KPHA E-NEWS UPDATE

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February 16, 2007 **Questions? director@kpha.us**

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Click the links to view all bills in full.

March 8 is Health Day at the Capital! We need as many health advocates as possible to be there! You can sign up for a display table and also for lunch. **Click here** for the flyer about Health Day at the Capital! This year we had to find legislative sponsors for Health Day to use the first floor of the Rotunda. Sen. Vicki Schmidt and Sen. Laura Kelly agreed to help. If one of them is your Senator, please send them a thank you. To find out who your legislators are **click here**.

AHA continues to meet every Friday. If you are interested in participating in person or by phone, email **corrie@kshealthconsumer.org** to be added to the AHA List serve. To see the bill activity spread sheet for this week **click here**.

RE: HEARING SB 77 - UNATTENDED CHILDREN IN CARS BILL

SB77 - The hearing on SB 77 is scheduled for next Tuesday, February 20, at 8:30 AM in the Senate Transportation committee, room 527N. The bill would make it unlawful to leave a child 8 years or younger alone in a motor vehicle unless they are accompanied by another person 13 years of age or older.

If you would like to provide written testimony on this bill, please contact Maggie Breen, Secretary for the Senate Transportation Committee at 785-296-7385 and let her know. You will need to have 20 copies of your written testimony to her by 8:30AM on Wednesday, February 14 (Capitol Building, 300 SW 10th, Room 261-E, Topeka Ks 66612-1504.

If you would like to provide verbal testimony on this bill, please contact Jan Stegelman at 785-296-1223. Even if you don't provide testimony, we would like to have a full room for the hearing, so if you can attend, that would be great.

Since all bills must be out of committees by Wednesday, February 21, we anticipate a quick vote by the committee on this bill. If your Senator is on the Transportation Committee, please contact them prior to Tuesday to ask them to support SB 77. Attached is a fact sheet with information about the bill.

RE: SENATE BILL 318

A hearing for this bill has been set for Tuesday, February 20th at 10:30 AM in Room 123-S (Senate Ways and Means Committee).

SB 318: directing access state tobacco settlement receipts to increase state tobacco prevention efforts. (Allocating extra MSA funds for tobacco prevention and cessation programs.)

To testify in support of the bill, please contact Mary Shaw at (785) 296-3775 by Monday, February 19th at 4:30 PM. (Yes, the legislature is open on Monday even though it is President's Day.) Please bring 45 copies of your testimony. Testimony will be limited to 3 minutes per person as the committee will be considering two other bills during that committee meeting and SB 318's testimony is last on the agenda.

To submit written testimony, send 45 copies to Mary Shaw at the State Capitol, Room 120-S, Topeka, KS 66612, also by Monday, February 19th. (No mail delivered that day and with the limited amount of time, you might have to FedEx/UPS your testimony to her). You may also send it to Mary Jayne at Tobacco Free Kansas Coalition by Monday at 1:30 PM and we can get it copied for you and taken to the legislature before 4:30 that afternoon. You would have to either fax your testimony or e-mail it to Mary Jayne. Fax # is (785) 272-9297 or her e-mail is: **mjhellebust@tobaccofreekansas.org**.

Here's the news from this week, from Rita Flickenger's Representaive Crow's articles, and, from other sources:

KANSAS HOUSE INTRODUCES RESOLUTION URGING CONGRESS TO REAUTHORIZE SCHIP

HCR 5011 recognizes the importance of the HealthWave children's health insurance program in providing health care to Kansas children and calls on the Kansas Congressional Delegation to make this year's SCHIP reauthorization a priority for ensuring that HealthWave is properly funded. SCHIP is the federal law which provides a share of the funding for the children's health insurance program which offers health insurance coverage for children of workers who are poor but do not qualify for Medicaid.

The resolution also urges Governor Sebelius to help identify and enroll Kansas children who are eligible for HealthWave or Medicaid. HCR 5011 was referred to the House Health & Human Services Committee on Monday, Feb 5th, but has not yet been scheduled for a hearing.

STUDENT WELLNESS AND CHILD OBESITY AT ISSUE

Vending Machines - State health officials sounded the alarm yesterday in the House Education Committee about childhood obesity, but school officials and soda companies balked at **HB 2275**, a proposal to shut down vending machines during the school day. "When schools allow children to purchase unhealthy snacks and beverages from vending machines they are very much like the parent who smokes while telling his child not to," said Gary Brunk, executive director of Kansas Action for Children.

Some school officials told the House Education Committee that the bill would be disruptive and self-defeating. A lobbyist for the Wichita school district said high school students would simply leave campus and buy food at convenience stores. Plus, she and other school representatives said schools statewide have launched nutrition initiatives to put healthier items in vending machines. A lobbyist for the Kansas Beverage Association said the issue "was yesterday's news." He said beverage companies have been working with school districts on a voluntary basis to provide lower-calorie drinks, bottled water, juices and other more nutritious snacks.

Opponents made the point that school districts have the power already to require the nutritional offerings in vending machines and to tighten operating times. And the local board is better able to tailor their policies in order to promote wellness in their schools. School districts are required by state law to have wellness policies and strategies.

Body Mass Index - The Education Committee also heard **HB 2090**, which would require schools to measure each student's height and weight in grades four, seven, nine and 12 to figure out their body mass index, or BMI. The information would be used by state officials to develop physical fitness policies and guidelines. Committee Chairman Clay Aurand, R-Courtland, said the panel would probably work on the two measures later this week.

Dr. Howard Rodenberg, state director of health at KDHE, said childhood obesity rates have tripled in the last 20 years. He said the bill would reduce future health care costs and improve academics. He emphasized that the state has an interest because, "Healthy children perform better in schools."

Schools raised concerns, saying the physical exams would take away from instructional time needed to prepare students for standardized testing under the federal No Child Left Behind requirements. They also expressed concern for schools and districts which do not have nursing staff to conduct the height and weight screenings. It was also suggested that the BMI often can be misleading. For example, a thin child may have a great BMI, but he or she may also have little upper body strength. There's just not one test that tells you everything you need to know about a child's health.

HEALTH CARE TASK FORCE IN SENATE

A Kansas Senate task force is urging passage of a package of health reform measures including two that would make significant changes in the state's HealthWave program and the private insurance market.

The package of proposals was unveiled yesterday at a Statehouse press conference that was attended by several of the Republican members of the Senate Health Care Task Force, but neither of the panels' two Democrats. Laura Kelly, D-Topeka, said that the task force never met and agreed on the package of proposals.

The most far-reaching of the measures would create a Kansas healthcare connector, a new insurance marketplace where individuals would purchase group coverage with assistance from their employers, rather than relying on employers to select a plan and purchase it for them. Individuals who buy insurance through the connector would be allowed to use pre-tax dollars, which, supporters say, would make premiums more affordable. The approximately 38,000 state employees now covered by a state plan would be used to initially constitute the group to ensure a large risk pool. The proposed "connector" is similar to a mechanism used in the universal coverage law now being implemented in Massachusetts. It remains to be seen whether the Kansas version would - as the Massachusetts law does - require individuals to purchase insurance and employers to participate in the system. A version of the connector model developed by the Heritage Foundation, a conservative, Washington, D.C. think-tank, is contained in Kansas **Senate Bill 309**, which was introduced earlier this week.

Sen. Jim Barnett, R-Emporia, chairman of the task force and candidate for Governor last fall, said the proposal is aimed at ensuring the approximately 300,000 Kansans who currently lack coverage. And he said it is designed to reform the current employer-based system, which he charged doesn't work. Barnett cited data supplied by the Heritage Foundation that shows that more than 60% of people who are uninsured at any given time previously had coverage. He said that, when people change jobs they lose their insurance. He said the best system would be for individuals to "own their own health insurance."

Marcia Nielsen, executive director of the Kansas Health Policy Authority, recently told members of a House task force that research showed that the primary reason people don't have insurance coverage is because they can't afford it.

Under Barnett's proposal, individuals would have a choice: purchase insurance through the connector, or pay into an account that could be used to cover any future health expenses. Sen. Kelly said there wasn't consensus on the panel about the connector proposal. Rather, she said there was general agreement that a connector model would be among the approaches considered by the health policy authority's Health for All Kansans Steering Committee over the course of the next year in developing a comprehensive health reform plan. She said she was "a little surprised to see that as a recommendation of the task force."

Covering children - Barnett and the Senate task force favor stepped-up efforts proposed by the health policy authority to enroll children in the state's HealthWave program, which is a combination of its Medicaid and State Children's Health Insurance programs. Currently, between 66% and 71% of uninsured children are eligible for Medicaid and SCHIP coverage but not enrolled. Kelly said there was bi-partisan support for that plank in the task force plan because we need to be sure kids are insured while we work on ideas to cover more adults. However, the task force did not reach agreement on Gov. Kathleen Sebelius' $10 million proposal to expand eligibility for HealthWave programs in an attempt to cover all children from birth to age 5. Barnett said, "We have concerns that the current system is not working and we think it's time to look for a different system." He explained that he would prefer to seek waivers from the federal government that would allow the state to buy private health coverage for Medicaid and SCHIP eligible children and

families.

Gov. Sebelius, in a statement late yesterday, said she was glad the Senate task force supported the expansion of HealthWave enrollment efforts but added, "I hope the full Senate will once again endorse my proposal to provide health insurance for every Kansas child from birth to age 5." The Senate approved funding for a similar proposal last year, but GOP leaders in the House declined to go along, citing concerns about the long-term costs of expanding eligibility criteria. In an indication that this year's proposal from the governor remained alive in the Senate, Senate President Steve Morris said he remained open to it. "I don't want to give up on anything that's viable," he said.

Though the governor continued to press for her birth-to-five initiative, she said she welcomed the increased legislative attention to what she called "the crisis in our health care system."

Prevention and detection - The Senate task force endorsed a proposal to significantly expand the number of potentially life-threatening, but treatable, conditions for which newborn babies are tested. Currently Kansas is one of only a handful of states that tests for fewer than 10 of these conditions. The proposal under consideration would expand that to 29, the number recommended by the Kansas Department of Health and Environment and the American College of Medical Genetics.

The task force also called for passage of Senate Bill 318, which would increase funding for tobacco prevention programs in Kansas by an additional $15 to $16 million. The state's award from the Master Settlement Agreement, the 1998 settlement between tobacco companies and states to reimburse them for medical costs attributed to smoking, will increase beginning in April 2008. **Senate Bill 318** requires that the additional funds be used exclusively for smoking prevention and cessation programs. The state receives about $50 million each year from the MSA. Most of the funds are used to pay for social and health services for children; $1 million is allocated for smoking cessation and prevention programs. The Centers for Disease Control recommends that Kansas spend about $18 million each year on those programs.

One idea that didn't make the Senate task force's list of recommendations was a proposal to allow parents to carry their children on health insurance policies up to age 25. The cut-off now is age 23. Barnett said the proposal would point the state in "the wrong direction." "We need to have a culture that says 'you need to go out and buy insurance,'" Barnett said. However, approximately 33% of uninsured, working-age Kansans are between the ages of 18 and 25.

WHAT OTHER STATES ARE DOING ON HEALTH CARE REFORM

There's no gold standard for state health care reform initiatives; no single model that points the way for states seeking to expand health coverage to the uninsured. Still, there are states that appear further down the path than others and no shortage of proposed reforms that share common elements. "There's no question that this is an issue that has leapt to the top of the visible heap in terms of health issues in 2007 state legislative sessions," said Richard Cauchi, health program director for the National Conference of State Legislatures.

It's not a new issue, Cauchi said. For the last decade, state legislatures have been grappling with the big question of how best to reform the health care system and provide coverage to the millions of their residents who lack it.

Media coverage and a new level of proposed - and approved - legislation have expanded the debate over what is needed and what is possible. Health reform legislation is or has been under consideration in at

least 16 states this year. But even that number is hard to pin down because of the different ways to define what constitutes a health reform initiative. It could be legislation that has been introduced or even the creation of governmental commissions to study the issue and propose policy changes.

This is not a topic to be discussed quickly and simply. The states that have implemented reforms spent many months with the stakeholders at the table, going through different levels of discussion and debate, then passing something in one chamber, then another, and coming to an agreement later. In other words, the process is as important as the final product.

Here's a survey of a few of the states that have had success, are debating legislation, or are in some other way seeking to address the issue of reforming the health system to expand access to care.

California - The plan: Expand enrollment in the state's public insurance programs to all children, regardless of their immigration status, who live in homes where the family income is as much as 300 percent above the federal poverty level, or FPL - which, for a family of three, is $51,500 a year. The plan also allows uninsured, legal resident adults with incomes below 100% of FPL - for single adults that means earning less than $10,200 a year - to enroll in Medi-Cal, one of the state's public programs. Legal resident adults with incomes between 100 and 250% of FPL - for those who are single that is between $10,200 and $25,500 - would be eligible for coverage through state programs.

If passed as proposed, state law would require all individuals to have a minimum level of coverage.

Who pays for it: The proposal, estimated to cost $12 billion, requires small businesses with 10 or more workers that do not offer insurance coverage to pay 4 percent of their payroll to a state fund. That fund would be used to subsidize health insurance for the working uninsured. Also, doctors and hospitals will pay 2 and 4 percent of their respective revenues to the state's Medicaid program to help cover higher reimbursements for those who treat Medicaid patients.

Status: Gov. Arnold Schwarzenegger unveiled the proposal on Jan. 8. It requires approval from the state's Legislature. Two other major plans to address the issue have been debated - the first in 2004 and the second in 2006 - but neither were approved.

Illinois - The plan: The Covering All Kids Health Insurance Act makes insurance coverage available to all uninsured children by making insurance more accessible to low-income families. The goal is to cover about 50 percent of uninsured children in Illinois whose families have incomes above 200% of the Federal Poverty Level, the eligibility ceiling for Illinois' State Children's Health Insurance Program. Two-hundred percent of the FPL is equivalent to an annual income of about $34,300 for a family of three. The All Kids program is also linked with other public insurance programs and relies on outreach efforts to educate parents about their options. Of the 250,000 eligible uninsured children in Illinois, the state predicts that 50,000 will be enrolled in the first year of the program.

Who pays for it: The program, estimated to cost $45 million to cover the 50,000 children targeted by the state, will be funded mostly - about 75 percent - through premiums and co-pays from the families enrolled in the program. The state also expects to save more than $50 million in the first year by moving most of the state's Medicaid enrollees into a primary-care case management program designed to improve quality of care and reduce costs.

Status: The program began covering children on July 1, 2006; as of January 2007, the All Kids program will be available to any child who has been uninsured for 12 months or more. The cost to the family will be

determined on a sliding-scale basis. For more information: http://www.allkidscovered.com/

Maine - The plan: Expand coverage, control costs and improve quality of health insurance programs through the state's Dirigo Health Reform Act to insure all uninsured Maine residents by 2009.

Who pays for it: Funding for DirigoChoice coverage and the cost and quality initiatives comes from employer and individual contributions, state general funds and federal Medicaid matching funds for those individuals who are eligible. DirigoChoice, a program that offers discounts on monthly premiums and reductions in deductibles, is available to small businesses, the self-employed and eligible individuals who do not have access to employer-sponsored insurance. Low-income enrollees have incomes below 300 percent of the Federal Poverty Level, which is equivalent to about $51,500 per year for a family of three.

Status: The health reform act was enacted in 2003. About 12,000 Maine residents enrolled in the DirigoChoice program in its first year, drawing criticism from some because the number was much lower than the state had anticipated. Most of those enrollees were low-income individuals who benefited from the subsidies. Gov. John Baldacci established a Blue Ribbon Commission in 2006 to make recommendations for long-term funding and cost-containment. Changes were implemented recently aimed at streamlining the administration of the program and making it easier for individuals to participate. Outreach and marketing strategies have also been increased to help boost enrollment. For more information: http://www.dirigohealth.maine.gov/

Massachusetts - The plan: Cover 95% of the state's uninsured residents in three years. Massachusetts residents are required to carry insurance coverage. Those who do not, and do not obtain a waiver for religious reasons, will be assessed a penalty on their income tax returns. Employers too are expected to chip in. Those who do not provide insurance to their employees are required to contribute financially to help cover the cost of health care for their employees.

Who pays for it: Individuals, employers and the government. The state requires employers with more than 10 employees to provide health insurance coverage. Individuals who can afford health insurance are required to purchase a coverage plan; government subsidies are available to families who make at or below 300% of the federal poverty level - which is equivalent to about $51,500 per year for a family of three - who may purchase insurance on a sliding scale using pre-tax dollars. The state's Medicaid program was expanded to give free coverage to children in those families. A "connector" (the Commonwealth Health Insurance Connector) will help individuals and businesses find affordable health coverage. The connector also allows individuals to keep their policies and health care providers if they switch employers.
Young adults may remain on their parents' plan up to two years after they are no longer considered dependents for tax purposes or until age 25. Low-cost health insurance options are being created for young adults ages 19 to 26. About $385 million in federal matching funds previously used to fund safety-net and uncompensated care will be redirected to help subsidize the reform. The state will also invest $308 million in general fund revenues over three years.

Status: Former Gov. Mitt Romney approved the insurance coverage law in April 2006. Massachusetts residents have until July 1 of this year to purchase an insurance plan.

For more information: Commonwealth Health Insurance Connector

Minnesota - The plan: Require all Minnesota residents to carry health insurance. Those who do not comply would be subject to a penalty based on income and what they would pay for coverage; anyone who does not comply may be subject to pre-existing condition limitations when they do apply for coverage.

Who pays for it: Individuals and the government. Residents who make up to 300 percent of the Federal Poverty Level, or the equivalent to about $51,500 per year for a family of three, could be eligible for a sliding-scale subsidy to help pay their premiums for private insurance. Employers are not required to participate, but incentives - and barriers that prevent employers from dropping insurance coverage - could influence employers' decisions. All insurers that provide policies to businesses or groups are required to participate in the individual market, and must offer at least three insurance plans. Unmarried children would be allowed to stay on their parents' policies up to age 25, regardless of student status. The plan is estimated to cost $900 million.

Status: The state is now discussing a plan to focus primarily on covering children and allowing individuals without insurance from their employer to pay for their own private insurance premiums with pre-tax dollars. Gov. Tim Pawlenty released the new proposal in mid-January after his State of the State speech. Legislation that would create one proposal, the Children's Security Program, is now in committee in the state's legislature.

New York - The plan: Make health insurance available to all children and enroll all eligible adults in Medicaid.

Who pays for it: No specifics on a New York plan yet; however, the United Hospital Fund, a not-for-profit health services research group in New York, estimated in a 2006 report that 2.4 million uninsured New York citizens could be covered for $4.1 billion a year using approaches that combine individual mandates; a modest employer assessment; and an expansion of public programs - much like the Massachusetts model.

Status: Gov. Eliot Spitzer asked the New York Legislature in early January to work on a budget that "in the very first year, guarantees access to health insurance for all of New York's 500,000 uninsured children."

Vermont - The plan: Insure 96% of Vermont residents by 2010. Participation in the plan is voluntary unless the goal is not met by 2010; the state will then consider an individual mandate.

Who pays for it: Individuals, employers and the government. Funding will come from federal matching funds, premiums, employer assessments and an increased tobacco tax. The health reform plan, called Catamount Health, is available for residents who have been uninsured for 12 months. Coverage is based on plans available to those who do not have insurance through their employers, but with less of a contribution from the individual or family. Families with an annual income up to 300% of FPL are also eligible for the state's Catamount Health program. Three-hundred percent of FPL is about $51,500 for a family of three. The state also provides premium assistance to low-income individuals with access to employer-sponsored insurance that previously have been unable to afford insurance. Employers must pay an annual assessment if they don't offer plans that pay some part of the employee's insurance. Those employers who do offer such a plan must still pay the annual fee for ineligible workers and for those who refuse to participate and do not have insurance from another source.

Status: The coverage expansion has been paired with an additional health reform effort: the Vermont Blueprint for Health. The Blueprint focuses on chronic care management and provides incentives for residents who monitor their health. Private insurers will begin selling Catamount policies beginning Oct. 1, 2007; the state plans to expand the Blueprint program across the state by 2009.

HEALTH CARE PRICE TRANSPARENCY

In a health care system that puts consumers first, it is essential that Kansas hospitals are committed to sharing meaningful and accurate pricing information to their patients. To help promote pricing transparency, Senator Jim Barone, D-Frontenac, has introduced a bill requiring hospitals to list prices for their most common services. SB 181 would require the Kansas Health Policy Authority (KHPA) to compile a list of 25 common non-emergent services performed during inpatient and outpatient hospital stays. The Kansas Hospital Association (KHA) is currently developing Web based software to make hospital prices available to consumers statewide.

A similar House bill would require disclosure of prices charged by health care providers and reimbursed by health insurance carriers for health or medical care services. That's **HB 2272**.

BULLYING BILL

Students and experts on bullying urged lawmakers Wednesday to adopt legislation that would require school districts to implement anti-bullying plans and report bullying incidents to the state. Several members on the House Education Committee said **House Bill 2310** was too broad, but Chairman Clay Aurand, R-Courtland, said he hoped the committee could "make this a bill that is best able to achieve its goals." Sue Ellen Fried, of Prairie Village, a longtime mental health advocate who has written several books on bullying, said youngsters today are confronted with much worse bullying practices than in the past, including cyber bullying, where people write demeaning comments to children over the Internet. "It is just as serious as beating kids up in the playground," she said. Aishlinn O'Connor and Kate O'Neill, both students at Shawnee Mission East High School, said bullying behavior also manifests itself in excluding students from certain groups or in jokes between friends that denigrate someone. Fried and Gina McDonald, vice president of education and awareness for the Kansas Children's Service League, said victims of bullying sometimes lash out. School shootings are often the result of a student reacting to being bullied, they said.

SEATBELT LAW

The House Transportation Committee was inundated with testimony from other advocates of a bill making the seat belt law a "primary" offense. Under current law, officers must stop a driver for another infraction, such as speeding, before addressing a "secondary" violation related to seat belt usage. **HB 2136** also would raise the fine for seat belt infractions to $60 from $10. That new revenue would be used for traffic records management, emergency medical services and trauma care.

Chairman Gary Hayzlett, R-Lakin, said his committee was unlikely to endorse the bill sought by the Kansas Department of Health and Environment, Kansas Department of Transportation and Kansas Highway Patrol. He said the committee might be willing to apply a "primary" offense label to seat belt laws targeting people 18 years or younger. An increase in seat belt fines is another possibility, he said.

Hayzlett said that the committee will try to strike a balance between encouraging the use of seatbelts and primary enforcement.

Committee members in both political parties had objections to the bill. Rep. Mike Burgess, R-Topeka, said he personally promotes seat belt usage but believes the bill amounted to government intrusion. "At this point," he said, "I'm not leaning in favor of a primary law."

Another member, Rep. Vince Wetta, D-Wellington, said he was once thrown through a windshield in a wreck, but still wasn't convinced this bill was a proper remedy. "I come from a time you didn't tell me what

to do when driving a car," he said.

The only person to testify against the measure was Chris Maurich, a lobbyist with the motorcycle group ABATE of Kansas. Laws shouldn't protect careless people from themselves, he said. Darlene Whitlock, co-chairwoman of Driving Force, a citizen task force put together by KDHE, KDOT and KHP, urged Hayzlett and his colleagues to accept a tougher enforcement standard. Traffic accidents are the No. 1 cause of death in Kansas for people younger than 34, she said, and 72 percent of people killed in Kansas traffic accidents from 2001 to 2005 weren't wearing a seat belt. Kansas ranks 43 among states in seat belt compliance. She attributed that poor ranking can be attributed to the state's lack of a primary seat belt law.

Col. William Seck, highway patrol superintendent, said the agency has aggressively pushed seat belt education and enforcement, however, he said, passage of a primary seat belt law is the next logical step. "If you ever have the chance to put forth a change that will undoubtedly save someone's life, this is it," he said.

HOUSE COMMITTEE HEARS BILL ON PILOT HEALTH INSURANCE PROGRAM FOR SMALL BUSINESSES

A bill to create a pilot program allowing 1,000 small-business workers into the state employee health plan was heard yesterday by the House Insurance and Financial Institutions Committee. **HB 2172**, a top agenda item for House Democrats this session, met opposition from a variety of insurance interests including the association that represents insurance agents and Coventry, one of the companies that provides coverage within the state employee plan. The state plan currently covers 88,000 people.

A lobbyist for the Kansas Association of Insurance Agents told lawmakers, "We are opposed to the basic concept of the state competing with private enterprise to provide health insurance to private businesses and non-state employees." A lobbyist for Coventry asked committee members to wait until the bill had been studied more by the Kansas Health Policy Authority.

The bill was supported by some small business owners and small-business advocate Kenneth Daniel of Topeka. "This proposal deserves a chance," Daniel said. "There is much to be learned from trying it, and the risks are minimal. It may be hard to get small businesses to join the plan or it may be easy. Either way, we are going to gain knowledge from the attempt. Marketing has been one of the biggest hurdles we have encountered in trying to get small businesses to take up insurance." The pilot program would allow 1,000 workers to join the state plan, paying the same premiums paid by state workers, but the workers and their employers would pay the costs. Supporters said the pilot would allow small companies that currently cannot afford insurance a shot at getting it.

The opponents said they feared the bill would invite a greater government hand in the insurance market. The committee also heard testimony for and against **HB 2328**, a companion measure that would create a no-interest loan fund administered by the Kansas Department of Commerce to help formation of small business associations in Kansas which would provide small businesses to negotiate together to secure health insurance for their workers. Rep. Nile Dillmore, D-Wichita, ranking minority member on the committee, also testified in support of both bills.

No action was taken on either bill.

KHPA TO LOBBY KANSAS CONGRESSIONAL DELEGATION

Kansas Health Policy Authority officials and state legislators will be in Washington, D.C. this week to talk to the Kansas congressional delegation about problems caused by the new federal rule requiring Medicaid applicants to prove their citizenship. Marcia Nielsen, health policy authority executive director, will lead the delegation, which was scheduled to meet yesterday with all six Kansas members of Congress, or members of their staffs.

"These federal guidelines have restricted the accessibility of health care to thousands of Kansans, which unfortunately, defeats the purpose of federally funded medical benefits," Nielsen said, referring to the complicated proof of citizenship rule that has kept approximately 20,000 children and pregnant women from qualifying for Medicaid. "During our upcoming meetings, we want to encourage our Congressional delegation to review this legislation to mitigate its impact on eligible citizens and state administrative operations and discuss policy alternatives."

Many of those initially denied eligibility because they couldn't produce documents proving their children were U.S. citizens will eventually be enrolled, health policy authority officials have said. But the process of helping applicants collect the necessary documentation is straining the system set up to handle Medicaid enrollment. "We still have applications we received in October that have not been processed," said Carla Deckert, deputy project manager at the Kansas Family Medical Clearinghouse, a Topeka-based facility that processes about 85 percent of Medicaid applications for the health policy authority. The clearinghouse is run by Maximus, a private contractor.

Kansas isn't the only state struggling to comply with the new citizenship rule, which was imposed by Congress to ensure illegal immigrants aren't receiving Medicaid services. A recent report by the Center on Budget and Policy Priorities, a national policy organization that studies issues affecting the poor, said that Iowa, Louisiana, New Hampshire, Virginia and Wisconsin also were having problems. "They're all reporting substantial declines in Medicaid enrollment," said Donna Cohen Ross, director of outreach research at CBPP. "The new documentation requirement has created a significant barrier to health coverage for low-income children."

When asked in January at the start of the new Congress about the problems Kansas was having with the new rule, 1st District Congressman Jerry Moran said he supported the intent behind the citizenship requirement. "I'm happy to listen to the arguments about why what we're doing isn't working," Moran said. "But I support the concept of people having to demonstrate that they are eligible. I do think that services in the U.S. can be an inducement for people to come here." Unfortunately, small children and infants often do not have the kind of identity documents.

In addition to meeting with the Kansas congressional delegation, health policy authority officials will attend a national health policy meeting while in Washington, D.C. Back to top

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Quarterly Report from KDHE Worth the Read

Kansas Health Statistics Report

Kansas Department of Health and Environment – Division of Health
Center for Health and Environmental Statistics – No 32 – February 2007

KDHE publishes a quarterly report that is very informative about the health of Kansans. If you haven't read

it here it is the email message with the link:

The February 2007 edition of Kansas Health Statistics Report, is available at the KDHE Center for Health and Environmental Statistics website at **http://www.kdheks.gov/ches/khsnews/khsr.html**. Click on February 2007 to open the PDF file of the issue. The Center publishes the Kansas Health Statistics Report quarterly. Kansas Health Statistics Report is available by electronic subscription.

Send name changes or additions to the e-mail subscription list to: **Kansas.Health.Statistics@kdhe.state.ks.us**. Back to top

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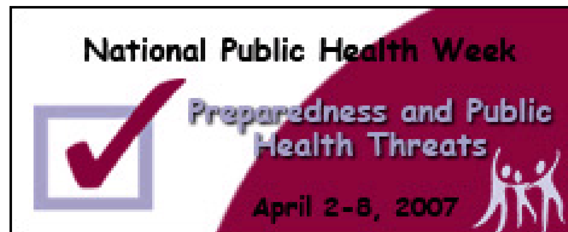
National Public Health Week Apr 2-8



Plan Now for National Public Health Week

Begin Planning and Become a Partner
This year, National Public Health Week (NPHW) will be celebrated April 2-8. The theme is ***"Take the First Step! Preparedness and Public Health Threats: Addressing the Unique Needs of the Nation's Vulnerable Populations."*** Each day during the week will focus on a different vulnerable population:

- **Monday:** Mothers with Children in the Household
- **Tuesday:** Local Food Banks
- **Wednesday:** Hourly Wage Workers
- **Thursday:** Schools K-12
- **Friday:** Individuals with Chronic Health Care Needs

Click here today to become a NPHW partner.

Host a First Step Workshop
APHA and NPHW partners are organizing ***"First Step Workshops"*** in communities across the country. These workshops will educate and encourage the five vulnerable populations to "Take the First Step" to prepare for public health emergencies. Please contact **kaitlin.sheedy@apha.org** if you would like to host a First Step Workshop in your community. You can also become involved in NPHW by signing up as a partner by **clicking here**. To learn more about NPHW, visit **www.nphw.org**. Back to top

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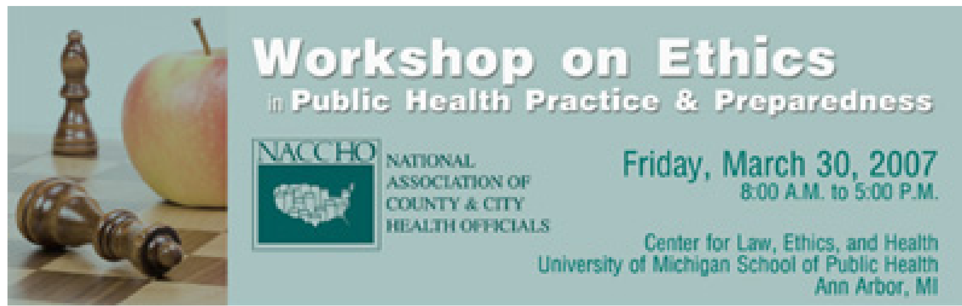
Info from KPHA Member, Dr. Michael Fox: Scholarships Available to Local Health Departments for Ethics Conference in March



NACCHO, the Center for Law, Ethics, and Health at the University of Michigan School of Public Health, and The Robert Wood Johnson Foundation will sponsor a full-day workshop to address ethics and public health practice. This workshop will be held on Friday, March 30, 2007, in Ann Arbor, MI. Ethics experts and public health practitioners will present on the difficult decisions that practitioners regularly face. Workshop presenters and participants will explore how public health practitioners and their partners use or could use ethics to confront an expanding list of difficult ethical issues. Examples of ethical issues include prioritizing the distribution of influenza vaccine during a shortage; exercising isolation and quarantine regulations; and preparing for a pandemic strain of influenza without knowledge about available countermeasures. The workshop will allow public health practitioners and scholars to learn from and share with one another. Public health practitioners will share ethical conundra from the field and ways they have addressed them. Scholars and researchers of public health law and ethics will explain how formal ethical frameworks have been and can be applied to issue areas in public health practice - from preparedness planning to routine day-to-day public health programs and activities. The workshop will also showcase exemplars of effective practitioner-academic partnerships in developing and applying public health ethical frameworks.

For more information on the workshop **click here**.

The National Association of County and City Health Officials
Ethics in Public Health Practice and Preparedness Workshop

Scholarship Application

Ann Arbor, MI
March 30, 2007

A unique opportunity to dialogue and learn from public health practitioners

The National Association of County and City Health Officials (NACCHO) is pleased to offer scholarships to public health practitioners addressing public health ethics in local health departments.

Selected applicants will receive travel support to attend the Ethics in Public Health Practice and Preparedness Workshop in Ann Arbor on Friday, March 30. The scholarship will cover two nights lodging, airfare, and other limited travel expenses. Selected applicants will arrive on Thursday, March 29, and depart by Saturday, March 31.

The conference offers presenters who will appeal to a diverse audience. These informative and interactive presentations will address ethics and routine public health practice, ethics and public health preparedness, and related issues. Visit **www.naccho.org** for updates on the Workshop and posting of the final agenda.

As a condition of the award, scholarship recipients are required to participate in a post-workshop teleconference focus group to discuss ethical issues pertinent to public health practice at the local level. The information from the focus group will be used to develop case studies that will:

- Discuss how participation in the workshop helped inform steps their local health departments plan to take to address ethics within their practice;
- Identify and describe best practices that local health departments have exercised to overcome ethical concerns and barriers;
- Identify resources utilized by local health departments to implement ethics into routine public health programs and activities; and
- Highlight ethical challenges experienced and lessons learned at the local level.

To be considered for the scholarship

- Your agency must be an active (dues paying) NACCHO member.
- You must complete the entire application, providing answers to all of the questions on the application (see attached).

Application evaluation criteria

- Applications will be evaluated by NACCHO workgroup members and graded on a scale of 25 points, based on the criteria below:
  - Adds to geographic/regional diversity of workshop attendees - 10 points
  - A completed application - 5 points
  - LHD ethical challenges (per answer provided) likely to add to diversity of workshop - 5 points
  - LHD ethical challenges likely to provide instructive case study for public health practice - 5 points

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KPHA Receives VISTA Program

This week, KPHA Incoming President Janis Goedeke, and member Kristi Schmidt were in Albuquerque, New Mexico for the VISTA Supervisory training! We received the letter of congratulations from the National and Community Service Corporation:

Kansas State Office
444 SE Quincy St. - Suite 260
Topeka, KS 66683-3572
Telephone (785) 295-2543
FAX (785) 295-2596

February 9, 2007

Elaine Schwartz
Executive Director
Kansas Public Health Association
215 SE 8th Avenue
Topeka, Kansas 66603

Dear Elaine,

Congratulations, The Kansas Public Health Associations has met the requirements for AmeriCorps *VISTA Sponsorship. Your application for the assignment of eight (8) AmeriCorps*VISTA Members has been approved pending return of the attached Memorandum of Agreement. This agreement contains the text, which formulates the formal agreement between the Kansas Public Health Association and the Corporation for National and Community Service's Kansas State Office. Please review this document carefully. If you are in agreement with the terms and conditions, please have the appropriate person sign, date and return both copies to our office. A fully executed copy will be returned for your agency files.

As we discussed a representative (ideally the Project Supervisor/Coordinator) must attend an AmeriCorps*VISTA Project Supervisor Orientation prior to the assignment of an AmeriCorps*VISTA Member. The attached Travel Registration Form should be completed by the staff person(s) who be attending the orientation. The next scheduled orientation is February 13-16, 2007. Please return (email or fax) the Travel Registration for each person that will attend by December 28, 2006.

The purpose of the following is to review the administration of the AmeriCorps*VISTA project. The following points are noted for that purpose.

1. Your application has been approved for the placement of Eight (8) AmeriCorps*VISTA Members.

2. All selected volunteer applicants must attend a three day Pre-Service Orientation (PSO) prior to entering service. The Corporation for National Service conducts these orientations quarterly and pays all travel expenses for the trainees. We must receive a completed AmeriCorps*VISTA application along with the Member Travel Registration Form and Sponsor Evaluation at least 45 days prior to the scheduled PSO in order for your applicants to be scheduled to attend PSO. Additional, information regarding recommending an applicant for AmeriCorps*VISTA service will be sent in a separate correspondence.

3. You must notify this office of any VISTA Member's unexcused/unapproved absence from the project which is more than 24 hours. This is for administrative purposes, which, if not properly handled, can adversely affect the individual VISTA concerned. You will also receive a form requiring your signature to certify that your VISTA(s) have been on-assignment during the previous pay-period. That form should be returned to this office as instructed.

4. We will conduct a site visit with your project within the first 6 months after your project starts and again during the third year of the project. This is intended to be a positive experience for all. It provides our staff with the opportunity to interview volunteers and project staff; review project progress; collectively identify and resolve any difficulties or concerns; provide technical assistance as needed; and jointly plan for project activities that respond to our respective goals and purposes.

5. Your reporting requirements are minimal. They are satisfied by completing the Progress Report online.

Simply log on to **eGrants** and complete the report for the period as noted below. These reports provide you with the opportunity to increase our awareness of your efforts and to request our assistance. This report also serves as a management tool for you. The schedule for submission of these forms is:

Report Period Begins	Due Date
January 1 - March 31	April 30
April 1 - June 30	July 30
July 1 - September 30	October 30
October 1 - December 31	January 30

Afterwards all reports due on a quarterly cycle as outlined until the final report which may be less or greater than a quarter.

6. As a VISTA sponsor, you are eligible to apply for continued project support for a total of three years without interruption. Three months prior to the end of your Memorandum of Agreement period, you should receive a continuation notice to submit a continuation application. Submission of this application does not assure its approval or commitment of the Corporation for National Service's resources. Each project is evaluated on its own merits and past performance, and subject to availability of resources.

7. VISTA volunteers may request to extend their service for a period of 30 days or more, or re-enroll for a period of one year. This request must be approved and justified by your agency. The request must be coordinated through our office and approval is subject to budget considerations. Volunteer extensions and reenrollments are not assured.

8. VISTA sponsor organizations are expected to provide reimbursement for volunteers who use their own vehicles or public transportation in performing project-related duties. It is strongly suggested that you maintain written policies and procedures, including reporting forms, as a management tool for monitoring and reimbursing these expenditures. Sponsors are responsible for determining service-related transportation needs of members. As such, Sponsors must reimburse members for approved on-site mileage at a rate consistent with their organization, but not to exceed the federal rate.

To make this official, please be sure to sign and return both copies of the Memorandum of Agreement. I wish you success with your project! As always, if you have any questions, please feel free to call our office at 785-295-2543 or email **Lbutler@cns.gov**.

Sincerely,

LaVera Butler
Kansas/Missouri Program Specialist
Corporation for National and Community Service
Kansas Field Office

This is an exciting opportunity for KPHA and public health! The Project will be a great addition to KPHA and members.

Here's the project plan:

Part II. PROJECT NARRATIVE

C. Needs and Activities
The AmeriCorp *Vista members will be performing a much needed service for our member organizations and the general public by putting together regional workshops on various health issues, such as the public health system, disease prevention, immunizations and epidemiology. There has been a lack of local training in these areas of public health, especially in rural areas and in low-income areas. We would like 8 volunteers: two stationed in Topeka at the KPHA office, and 6 stationed at multi-sites--2 at 3 county health departments in low-income areas. At the county level they will be working with health department staff who work in the area of health education. They will be assisting with in-service education, public education, and programs such as Head Start, etc.

The AmeriCorp *Vista members need not be knowledgeable in these health education issues, but will be primarily event coordinators for the training and performing tasks such as scheduling, lining up speakers, arranging for facilities, marketing the trainings, evaluating their effectiveness, introducing speakers, and determining how the trainings will be done, i.e., classroom style, lecture style, train the trainer, group interaction, etc. Trainings for health professionals will be done separately from trainings for the general public. Two AmeriCorp *Vista members will be stationed in the Topeka KPHA office under the supervision of the Executive Director, and six AmeriCorp *Vista members will be stationed to work locally with 3 health departments.

One of KPHA's Board members Janis Goedke is the Health Director for Crawford County and has been asked to be one of the counties for placement of two volunteers. Crawford was chosen because they are a county with persons below poverty, their percent in 2003 was 15.2% compared to the state's average of 10.4%. Kristi Schmidt, Health Director of Finney County, and also a KPHA member has been asked to receive two volunteers, since their poverty rate in 2003 was 13.2%. The other two VISTA members will be placed in a county serving the low-income population determined by the KPHA Board.

D. Strengthening Communities
Specifically, poverty-related communities will benefit due to the training provided to the public and to the staff who work in the area of public health, immunization and epidemiology, to improve the health of the public. Statistics show that poverty-stricken areas have less access to good health and would benefit from these trainings. KPHA will benefit because the proposed project will strengthen our organization's capacity to address the need(s) of the community by not only educating the public about the specifics of these areas, but by assisting the public health workforce staff in the delivery of these services.

The project's anticipated outcomes include more informed professionals and community members. We would hope that with this training health statistics will improve and disease outbreaks would decline. Strategies our organization will employ to achieve these outcomes will include supervision of the AmeriCorp *Vista members by highly trained professionals who work in the field of public health. Since public health works directly with the medically underserved, the volunteers will receive an enlightened experience. Back to top

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AmeriCorps*VISTA Project Plan

Service Descriptor/Activity: Education and Public Awareness (KPHA Regional Trainings in Public Health Issues)

Identify Goal(s) to which members' activities are directed.

Develop and implement educational and public awareness trainings for the public health workforce and for the public, especially the low-income community. This will create a sustainable source of income for the sponsoring organization once these trainings are established and will build and strengthen capacity for all four Vista member sites. During this three year project, VISTA members will develop a sustainable system for providing trainings year after year, and will evaluate the effectiveness of the trainings for the public health workforce and the public each year.

Activities: What action steps are needed to accomplish this goal?

During project year one, ten AmeriCorps*VISTA members will work with KPHA staff in Topeka and the immediate supervisors at the other 3 locations to develop and implement plans and materials for the overall operation of the project.

1. Conduct an assessment of both KPHA and the individual county health department's current education programs to determine trainings needed.
2. All eight Vista members will conduct planning meetings with KPHA and with local staff at the 4 sites, and a task force of other KPHA member volunteers.
3. Draft state and local plans for trainings sponsored by each site and gain approval for these plans from KPHA and sponsoring health departments.
4. Design, collect, and print training session materials.
5. Secure training locations, speakers, and equipment needed for trainings.
6. Contact local public and private agencies to obtain lists of potential participants.
7. Conduct recruitment campaign via speaking engagements, web, emails, postal mail, and telephone and register eligible participants.
8. Develop systems to track numbers of trainings, attendees and evaluation materials for the trainings to determine effectiveness.

Output (PERFORMANCE MEASURE): During the first year, components and logs of existing training programs for all sites will be developed along with logs of new state and local trainings for the public health workforce and the public
Indicators: number of current and new training components log developed
Target: Section trainings will be developed for all 7 Health Sections within KPHA for the public health workforce, or/and the public to attend, and at least two additional new trainings for each of the three local health department sites will be developed
Instrument: Training component logs, materials, and documents
Intermediate Outcome: the public health workforce and the public will be notified of additional trainings being provided in their areas
Indicators: KPHA member volunteers will assist in project development and implementation and registration for trainings are received
Target: 80% of the membership will be notified and will acknowledge awareness of new trainings, with plans to attend trainings
Instrument: Supervisors reports, including attendee lists.
End Outcome (PERFORMANCE MEASURE): The seven trainings for KPHA and at least 2 new trainings for each health department site have been presented. **Back to top**

Kansas TRAIN

Visit our site at **http://ks.train.org**.

Partners
in Information Access for
the Public Health Workforce

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