose has been to advocate and promote the civil and human rights of people with disabilities in all aspects of life.

The Kansas Association of Centers for Independent Living (KACIL) also supports my comments made today. Both KACIL and SILCK work to ensure that people with any type of disability of any age are not subjected to discrimination under any program or activity. Instead we advocate for the integration and independence of all people including those with disabilities.

In these times when we are striving to promote a political point of view; we forget that all citizens have certain basic rights and responsibilities. Those rights and responsibilities have been ratified in our United States and Kansas Constitution.

The U.S. Constitution provides that, "No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States." The Kansas Constitution provides that, "All men (and women) are possessed of equal and inalienable natural rights, among which are life, liberty and the pursuit of happiness".

In reading these constitutional provisions, I don't find parenthesis with the words except for women with disabilities. The way, in which this bill is written, we are placing basic exclusions as it relates to singling out women with disabilities.

The SILCK and other disability rights advocates wonder, 'Why is this necessary to place in statute?' Particularly when we know that this statute has been on the books since 1969. K.S. A. 65-445 has been amended several times over the years, yet never in the 37 year history has there been a reason or a necessity to amend regarding a specific class of women. This causes us to wonder; perhaps the crafters of the bill assume that women with disabilities do not have the capacity to make informed decisions.

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By adding the language contained in lines 33 through 42 on page one to KSA 65-445, we find segregates those with disabilities from the general populations, and has a strong potential to instill an attitudinal barrier that women with disabilities do not have the capability to make informed decisions about their pregnancies.

Regardless of your position on abortion, we are simply referring to the acceptance of separate groups of people within Kansas society based solely on the basis of disability of the individual.

If this legislation were to pass it means a backward step in the recognition of the rights of persons with disabilities.

Since the Secretary of Health and Environment has the authority to determine what information is collected by medical facilities related to termination of pregnancies, and can require that disability status is included in the reporting form, we feel it is not necessary to include this language in statute.

Therefore, we find no reason for including this type of demeaning and discriminatory language in SB 528.

The SILCK and KACIL recommend the striking of lines 33 through 42 on page one.

Topeka Independent Living Resource Center

785-233-4572 V/TTY • FAX 785-233-1561 • TOLL FREE 1-800-443-2207
501 SW Jackson Street • Suite 100 • Topeka, KS 66603-3300

March 16, 2006

Testimony Presented to the House Health and Human Services Committee
Proposing to Strike the Reporting Requirements for Disability Status in SB 528
By
Ami Hyten, Assistant Executive Director

Dear Chairperson Morrison and Committee Members,

The Topeka Independent Living Resource Center (TILRC) is a civil and human rights organization. Our mission is to advocate for justice, equality and essential services for a fully integrated and accessible society for all people with disabilities. TILRC has been providing cross-age, cross-disability advocacy and services for over 25 years to people across the state of Kansas.

TILRC joins with the Disability Rights Center (DRC) and other Kansas disability organizations in our challenge to the discriminatory inquiry which is being proposed as part of the reporting requirements of SB 528. We echo the DRC's questions with respect to the reporting requirements for people with disabilities contained in SB 528.

Inquiry into the existence, nature or severity of disability is prohibited by federal law in both employment and in housing. (*See 42 U.S.C. 12111 – 12117 and 42 USC 3601 et seq.).* We believe that this prohibition is critical to supporting the civil and human rights of people with disabilities, to address the historical isolation, segregation and discrimination identified as in need of remediation in the Americans with Disabilities Act. The Americans with Disabilities Act recognized that *"individuals with disabilities are a discrete and insular minority who have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, . . . based on characteristics that are beyond the control of such individuals and resulting from stereotypic assumptions not truly indicative of the individual ability of such individuals to participate in, and contribute to, society;" (42 U.S.C. 12101(a)(7).* It is our belief that categorizing and stereotyping people on the basis of a disability diagnosis unnecessarily perpetuates the historical restrictions, limitations, and inequities experienced by people who are treated as "labels" rather than as brothers and sisters. We encourage this committee to follow the federal precedent of restricted inquiry into housing and employment issues, by striking the disability status reporting requirements from SB 528.

Thank you for your time and commitment to this critical issue of human and civil rights.

Advocacy and services provided by and for people with disabilities.

Attachment 11
HHS 3-20-06

Southeast Kansas Independent Living Resource Center

WRITTEN TESTIMONY TO
HOUSE HEALTH AND HUMAN SERVICES COMMITTEE
on SB 528
March 16, 2006

Mr. Chairman, members of the committee, thank you for the opportunity to provide you with written testimony on SB 528- Reporting statistical data regarding termination of pregnancies.

The Southeast Kansas Independent Living Resource Center (SKIL) strongly opposes the language amending KSA 65-445 that requires reporting of "...disability status of any pregnant female terminating a pregnancy ***including physical disabilities and mental disabilities such as depression, cognitive limitations, substance abuse and other conditions***", and requests that this language be removed from the bill.

SKIL, as a disability rights and civil rights organization, believes that it is discriminatory to include the disability status of a woman terminating a pregnancy in statute when no other personal information about women is included in the statute. SKIL has worked for over 12 years fighting discriminatory practices towards people with disabilities, as well as educating the public in an effort to dispel attitudinal barriers and promote full inclusion of people with disabilities in society. Adding this language to KSA 65-445, segregates those with disabilities from the general population, and has a strong potential to instill an attitudinal barrier that women with disabilities do not have the capability to make informed decisions about their pregnancies. Since the Secretary of Health and Environment has the authority to determine what information is collected by medical facilities related to termination of pregnancies, and can require that disability status be included in the reporting form, we feel it is not necessary to include this language in statute.

Thank you in advance for your consideration to remove lines 36 - 39 in SB 528.

Attachment 12
HHS 3-20-06

Respectfully Submitted by:

Anne-Marie Hughey
SKIL Legislative and Policy Advocate
913-787-1862

Self-Advocate
Coalition of Kansas

To: House Health and Human Services Committee
Re: Senate Bill 528

My name is Kathy Lobb and I am the legislative liaison with the Self Advocate Coalition of Kansas, better known as SACK. We are a statewide advocacy group for people with developmental disabilities made up of over 20 local self advocacy groups across the state. I think that a woman has a right to choose what happens to her own body. This right is very important to every woman whether or not she has a disability.

This bill makes it harder for women with any disability to make her own choice in her life. It implies that women with disabilities are not capable of making this important choice. SACK has been fighting for the right of people with disabilities to take control of their own lives for a long time; they should be treated the same as anyone else not singled out because they have a disability. This bill would make it much harder for a woman with a disability to make a choice about whether or not she wants to raise a child from an unplanned pregnancy especially from a rape.

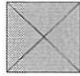
I hope you will not support this bill with its unfair treatment of women especially those with disabilities. Thank you for the opportunity to share SACK's concerns with you.

Sincerely,
Kathy Lobb

2518 Ridge Court,
Room 236
Lawrence, Kansas 66046

Phone: 1-888-354-7225 or
785-749-0121
Fax: 785-843-3728
Email:kssack123@aol.com
Web: kansassack.org

Attachment 13
HHS 3-20-06



Elizabeth R. Hatcher MD PhD

5847 SW 29th Street

Topeka, KS 66614-2462

Certified by the American Board of Psychiatry and Neurology

Diplomate of the Greater Kansas City Psychoanalytic Institute

Fellow of the American Psychiatric Association

Kansas License #4-22342

Telephone 785-273-7292~ Fax 785-273-1201

March 15, 2006

Rep Jim Morrison, Chair

House Health and Human Services Committee

300 SW 10th Avenue #171W

Topeka, Kansas 66612-1504

Dear Mr. Morrison:

Julie Burkhart of the ProKanDo PAC contacted me this week with the request that I review and comment on Senate Bill # 528. She faxed me a copy of the bill, which I have read carefully; and a list of □Talking Points□ developed by her organization, which I have skimmed.

I'm a psychiatrist in private practice here in Topeka. After graduating from medical school in Maryland, I came to Kansas in 1987 to serve a psychiatry residency at Menninger. Finishing that training in 1991, I served on the Menninger staff for six years, meanwhile obtaining psychoanalytic training at the Topeka Institute for Psychoanalysis. Having moved into private practice, I completed analytic training in 2004 under the auspices of the Greater Kansas City Psychoanalytic Institute.

As drafted, Senate Bill #528 appears redundant and intrusive. It certainly violates the principle, often said to be dear to Republicans' hearts, that less government is better. It creates a maze of red tape whose only use seems to be the harassment of physicians and patients. It gives the State a fishing license to collect medical information which it does not need to know, and which as collected can have no valid scientific usefulness. For example, let no legislator imagine that this information would enable public health officials learn about the causes and reduce the occurrence of birth defects in Kansas. It even violates the right to privacy of people whose connection with the procedure is merely coincidental.making me wonder whether one purpose of the bill is to develop witness lists for criminal investigations. As a government document, it's sinister.

The Bill would let the state select certain medical procedures, brand them as wicked by presumption, and regulate and inspect them and their practitioners as if guilty until proven innocent. It would label women needing (for excellent medical reasons) abortions at or after 22 weeks, and their physicians, as suspects. Such an approach flies in the face of American legal principle. The Bill would compel state officials to barge inappropriately into the sacrosanct relationship between doctor and patient.a venue whose privacy is mandatory if both parties are to have the information, the protection, and the trust that are requisite for sound healthcare decision-making and treatment. If enacted, it would risk scaring women away from obtaining the medical care they need. Its requirements would likely increase the psychological trauma already undergone by the women to whom it applies, and by their families.

I agree with the ProKanDo observation that this bill has all the hallmarks of Attorney General Kline's personal crusade to deprive women of the right to make their own decisions regarding reproduction. Someone in Kline's office should have respect for the accumulated laws and the representative government of the people whom he serves. Instead, Kline thinks nothing of using his office as his private bully pulpit to foist his prejudices into law.

Self-righteous people like Kline appear all too ready to pass judgment upon other. That is a prideful act without support in either Scripture or systematic theology. If I'm right, then Senate Bill 528 is bad law, bad medicine.and bad morals too.

Attachment 14
HHS 3-20-06

Respectfully submitted,

Elizabeth R. Hatcher MD PhD

P.S. I hope that this submission "can do" as testimony, and that my personal appearance before the committee won't be necessary. I have a full patient schedule this afternoon. If I'm wrong, I would appreciate it if someone from the Committee or from ProKanDo will let me know via voice mail on my cell phone (not the work #), 785-224-8827. Thanks. erhmd

Northern Nevada Genetic Counseling
4430 Fairview Road
Reno, NV 89511

Rep. Jim Morrison, chair
House Health and Human Services Committee
300 SW 10th Ave,, Room 171W
Topeka, KS 66612-1504

The Honorable Mr. Morrison,

I am a certified genetic counselor with Northern Nevada Genetic Counseling. I am opposed to Senate Bill No. 528 (SB 528), and hope your committee will consider my comments.

I feel it's unreasonable to require a written report, submitted to the state of terminations of pregnancy within your state. The information that is required on the proposed report is a violation of a women's medical privacy. I see no justification, especially, for requiring that the report include disability status of the pregnant female. And, such information is not likely to be complete and accurate, depending upon the woman's report of disability. A care facility, or involved physician, may not have access to medical records that might contain this information, from a primary care physician. These records may be form an out-of-state provider, adding to the difficulty in accessing them. To require that the provider obtain such records may significantly delay the termination procedure—and may even make in unavailable to the woman, if not obtained within 22 weeks gestation. This is to the detriment of the pregnant woman, especially if the fetus has anomalies that may be incompatible with life. Delay of the procedure also increases the risk from the procedure to the pregnant woman.

Sincerely.

Robbin Palmer, Ph.D.
Certified Genetic Counselor
Northern Nevada Genetic Counseling

Attachment 15
HHS 3-20-06

Kansas Commission on Disability Concerns

Testimony to Health and Human Services Committee
SB 528; An act concerning public health, relating to the reporting of
statistical data regarding termination of pregnancies.
March 20, 2006

Chairperson Morrison and members of the committee, I am Kerrie Bacon, Legislative Liaison for the Kansas Commission on Disability Concerns (KCDC). We are charged with providing information to the Governor, the Legislature, and to State agencies about issues of concern to Kansans with disabilities (K.S.A. 74-6706).

The Kansas Commission on Disability Concerns opposes SB 528 because it is requiring the reporting of medical data on just women with disabilities. This is an invasion of medical privacy and discriminating against women with disabilities. If you proceed with the bill, we recommend you strike the language on page 1, lines 36 through 39 and page 3, line 19, "and any disability of the mother."

The commission encourages you to either oppose the bill or make the recommend amendments before sending it to the full House.

Thank you for your time.

1000 S.W. Jackson, Suite 100, Topeka, KS 66612-1354
Voice: (785) 296-1722 Toll Free: 1-800-295-5232
TTY: (785) 296-5044 Toll Free TTY: 1-877-340-5874 Fax: (785) 296-3490
www.kcdcinfo.com

February 14, 2006

The Honorable Jim Barnett, Chairperson
Senate Committee on Public Health and Welfare
Statehouse, Room 120-S
Topeka, Kansas 66612

Dear Senator Barnett:

SUBJECT: Fiscal Note for SB 528 by Senate Committee on Public Health and Welfare

In accordance with KSA 75-3715a, the following fiscal note concerning SB 528 is respectfully submitted to your committee.

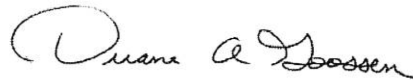
SB 528 would change the procedures medical facilities that perform abortions must follow when filing reports with the Department of Health and Environment. The reports would be submitted to the Department as they currently are, but the following new information would be included in the reports: detailed reasons for the late-term termination of a pregnancy; the disability status, if any, of any pregnant female; details regarding any specific fetal anomalies including, but not limited to, diagnoses of Down's syndrome; the total number of teenagers receiving abortions; and the state of residence for each of those teenagers.

Estimated State Fiscal Effect				
	FY 2006 SGF	FY 2006 All Funds	FY 2007 SGF	FY 2007 All Funds
Revenue	--	--	--	--
Expenditure	--	--	--	$30,000
FTE Pos.	--	--	--	--

Attachment 17
HHS 3-20-06

The Bureau of Vital Statistics of the Department of Health and Environment indicates that the bill would increase expenditures from the Civil Registration and Health Statistics Fee Fund by $30,000 to change the web-based data entry forms and the Department's database system. Any increase in expenditures resulting from the passage of this bill would be in addition to amounts recommended in *The FY 2007 Governor's Budget Report.* The bill would also increase costs for medical facilities that perform abortions by requiring providers to test fetuses for anomalies. The fiscal effect for medical facilities is unknown.

Sincerely,



Duane A. Goossen
Director of the Budget

cc: Aaron Dunkel, KDHE