Approved 1-19-84 sh
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Marvin L. Littlejohn at
Chairperson

1:30 a.m./p.m. on January 17, 1984 in room 423-S of the Capitol.

All members were present except:

Committee staff present:

Emalene Correll, Research
Bill Wolff, Research
Sue Hill, Secretary to Committee

Conferees appearing before the committee:

Barbara Sabol, Department of Health and Environment
Joseph G. Hollowell, Jr., M.D., M.P.H., Department of Health & Environment
Joan Remmers, Ks. Assoc. Home Health Agencies, Sabetha, Ks.
Sister Judith Sutera, Ks. Assoc. Home Health Agencies, Atchison, Ks.
Mary Canfield, Ks. Assoc. Home Health Agencies, Topeka, Ks.
Ken Schafermeyer, Ks. Pharmacists Assoc.
Gary Robbins, Ks. Optometric Association
Sherman Parks, Jr., Ks. Chiropractic Association
Bill Williams, Ks. Dental Association

Attachment No. 1., visitors register.

Chairman called meeting to order, calling attention to bills that we will be having hearings on tomorrow. Further, calling attention to the Health Care Review Commission report that has geen given to committee members.

Chairman then introduced Secretary of Department of Health and Environment, Barbara Sabol. (See Attachment No. 2., and Attachment No. 3), for details, on outline of the re-organization of H. & E. Dept., and a chart to accompany it.

Ms. Sabol stressed that no health program has been adversely affected by the re-organization. She highlighted some of the priorities they will be striving to address. Ms. Sabol then introduced Dr. Joseph G. Hollowell to present an update on the Health Care of Kansans.

Dr. Hollowell presented his remarks from printed texts, (see Attachment No. 4), Health Status, Problems, Programs and Issues; and (Attachment No. 5.), charts to accompany Health Status report. He stated there are some health objectives the Department of Health and Environment is hoping to address. i.e., Reducing or eliminating pre-mature deaths, eliminating unnecessary disability and chronic disease, increasing the quelity of life for those individuals whose years will entend into the 80's. Preventive measures against alcohol related accidents, and disease related to tobacco users, and he stated there is a newly organized office of health toxicology. See attachments for further detail.

Ms. Sabol then requested two pieces of legislation for consideration. i.e., an act relating to adult care homes, concerning assessment of civil penalties for violation of standards, amending K.S.A. 39-946, (See Attachment No. 6.), and an act relating to boarding homes for children and registered day care homes; amending K.S.A. 65-516, and 65-519 and repealing the existing sections. (See Attachment No. 7.) Ms. Sabol citing some examples of specific cases where, a patient had insulin ordered and it was not administered for 5 days, exposure to electrical wiring, thus causing extremely safety hazards for the patients. In the examples cited

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

for children in day care homes, the law does not currently allow child care in a place where a person lives who has been convicted of child abuse, or who has had a diversion agreement. The language here, Ms. Sabol pointed out, needs to be more clearly defined.

Discussion between staff and Ms. Sabol on terminology on child abuse, and the intent they desire in the bill. It was brought out there are times when abuse occurs and complaint charges are not filed, so differences in substantiated and alleged terminology raises questions.

Rep. Harder moved our committee introduce these two bill requests, motion seconded by Rep. Cribbs, and motion carried.

Ms. Joan Remmers, Ks. Association of Home Health Agencies presented request. (See Attachment No. 8.) Asked for legislation to preclude the pre-filling of insulin syringes by Home Health Aides. Much discussion followed her comments about Registered Nurse hourly costs, vs., Home Health Aides hourly costs; training programs involved; individual needs of patients in Home Health Care situations; and answering questions along with Ms. Remmer were Sister Sutera and Mary Canfield.

Representative Branson moved we draft and introduce a bill per this request. Motion seconded by Rep. Blumenthal. More discussion followed, then motion carried.

Ken Schafermeyer of Ks. Pharmacists, representing his Association, Ks. Chiropractic Assoc., Ks. Dental Assoc., Ks. Optometric Assn., and the Ks. Assoc. of Professional Psychologists. This collective group is requesting legislation to resolve a problem with the availability of health care services. Existing law contains no assurance that health care providers may not be arbitrarily excluded from Health Maintenance Organization. (See Attachment No. 9.), for details of this presentation. Answering questions from committee along with Mr. Schafermeyer were, Gary Robbins, Sherman Parks, Jr., and Bob williams, in regard to varied aspects and complications of this bill request. Following lengthy discussion, Rep. King moved a bill be drafted and introduced, per this request. Rep. Buehler seconded the motion, and motion carried.

Sherman Parks, Jr., Chiropractic Assn. spoke to a request for expanding legislation passed last year in SB 112, to include language; a licensed doctor of chiropractic to be included. Mr. Parks presented a printed bill request, see (Attachment No. 10.) for details.

Motion to have the bill drafted and introduced was made by Rep. King, seconded by Rep. Williams, motion carried.

Chair called attention to committee that SB 457 was sent over to House very late in 1983 session and action was not taken on it, so it has been carried over. Staff briefed committee on this bill, that it was technical clean up, re-numbering sections. Chair asked for wishes of committee in this regard, and Rep. Green moved we pass this bill favorably. Rep. Walker seconded, and motion carried.

Chairman adjourned the meeting at 3:00 p.m.

Date: 1-17-84

GUEST REGISTER

HOUSE

PUBLIC HEALTH AND WELFARE

PLEASE PRINT NAME

| NAME | ORGANIZATION | ADDRESS |
|---|---|---|
| Jeanette E. Livingston | AARP-NRTA Legislative Committee | 7220 Asbury Dr. |
| Gary Jenkins | United Methodist Homes of Topeka | 7220 Asbury Dr., Topeka |
| Stu Entz | KAHA | Topeka |
| KEITH R LANDIS | CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS | " |
| Judy Gingerich | KDOA | Topeka |
| Marilyn Bradt | KINH | Lawrence |
| Sister Judith Sutera | Ks. Assoc. Home Health Agencies | Atchison |
| Mary Canfield | Ks. Assoc Home Health Agencies | Topeka |
| [illegible] | KS. Assoc. Home Health Agencies | Topeka |
| CHARLOTTE DUGAN | KS ASSOC HOME HEALTH AGENCIES | BOX 282 JUNCTION CITY, KS 66441 |
| Joan A Bemmers | Ks ASSOC Home Health Agencies | 716 So 11th, Salina KS |
| Gary Robbins | Ks optometric assn | Topeka |
| Joe Hollowell | KDHE | Topeka |
| Barbara Sabol | " | " |
| Barb Reinert | KS Women's Political Caucus | " |
| Charles V. Hamm | K.D.H.E | Topeka |
| Aileen Whitfill | SRS | Topeka |
| Dick K Hummel | KS HEALTH CARE ASSN | TOPEKA |
| Dale Goter | HMS | - |
| Sherman A. Parks, Jr | Kansas Chiropractic Assn | Topeka |
| Kathy Wade Apps | Ks Chiropractic Assn | Topeka |
| Bob Williams | Ks Dental Assoc. | Topeka |
| Ken Schafermeyer | KS Pharmacists Assoc | " |

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#2.

## SUMMARY: KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT REORGANIZATION

| FORMER BUREAU/PROGRAM | CHANGE |
|---|---|
| **DIVISION OF HEALTH** | |
| Bureau of Food and Drug | Food and Drug was combined with Food, Service and Lodging and is now housed in the Bureau of Disease Prevention and Control. |
| Bureau of Community Health Services | Community Health Services became Community Liason and Development Functions within the Bureau of Community Health. |
| Bureau of Maternal and Child Health | Maternal and Child Health functions are now housed in the Bureau of Family Health. |
| Bureau of Epidemiology | Epidemiology functions are now housed in the Bureau of Disease Prevention and Control. |
| Bureau of Emergency Medical Services | Emergency Medical Services are now housed in the Bureau of Community Health. |
| Bureau of Registration and Health Statistics | Registration and Health Statistics are now housed in the Bureau of Community Health. Research and Analysis functions are now housed in the Division of Policy and Planning, as is data processing. |
| Office of Health Promotion and Health Education | Health Promotion and Education is housed in the Bureau of Community Health. |

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## SUMMARY: KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT REORGANIZATION (cont.)

| FORMER BUREAU/PROGRAM | CHANGE |
|---|---|
| **DIVISION OF HEALTH (cont.)** | |
| Bureau of Health Planning | Health Planning became an office in the Division of Policy and Planning. |
| Crippled Children's Program | This program was renamed "Crippled and Chronically Ill Children" and is housed in the Bureau of Family Health. |
| **DIVISION OF ENVIRONMENT** | |
| Bureau of Environmental Toxicology | Indoor Air Quality functions are now housed in the Bureau of Air Quality and Radiation Control. Toxicology functions are housed in the Office of the Director of the Division of Environment. |
| Bureau of Water Quality | Water Quality functions are now housed in the Bureau of Water Protection. |
| Bureau of Water Supply | Water Supply functions are housed in the Bureau of Water Protection. |
| Bureau of Environmental Sanitation | Sanitation functions have been housed temporarily in the Bureau of Waste Management. |
| Bureau of Radiation Control | Radiation functions will be housed in the Bureau of Air Quality and Radiation Control. |
| Bureau of Air Quality | Air Quality functions was housed in the Bureau of Air Quality and Radiation Control. |

## SUMMARY: KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT REORGANIZATION (cont.)

| FORMER BUREAU/PROGRAM | CHANGE |
|---|---|
| **DIVISION OF ENVIRONMENT (cont.)** | |
| Bureau of Food Service and Lodging | Food Service and Lodging was combined with Food and Drug and will be housed in the Bureau of Disease Prevention and Control. |
| Bureau of Technical and Support Services | (1) Public Information functions is housed in the Secretary's Office.<br>(2) Training and Certification (KETS and Sanitarians) are housed in the Bureau of Water Protection.<br>(3) Planning functions are now housed in the Division of Policy and Planning.<br>(4) Grants coordination with EPA is now handled by the Director of the Division of Environment. |
| Bureau of Oil Field and Environmental Geology | No change. |
| **OFFICE OF LABORATORY SERVICES** | Laboratory Services has been renamed Laboratory Services and Research. |
| **OFFICE OF HEALTH FACILITIES** | Health Facilities was merged with Child Care Licensing and is now housed in the Bureau of Adult and Child Care Facilities. |
| **ADMINISTRATIVE SERVICES** | Administrative Services was renamed the Division of Administrative and Support Services. |

## SUMMARY: KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT REORGANIZATION (cont.)

### NEW DEPARTMENTWIDE PROGRAMS/FUNCTIONS

Centralized Policy and Planning Functions

Centralized Public Information Functions

Centralized Management Analysis and Evaluation

Centralized Regulation Promulgation and Review
(housed in the Division of Policy and Planning)

Centalized Data Processing

#-3

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

Presentation of Agency Health Legislative Program

By

Barbara J. Sabol, Secretary

To

House Public Health and Welfare Committee
January 17, 1984

Today I will highlight the recent reorganization of the Kansas Department of Health and Environment the budget and legislation I would like this committee to introduce. Dr. Hollowell, Director of the Division of Health, will direct his remarks towards current programs and trends in the health area.

I. The Reorganization

1. Background

   A. In past 10 years, increasing emphasis on environmental issues as they impact on health.

      (1) Need for us to change to keep up with the times.

      (2) Need to improve agency coordination and communication.

   B. Legislative Session of 1983

      (1) Legislature's concerns.

      (2) Bills to unclassify employees.

   C. Need to change now, not in 2 years. Rationale: now confronted only for one year. If wait, will be confronted for 3-4 years. Problems will not go away.

2. Process

   A. Began in March to speak with agency leaders and received their input.

   B. Examined other states' organizations.

   C. Examined other Kansas state agencies.

   D. Studied programs and the legislative mandates from which they grew.

   E. Hired consultant to study internal and external communication processes.

   F. Talked to staff of Budget Division and Legislative Research.

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G. Had "open door" policy for KDHE staff comments after distribution of draft. Also, Friday "open door" policy. Approximately fifty employees responded.

H. Met with bureau chiefs. Met with section staff also.

I. Evaluated comments received from outside KDHE.

J. Sent copies of first draft to all advisory commission members, all SHCC members and interested legislators.

K. Conferred with Attorney General's office about legal questions.

L. Met with Governor's Staff and Department of Administration Staff.

3. Changes: Highlights (See Chart)

A. Created two new divisions: (Administrative and Support Services and Policy and Planning.)

B. Identified and coordinated policy responsibilities. Reduced number of bureaus from eighteen to eight.

C. Bureau chiefs have strong management, administrative and policy skills.

D. Food and Drug and Food, Service and Lodging combined.

E. Centralized Public Information Office.

4. Future Actions

A. Constantly revised.

B. Statutory constraints. Need for legislation to balance statutes.

II. <u>The Budget</u>

The priorities addressed in the budget are:

<u>"A" Level</u>

- Expansion of Laboratory's capability to analyze environmental sampling.
- Maintaining the following programs at a level with the least possible reduction, including the 5% salary increase.
- Laboratory

- Waste Management
- Groundwater Pollution
- Health Facilities
- Maintaining Aid to County/Other Assistance at same level as FY 1984.

"B" Level

- Low Level Waste Compact
- Items listed in "A" above

"C" Level

- Pollution Abatement and Clean up Fund
- Laboratory Improvement Effort
- Local Public Health Financing
- Highway Safety Program Improvement
- Emergency Medical Service Communication System
- Capitol Improvements
- Items listed in "A" and "B" above

III. Legislation

A. Civil Penalties for Violations in Adult Care Homes

Legislation provides authority for the Kansas Department of Health and Environment to assess immediate civil penalties for certain violations of licensing requirements. This will provide a deterrent to reoccurrence of violations and will encourage more timely corrective measures. Fines will be linked to the severity of the infraction.

B. Child Care Licensing

The changes proposed for the Child Care statutes result from our discovery of flaws in those statutes. The law does not allow child care in a place where a person lives who has been convicted of child abuse or who has had diversion

agreements. We have discovered that individuals can be convicted of crimes against children such as battery, which legally is not "child abuse". These amendments would broaden the protection for children.

=4

# Health Status

## Problems, Programs and Issues

Joseph G. Hollowell, Jr., M.D., M.P.H.

Director of Health

Kansas Department of Health and Environment

Today I would like to review some health trends with you and point out some significant issues. I will discuss problems that will become greater over the next decade. I will point to problems for which the cause is known, but solutions difficult, and to problems which are decreasing although not as rapidly as other similar problems. In addition I shall describe some of the department's health programs which relate to these issues.

The health of Kansans generally is good when using almost any indicator. The death rate of Kansans continues to decrease (see Figure 1). Notice that the crude death rate for Kansans is higher than the national crude death rate. When the death rate is adjusted for age, the Kansas rate is significantly lower than the national rate. This indicates that Kansans are living longer and dying at a older age. The Department's efforts over the past 95+ years have dealt largely with infection control and sanitation, infant and maternal mortality, and attention to the quality of food have played a part in contributing to the longevity of Kansans. The large decrease in infant and maternal mortality over the last several decades has been a major influence in the decreasing death rates. (See Figure 2.) Since the beginnings of public health in Kansas the state department's programs have been implemented largely through the efforts of local health departments. The partnership between the state and county departments of health has fabricated an effective public health structure in Kansas.

The health objectives of our department are directed toward 1) reducing or eliminating premature deaths 2) eliminating unnecessary disability and chronic disease, and 3) increasing the quality of life for those individuals whose years will now extend into the 80s.

A review of trends helps to determine where we are now and helps to identify the remaining and emerging problems which have resulted from the progress in the health of Kansans.

It is important to begin with some of the data that we know about Kansas health. The Annual Summary of Vital Statistics for Kansas - 1982, just published, contains most of this information.

1. Problems Related to Decreasing Death Rates:

In 1900 only 4% of the population of the Unites States were age 65 or older. By 1980 the national proportion had increased to 11.3% and in Kansas the elderly category equals 13% of the population. As the baby boom children of the 1940s and 1950s grow older the proportion of

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population 65 and older will reach 18-22%. (See Figure 3.) In Kansas substantial changes have taken place. In the two decades between 1960 and 1980 our total Kansas population increased by 8.5%. The population over age 65 has increased by 27.5% and the population over age 75 has increased by 46.7%. It should be obvious that the population structure per se has implications for the health problems of the state and special consideration is warranted for people in the age group 75 and older. During the last decade the provision of long term care services emerged as one of the most important health and social concerns. As you can see the basis for this concern will not diminish. Our department has many interests and responsibilites in this area. We are concerned with the standards of care for individuals living in adult care facilities, and for community services for individuals living in their own homes. We are concerned that these conditions are safe, healthy, and nutritious; that individuals enjoy their basic rights and will live their remaining years in dignity. The Department of Health and Environment along with the Departments of Social and Rehabilitation Services and Aging will be studying the benefits and costs of having a qualified nurse on duty 24 hours a day for individuals living in adult care facilities. We will be taking additional steps to assure that complaint procedures are adequate and effective in dealing with problems in adult care facilities. During this session the Governor will be asking for legislation which could lead to better care of the elderly in some circumstances. I speak specifically of modifications in the receivership law which would require a licensee to be responsible for costs incurred by the State in operating the receivership. Additional legislation will allow the department to assess fines immediately upon the discovery of major infractions which jeopardize the life, health, or safety of individuals in adult care facilities.

The Department, in addition, has programs addressing the aging process so that the outcome will be one with less chronic disease, less disability, more active and vigorous old age. I refer here to our active health promotion programs in which high risk factors are identified and individuals are encouraged to make decisions which would lead to more wellness and better health during their lives. The Department is keenly interested in and, along with other agencies is studying and supporting, the development of community systems which would offer community and home based services to the elderly and disabled population. Programs such as project LIVELY address this particular concern and interest. Project LIVELY encourages local communities and the aging individual to avoid creeping dependency so that nursing home placement will become a less likely need for the frail elderly.

2. Populations Which Are Not Fully Represented by the Decreasing Mortality Rate

There are several specific groups like this. However, I will address two, namely, the overall black mortality rate and the black infant mortality rate. (See Figure 4.) The average age of death for blacks is about 10 years younger than for whites. In part this is related to the black infant mortality rate which I will discuss later. However, earlier death in blacks is also due to higher blood pressure, other specific diseases such as sickle cell disease and certain kinds of

cancer. In our Bureau of Family Health there are programs specifically directed at the sickle cell problems in Kansas. Laboratory screening is available for anyone through local health departments. There is a program available to address the health care needs associated with the morbidity of sickle cell disease as well. The prevalence rates of high blood pressure are greater among blacks than whites. However, both will benefit from the hypertension programs which exist in counties and which have been specifically targeted to populations which include both blacks and the aged.

The black infant mortality rate is another statistic which is not improving at the same degree as the overall infant mortality rate or the white infant mortality rate in Kansas. Figure 5 shows the changes in infant mortality rate since 1972. Whereas the white infant mortality rate has decreased from 16.5 to 9.6, the black infant mortality rate has decreased from 25.2 to 20. A comparison of rates shows the ratio of the black to white rate in 1972 to be 1.5 to 1, in 1982 the ratio is 2.1 to 1. Clearly the black rate is improving more slowly than the white rate. In the past year we have targeted monies and programs to address this concern with a specific focus on education, nutrition, and health services during the prenatal period. Approximately 85% of the births to black individuals and approximately that portion of the deaths occur in 4 counties, namely, Wyandotte, Sedgwick, Shawnee and Geary. We have begun to integrate all health services and whatever other services we can identify in these counties so that the high risk pregnancies are indentified early. Follow up home visits are initiated if necessary, and a resource person by way of a home visitor is identified for each family at risk. Attention is given to the nutrition needs of this group, and to the follow-up of the infants after birth. These programs have just begun and the effectiveness of this effort will be evaluated over the next few years. The socio-economic factors in this group, traditional health and health provider practices in these communities are complex and not easily changed. Poverty is a major factor. We believe that these efforts if properly targeted and supported will have benefit in the long term.

3. Programs Which Have Identifiable Causes but Difficult Cures

You will note that from Figure 6 that the causes of death have changed. Infections, infant and maternal mortality are down; chronic diseases, cancer, and accidents are up. I would like to review with you examples of material which I presented last year because I think it is important and because it hasn't changed appreciably.

In the first example, Figure 7, auto vehicle deaths are equal to all other accidental deaths and victims are generally young males (Fig. 8). Deaths are in great part alcohol related (Fig. 9) and seldom involve seat belt use. (Fig. 10). In addition, severe injuries outnumber deaths manyfold. You heard last week from the Head Injury Association that severe and moderately severe head injuries are triple the number of deaths in Kansas per year. There are probably 1500 occurrences of combined severe and moderate head injuries annually. These represent an enormous cost to the state, not only through lost productivity of its citizens but actual costs (private and public) for medical and other

health services. Several Health and Environment programs relate to accidents and accident outcome. Our Office of Emergency Medical Services is involved with the statewide system for the adequate treatment of injuries <u>after</u> an accident has occurred. Educational programs speak to the use of seat restraints which will modify an injury. Most cost effective, however, would be the prevention of accidents. My own view is that calling them accidents is misleading. The causes are clear in over half of the cases: 1) The driving behaviors of young males, and 2) The use of alcohol while driving. The State needs clear strategies for changing these behaviors. Our Department nor any other department alone can effect these changes. There needs to be statewide strategies. Some of these are beginning, and our department is participating fully in them. We need clear disincentives to driving under the influence of alcohol. The public needs to be educated as to what are probably not "accidents" <u>per se</u>. Strategies to change the driving behaviors of young individuals should be developed. These issues represent instances where the cause is clear and the objectives for our efforts are clear, but the methods of achieving the objectives are extremely complex and difficult.

The second similar example is that of the relationship between lung cancer and smoking. Smoking is considered the number 1 public health hazard at this time. There is a clear causal relationship between smoking and lung cancer, chronic obstructive pulmonary disease, cardiovascular disease, and other problems. There is an occasional person who gets lung cancer who does not smoke but this is very rare, less than 7%. The annoyance and the risk to nonsmokers in terms of possibly cancer, allergies, chronic lung disease, eye, nose and throat irritation is significant. Not only are the death and morbidity rates high from smoking (it is estimated that 300,000 unnecessary deaths occur annually in the U.S.-3,000 of these in Kansas), but the cost of health care associated with this morbidity and subsequent mortality is also extremely high. The nonsmoker at times is often not protected from the ambient pollution by those who do smoke. Our Department strongly supports a policy of no smoking in the workplace and is working with the Departments of Social and Rehabilitation Services and Administration to provide workers in the State civil service system with options of no smoking in the workplace as well as other health related options in the workplace.

4. General Programs

For the general health of Kansans lifestyle factors are emerging, as major determinants in health outcomes. Some of these have already been mentioned, e.g., smoking, alcohol usage, and the country's driving habits. Eating habits, physical fitness, attention to stress and safety are others. Our programs dealing with lifestyle and behaviors are being given greater emphasis in 1985. The combination of EAP/PLUS for Kansas workers will be promoted. Incidentally, the Project PLUS has just received a national award, one of thirty-five given by the Secretary of Health and Human Services to outstanding health promotion programs in 1983. There were four others in Kansas receiving an honorable mention.

We are also giving attention to special populations such as the migrants and the refugees. Large numbers of refugees are settling in

Kansas. Migrant farmer workers for years have come to Kansas and many have settled here.

With the reorganization there are greater opportunities for the Division of Health to contribute to environmental investigation and decisions. For example, an office of health toxicology has been organized and will study the health information we have to assist in making decisions on cleanup, vis a vis, uncontrolled hazardous waste sites in Kansas.

Attention to the adult and child care facilities regulatory programs have been put together in one bureau. Epidemiology, Food and Drug and Food, Service and Lodging functions are now in one bureau called Disease Prevention and Control. The Family Health Bureau administrates our service programs such as WIC (Women, Infants, & Children), M & I (Maternal & Infant) programs and Crippled and Chronically Ill Children's program. The Bureau of Community Health organizes and administers educational programs.

We continue to find problems with the child care licensing statutes. We will be recommending a change which will further assure the safety of children in out-of-home settings.

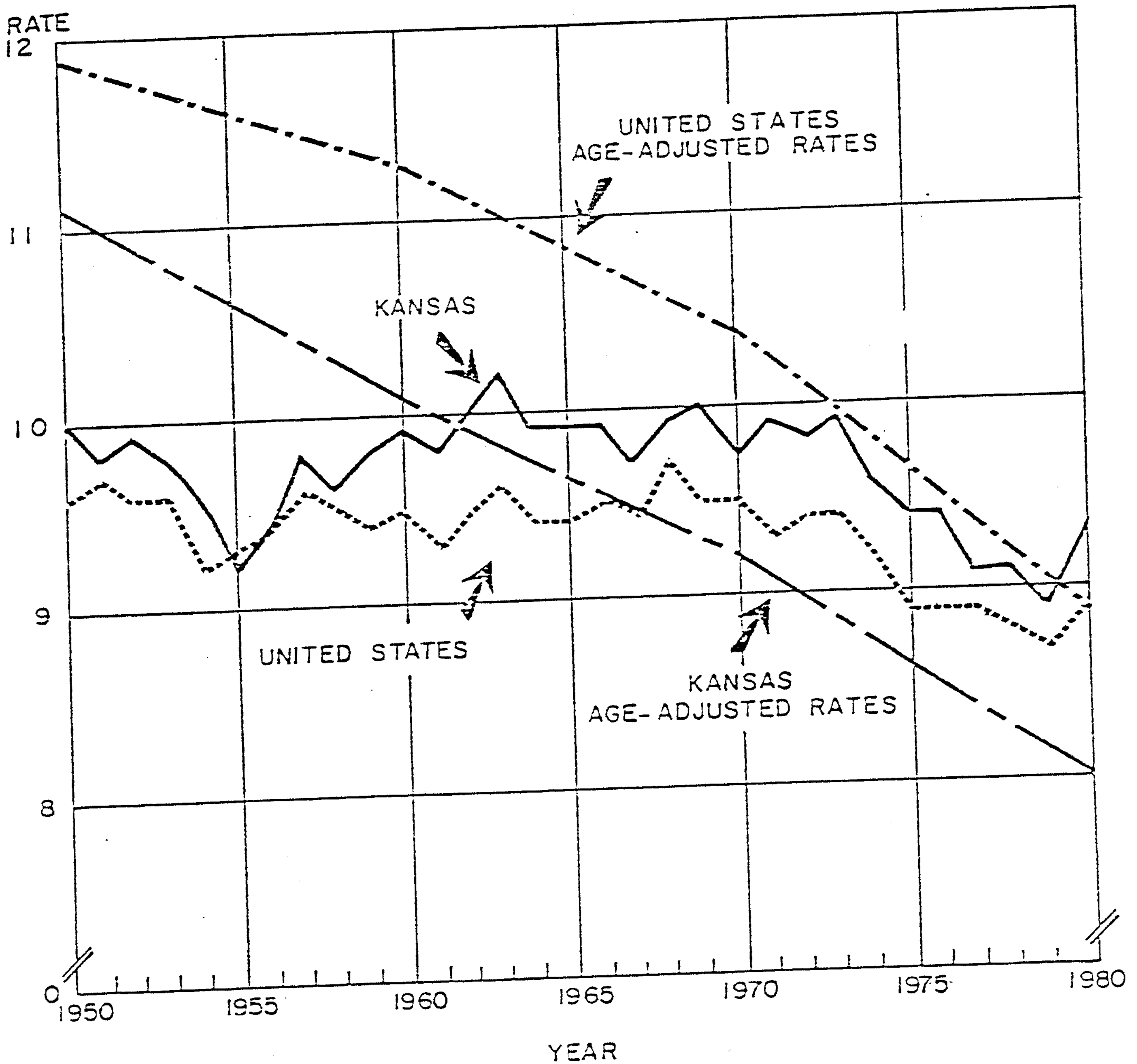
In Summary

Health problems today are vastly different from those at the turn of the century or even 25 years ago. The improvements in life expectancy have uncovered pockets resisting improvement, have created new problems - those associated with old age. The changing times have given us greater understanding of some diseases, but have placed new challenges on our ability to understand other diseases and our ability to prevent them. We are attempting to focus and rechannel our limited resources to address these changing problems.

FIGURE 1

#5 1-17-4

# CRUDE DEATH RATES BY YEAR KANSAS AND THE UNITED STATES, 1950-1980 AND AGE-ADJUSTED RATES, KANSAS AND THE UNITED STATES, 1950, 1960, 1970, 1980




Residence data.
United States 1979 and 1980 rates are provisional.
The 1980 United States population was used as the standard for computing all age-adjusted death rates.

Sources: Bureau of Registration and Health Statistics
Kansas Department of Health and Environment
National Center for Health Statistics

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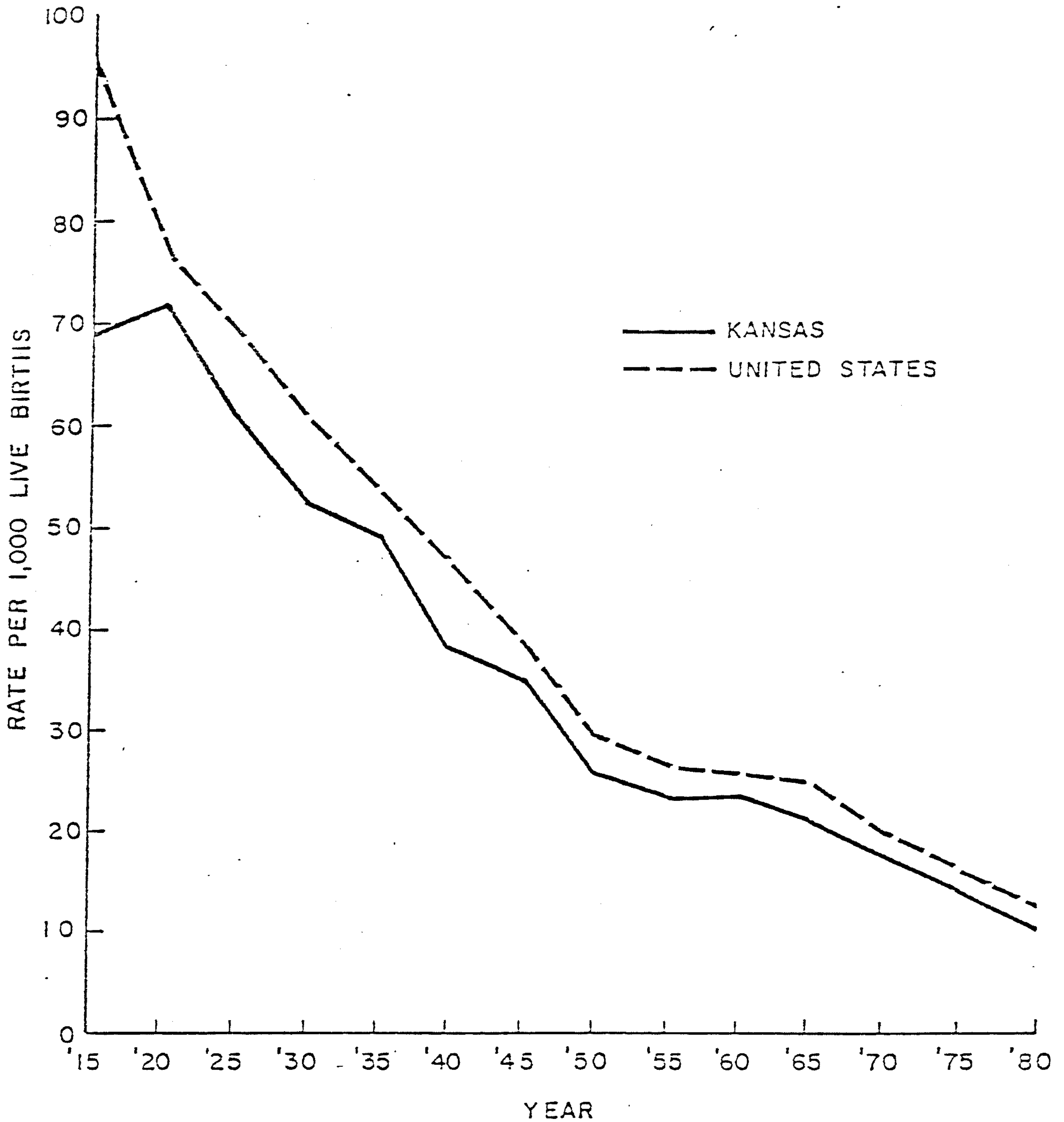
FIGURE 2

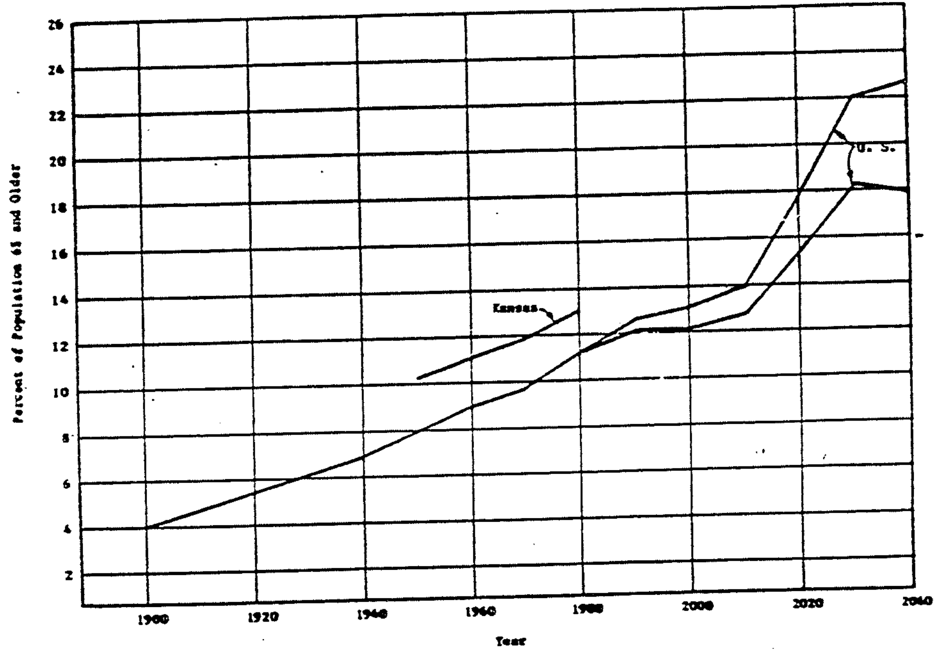



Sources: Bureau of Registration and Health Statistics
Kansas Department of Health and Environment
National Center for Health Statistics

Att. 5 6

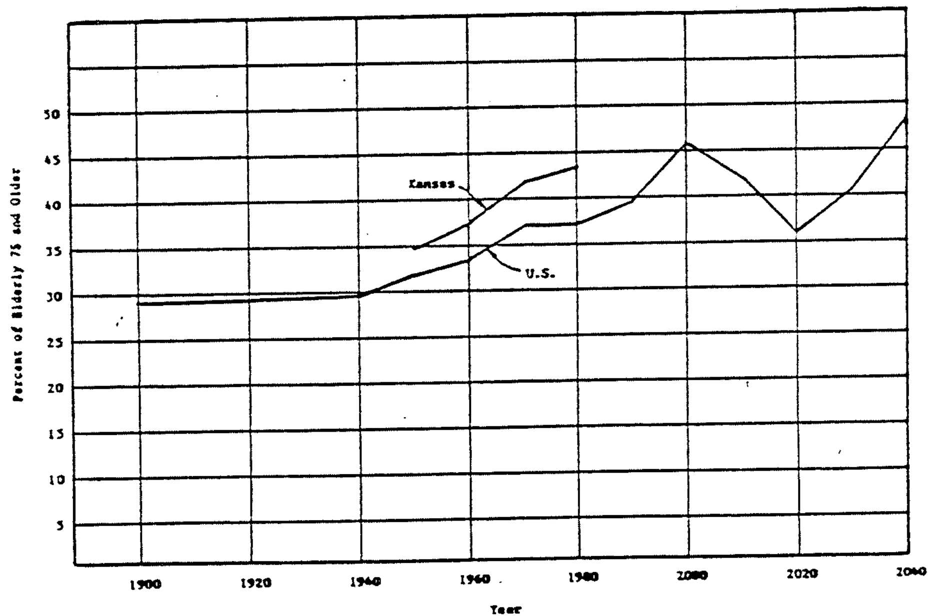
Population 65 and Older
Kansas and United States

FIGURE 3




Source: Subcommittee on Human Service, Select Committee on Aging, Future Directions for Aging Policy: A Human Service Model, Publication No. 96-226, May, 1980, pp. 9 and 14; and Kansas Department of Health and Environment, Bureau of Research and Analysis.

Population 75 and Older
Kansas and United States

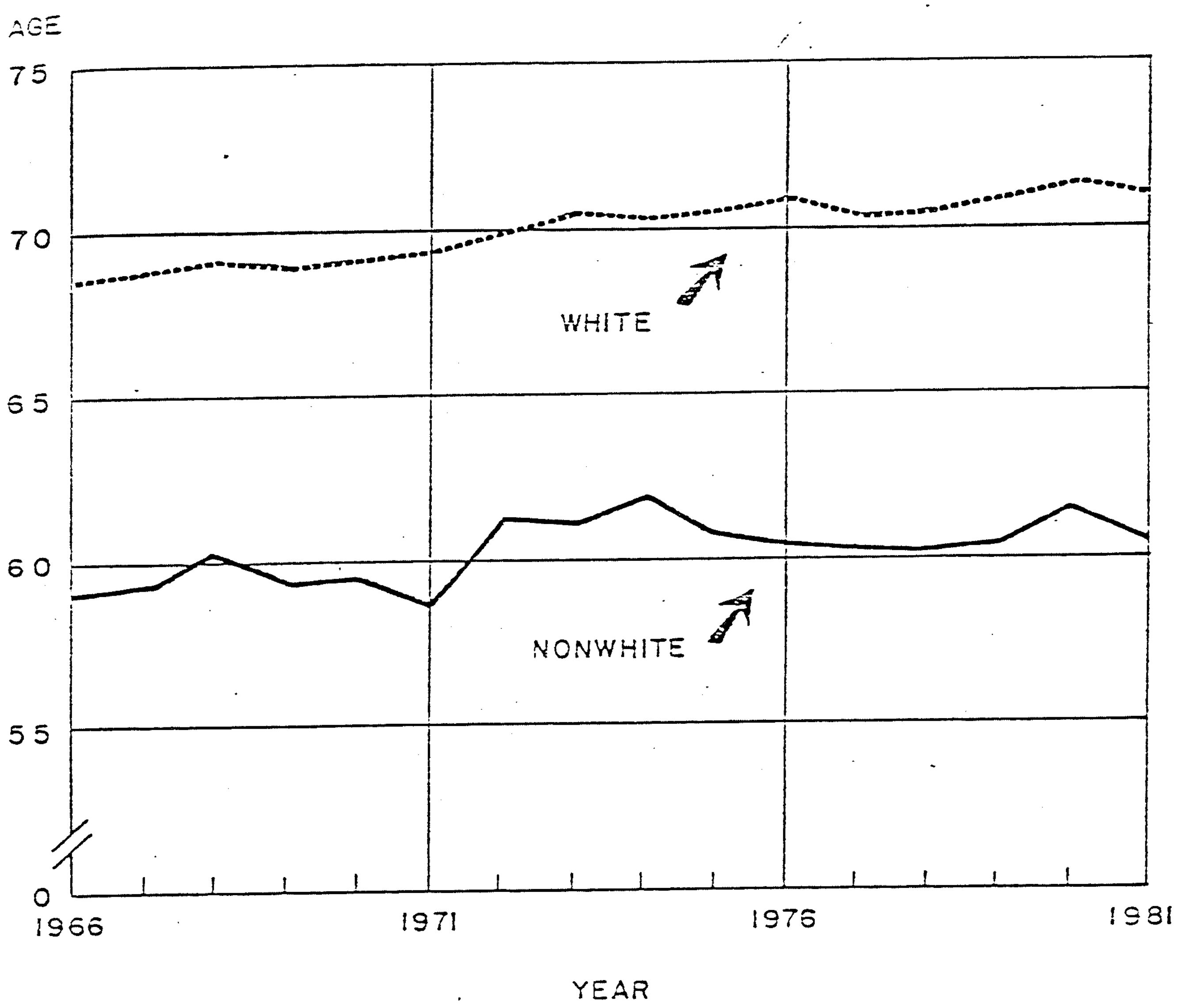



Source: Subcommittee on Human Services, Select Committee on Aging, Future Directions for Aging Policy: A Human Service Model, Publication No. 96-226, May, 1980, p. 16; and Kansas Department of Health and Environment, Bureau of Research and Analysis.

Atch. 5c

FIGURE 4

# AVERAGE AGE AT DEATH BY RACE
## KANSAS, 1966-1981




Residence data.

Source: Bureau of Registration and Health Statistics
Kansas Department of Health and Environment

Atch. 5d

INFANT MORTALITY BY RACE

Ten Year Period

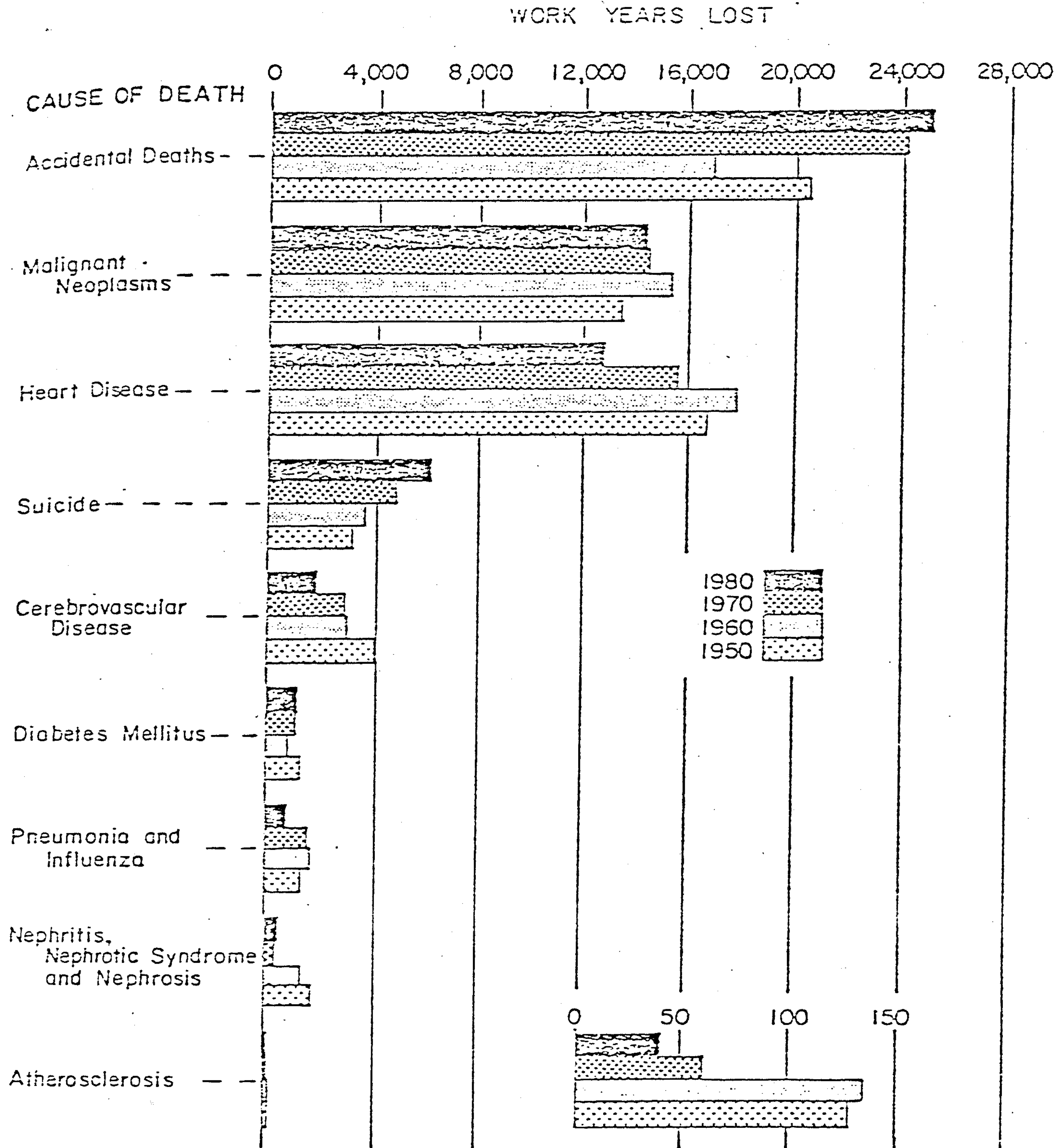
1972 - 1981

| | Black | White | Total |
|---|---|---|---|
| 1972 | 25.2 | 16.5 | 17.2 |
| 1973 | 28.0 | 14.7 | 15.5 |
| 1974 | 23.5 | 15.2 | 15.7 |
| 1975 | 23.8 | 13.2 | 13.9 |
| 1976 | 27.4 | 12.8 | 13.9 |
| 1977 | 24.8 | 12.2 | 13.0 |
| 1978 | 23.0 | 11.1 | 12.0 |
| 1979 | 20.6 | 10.2 | 11.0 |
| 1980 | 21.7 | 9.1 | 10.1 |
| 1981 | 22.1 | 9.9 | 11.0 |
| 1982 | 20.0 | 9.6 | 10.1 |

Atch. 5e

FIGURE 6

# WORK YEARS LOST DUE TO THE LEADING CAUSES OF DEATH KANSAS, 1950, 1960, 1970, 1980

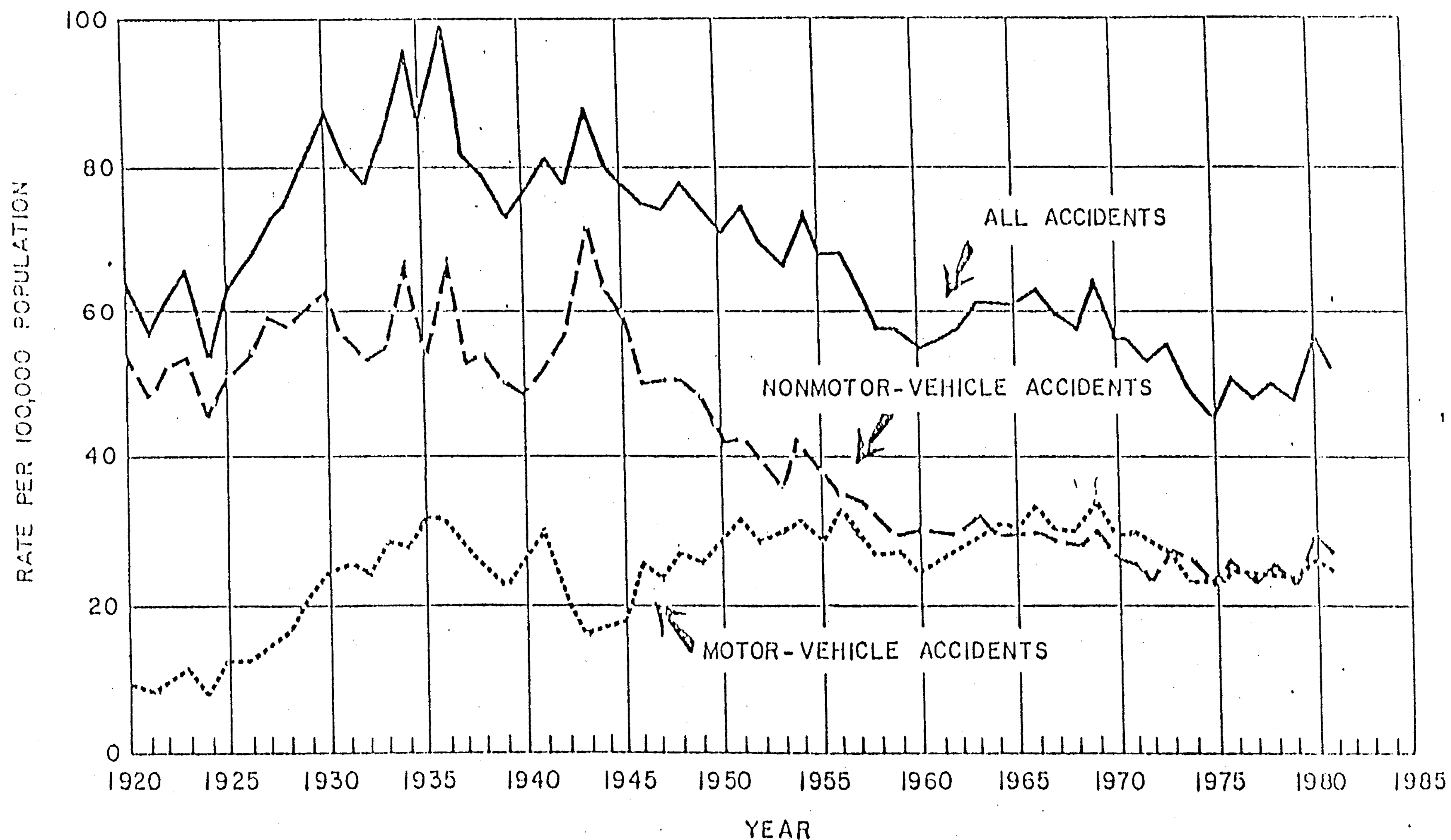



Residence data.

Source: Bureau of Registration and Health Statistics
Kansas Department of Health and Environment

Atch. 5f.

ACCIDENTAL DEATH RATES BY TYPE OF ACCIDENT
KANSAS, 1920-1981

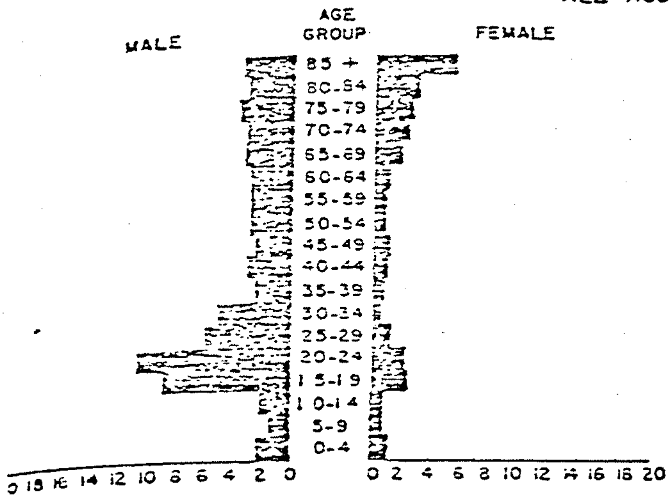


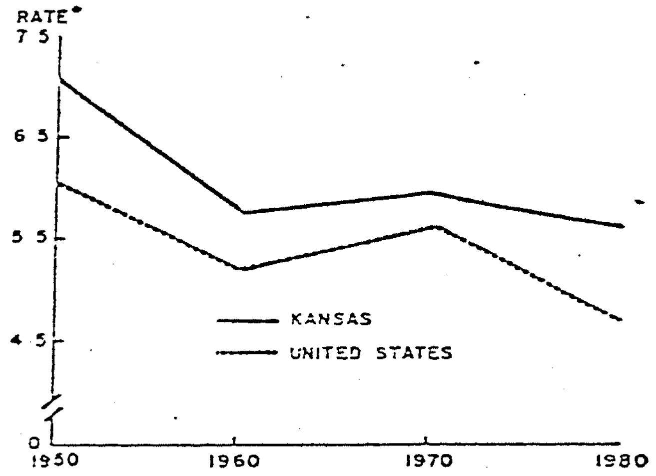

Source: Bureau of Registration and Health Statistics
Kansas Department of Health and Environment

Atch. 5

LEADING CAUSES OF DEATH BY AGE GROUP AND SEX, KANSAS, 1980 AND TRENDS IN KANSAS AND THE UNITED STATES, 1950, 1960, 1970, 1980

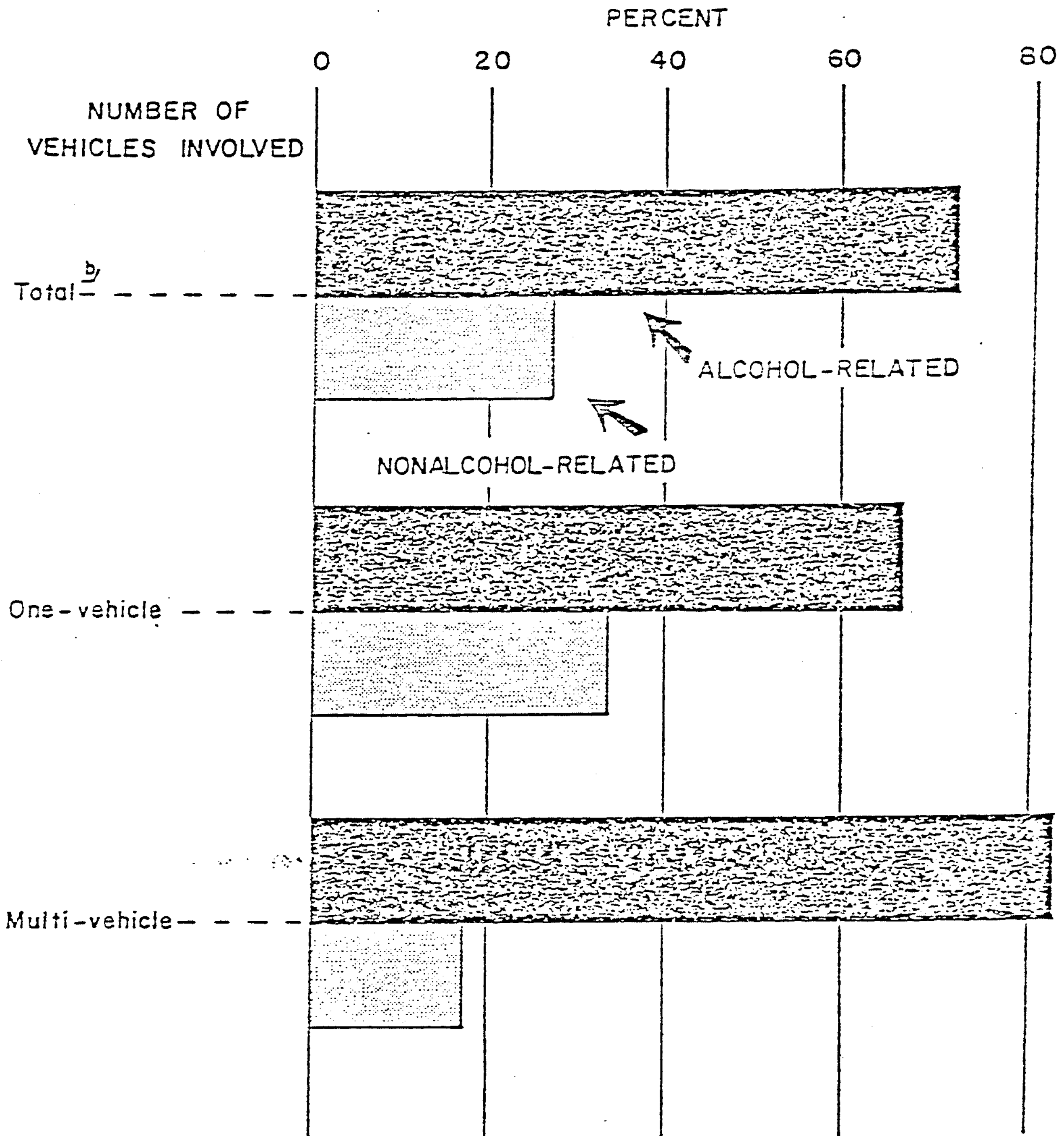
ALL ACCIDENTS # 4




Atch. 5h.

# MOTOR-VEHICLE ACCIDENT DEATHS: PERCENT DISTRIBUTION OF ALCOHOL STATUS BY NUMBER OF VEHICLES INVOLVED, KANSAS[a], 1981




[a] Motor-vehicle accidents occurring in Kansas that 1) resulted in the death of a Kansas resident or 2) resulted in the death of a nonresident in Kansas.

[b] This total does not include pedestrian accidents, pedal cyclist accidents or those accidents that did not specify condition of the driver(s) on the Kansas Motor-Vehicle Accident Death Statistical Transcript.

Source: Bureau of Registration and Health Statistics
Kansas Department of Health and Environment

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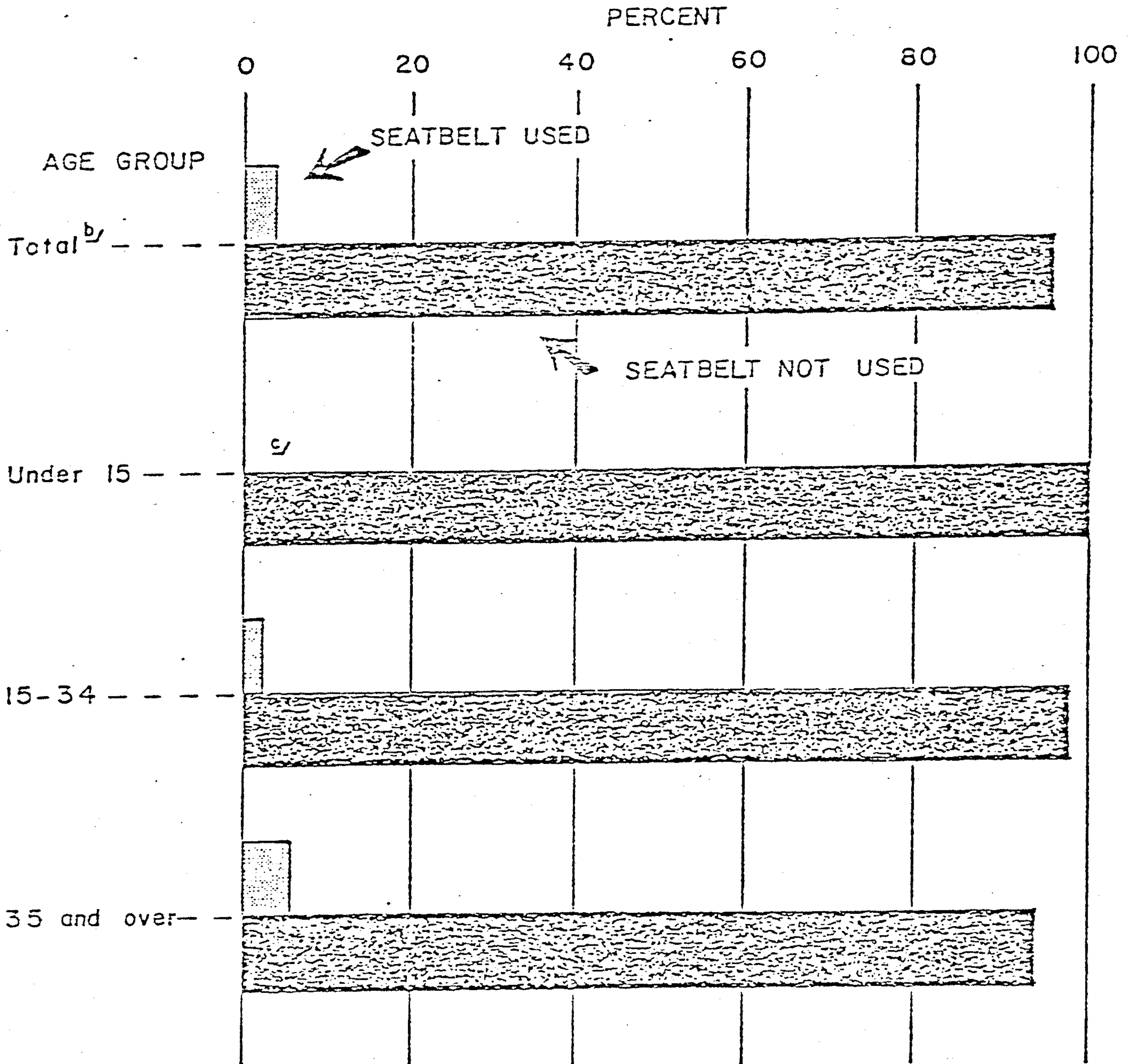
# MOTOR-VEHICLE ACCIDENT DEATHS: PERCENT DISTRIBUTION OF SEATBELT USE BY AGE GROUP OF DECEDENT, KANSAS,[a] 1981




[a] Motor-vehicle accidents occurring in Kansas that 1) resulted in the death of a Kansas resident or 2) resulted in the death of a nonresident in Kansas.

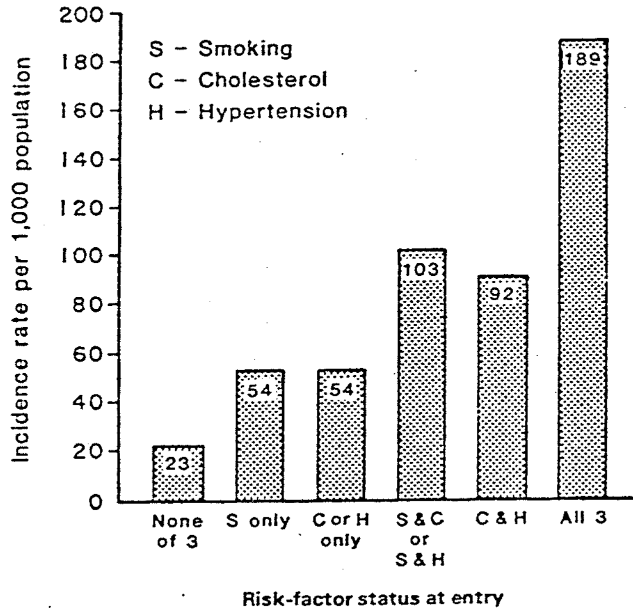
[b] This total does not include pedestrian accidents, pedal cyclist accidents or those accidents that did not specify seatbelt use on the Kansas Motor-Vehicle Accident Statistical Transcript.

[c] None of the decedents under 15 years of age used a seatbelt.

Source: Bureau of Registration and Health Statistics
Kansas Department of Health and Environment

Atch. 5 J.

FIGURE 1. Interaction of major risk factors* on incidence of first major coronary event†




*Hypercholesterolemia (C)—≥ 250 mg/dh; elevated blood pressure (H)—diastolic pressure ≥ 90 mm Hg; cigarette smoking (S)—any current use of cigarettes at entry.

†A nonfatal or fatal myocardial infarction or sudden death from CHD.

Source: National Pooling Project Study

Att. 5K

#6

DRAFT
1/17/84

__________Bill No.________

By________________________

AN ACT relating to adult care homes concerning the assessment of civil penalties for violation of standards, amending K.S.A. 39-946.

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

New Section 1. (a) The secretary of health and environment shall classify each of the standards adopted pursuant to article 9 of chapter 39 of the Kansas Statutes Annotated as relating to one or more of the categories established in this section.

(1) Class I violations are those actions which have resulted in death or serious physical or mental harm to a resident or which create a condition or occurrence which can be predicted with substantial probability to result in death or serious physical or mental harm to a resident.

(2) Class II violations are those which create a condition or occurrence in the operation or maintenance of a facility directly threatening the health, safety, rights, nutrition, or condition of a resident.

(3) Class III violations are those which indirectly threaten the health, safety, rights, nutrition, or condition of a resident or sanitation in the facility.

(4) Class IV violations are those which have little or no effect on the health, safety, rights, nutrition, or condition of a resident or sanitation in the facility.

(b) When the secretary determines that an adult care home is not in compliance with a class I standard, the secretary may immediately assess a civil penalty in the manner specified in K.S.A. 39-946(a).

(c) When the secretary determines that an adult care home is not in compliance with a class II or class III standard, the secretary may issue a correction order in the manner specified in K.S.A. 39-946(b).

Sec. 2. K.S.A. 39-946 is hereby amended to read as follows: 39-946. (a) ~~If upon reinspection by the state fire marshal or the marshal's representative or a duly authorized representative of the secretary of health and environment it is found that the licensee of the adult care home which was issued a~~

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~~correction order has not corrected the deficiency or deficiencies specified in the order, the secretary of health and environment or the secretary's designee shall issue a citation listing the uncorrected deficiency or deficiencies. The citation shall be served upon the licensee of the adult care home either personally or by certified mail, return receipt requested. The citation shall also specify whether the uncorrected deficiencies have an endangering relationship to the health, safety or sanitation of the adult care home residents.~~ Whenever the secretary determines that a class I violation as defined in New Section 1 exists in an adult care home, the secretary may assess immediately a civil penalty not to exceed five hundred dollars ($500). A written notice of assessment shall be served upon the licensee of an adult care home either personally or by certified mail, return receipt requested.

(b) The secretary of health and environment may assess a civil penalty in an amount not to exceed one hundred dollars ($100) per day per deficiency against the licensee of an adult care home for each day subsequent to the last day ~~following the issuance of a citation pursuant to this section~~ allowed for correction of a deficiency in a correction order that the adult care home has not corrected the deficiency or deficiencies listed in the ~~citation,~~ correction order, but the maximum assessment shall not exceed five hundred dollars ($500). A written notice of assessment shall be served upon the licensee of an adult care home either personally or by certified mail, return receipt requested.

(c) All civil penalties assessed shall be due and payable within ten (10) after written notice of assessment is served on the licensee, unless a longer period of time is granted by the secretary. If a civil penalty is not paid within the applicable time period, the secretary of health and environment may file a certified copy of the notice of assessment with the clerk of the district court in the county where the adult care home is located. The notice of assessment shall be enforced in the same manner as a judgment of the district court.

Sec. 3. K.S.A. 39-946 is hereby repealed.

Sec. 4. This act shall take effect and be in force and after its publication in the statute book.

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DRAFT
1/17/84

__________Bill No.________

By__________________________

AN ACT relating to boarding homes for children and registered day care homes; amending K.S.A. 65-516 and 65-519 and repealing the existing sections.

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

Section 1. K.S.A. 1983 Supp. 65-516 is hereby amended to read as follows: 65-516. (a) No person shall maintain a boarding home for children or maintain a family day care home if, in such boarding home or family day care home, there resides, works or volunteers any person who: ~~(a) Has been convicted of child abuse~~ (1) has a conviction by any law of a crime involving mistreatment of a child, or violence against a person, or shall have a record of substantiated sexual abuse or a record of any other type of substantiated child abuse; ~~(b)~~ (2) has had a child declared to be deprived or a child in need of care; ~~(c)~~ (3) has had a child removed from the home pursuant to the Kansas juvenile code, ~~or~~ the Kansas code for care of children or a similar code of other states; ~~(d)~~ (4) has been convicted of a sexual offense; ~~(e)~~ (5) has signed a diversion agreement pursuant to K.S.A. 22-2906 et seq., and amendments thereto, involving a charge of child abuse or a sexual offense; ~~(f) has been found to be an person in need of a guardian or conservator, or both pursuant to the act for obtaining guardian or conservator, or both any person who shall be counted in the total number of children allowed in care;~~ ~~(g)~~ (6) has been found to be unfit to have custody of a minor child pursuant to K.S.A. 60-1610 and amendments thereto; or ~~(h)~~ (7) has an infectious or contagious disease.

(b) Any person who resides in the home and who has been found to be an incapacitated person in need of a guardian or conservator, or both, pursuant to the act for obtaining a guardian or conservator, or both, shall be counted in the total number of children allowed in care.

Sec. 2. K.S.A. 1983 Supp. 65-519 is hereby amended to read as follows: 65-

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519. (a) The secretary shall issue a certificate of registration to any person who applies for registration on forms furnished by the secretary and who attests to the safety of the family day care home for the care of children and certifies that no person residing, working or volunteering in the family day care home: (1) ~~Has been convicted of child abuse or a sexual offense~~ Has a conviction by any law of a crime involving mistreatment of a child, or violence against a person, or shall have a record of substantiated sexual abuse or a record of any other type of substantiated child abuse; (2) has had a child declared to be deprived or a child in need of care; (3) has had a child removed from the home pursuant to the Kansas juvenile code, ~~or~~ the Kansas code for care of children or a similar code of other states; (4) has signed a diversion agreement pursuant to K.S.A. 22-2906 et seq., and amendments thereto, involving a charge of child abuse or a sexual offense; (5) ~~has been found to be an incapacitated person in need of a guardian or conservator, or both, pursuant to the act for obtaining a guardian or conservator, or both~~ has been convicted of a sexual offense; (6) has been found to be unfit to have custody of a minor child pursuant to K.S.A. 60-1610 and amendments thereto; or (7) has an infectious or contagious disease.

(b) Any person who resides in the home and who has been found to be an incapacitated person in need of a guardian or conservator, or both, pursuant to the act for obtaining a guardian or conservator, or both shall be counted in the total number of children allowed in care.

~~(b)~~ (c) The secretary shall furnish each applicant for registration a family day care home safety evaluation form to be completed by the applicant and submitted with the registration application.

~~(c)~~ (d) The certificate of registration shall be renewed annually in the same manner provided for in this section.

~~(d)~~ (e) The secretary shall have access to any court orders or adjudications of any court of record or any records of such orders or adjudications in the possession of the department of social and rehabilitation services concerning persons residing, working, or volunteering in a boarding home for children or a family day care home in order to determine whether or not the home meets the requirements of K.S.A. 65-516 and 65-519, and amendments thereto.

Sec. 3. K.S.A. 1983 Supp. 65-516 and 65-519 are hereby repealed.

Sec. 4. This act shall take effect and be in force and after its publication in the statute book.

#8

January 17, 1984

As the statewide association that represents the home health industry in Kansas, we feel the prefilling of insulin syringes should be the function of a nurse, rather than that of a home health aide, for the following reasons:

1) The people we serve are primarily aged, disabled and infirmed and in many instances living alone.

2) Nurses are legally responsible and liable for the actions of the home health aide they supervise.

3) Generally, Kansas home health agencies choose to send a nurse to perform this task. No state law exists to preclude home health aides from prefilling insulin syringes. Medicare reimbursement for those visits is made as if the visit were performed by a home health aide.

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Kansas State Board of Nursing opinion:

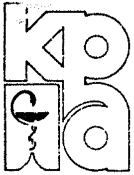
> " Insulin is a potent and potentially dangerous drug. We believe its administration including the filling of insulin syringes should be managed by the licensed nurse."

Attorney General opinion:

> " Because K.S.A. 65-1124 exempts persons performing auxiliary patient care services under proper supervision from the licensure requirements of the Nurse Practice Act, K.S.A. 65-1113 et seq., "home health aides," as described in and regulated by 42 C.F.R. 405.1227, are not violating the Nurse Practice Act by filling syringes with insulin for subsequent self-administration by blind patients. Cited herein: K.S.A. 65-1113, 65-1122, 65-1124, 65-1626, 42 C.F.R. 405.1227.

Medicare Home Health Agency Manual:

> Chapter II - Coverage Issues Appendix
> " If state law, however, precludes a home health aide from prefilling insulin syringes payment may be made for this service as part of the cost of skilled nursing services when performed by a nurse for a blind diabetic who is otherwise unable to prefill his or her syringes. There are no adverse consequinces with respect to reimbursement to the home health agency for providing the service in this manner.
> If state law does not preclude a home health aide from prefilling insulin syringes, but the home health agency chooses to send a nurse to perform only this task, the visit is reimbursed as if made by a home health aide."



THE KANSAS PHARMACISTS ASSOCIATION
1308 WEST 10TH
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KENNETH W. SCHAFERMEYER, M.S., CAE
PHARMACIST
EXECUTIVE DIRECTOR

Statement to the House Committee on Public Health and Welfare

Subject: Patient Freedom of Choice and Provider Right to Participate Legislation

Date: January 17, 1984

Mr. Chairman, Members of the Public Health and Welfare Committee. Thank you for the opportunity to address you this afternoon and request a very important bill. I am Ken Schafermyer, Executive Director of the Kansas Pharmacists Association. With me today are representatives of the Kansas Chiropractic Association, Kansas Dental Association, the Kansas Optometric Association and the Kansas Association of Professional Psychologists. Together, our five Associations are requesting that the Legislature resolve a problem with the availability of health care services.

THE PROBLEM

Existing Kansas law contains no assurance that health care providers such as pharmacists, chiropractors, dentists, optometrists, or psychologists may not be arbitrarily excluded from health care plans.

Assume a less-than-diligent health care plan administrator decides not to bother offering participation agreements to various practitioners and decides to only talk to a few providers in the community. In that case, the individual providers who have been arbitrarily excluded from participation in the plan and the patients served by those providers have no effective means to have the provider gain participation in the health care plan.

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If a provider such as a pharmacist, chiropractor, dentist, optometrist or psychologist offers to render services covered by the plan <u>and</u> agrees to be bound by the terms and conditions of a preferred provider organization, for example, nothing in existing Kansas law protects the provider from being arbitrarily denied the opportunity to render care to patients covered by the plan.

I would like to give you two examples to demonstrate this problem in Kansas:

1. An HMO in the Kansas City area has refused to allow some pharmacists to participate in the plan. Instead, the HMO established an exclusive contract with a chain of pharmacies based in Cleveland, Ohio. Before this contract was finalized, a group of pharmacies from both Missouri and Kansas worked through a service corporation to offer a bid to the HMO. These pharmacies were denied the right to participate even though their <u>bid was lower</u> than that of the chain. Many patients expressed a great deal of concern that they were no longer able to receive pharmaceutical services from a pharmacist who they had come to know and trust. In many cases the pharmacist kept a complete medication profile of the patient, discussed drug therapy with the patient and his or her physician and provided advice on over-the-counter medications, the administration of drugs, etc. Patients were unhappy that they had to drive across town to receive prescriptions from a pharmacy where the personnel seemed to turn over about every six months.

occurred in Salina

2. According to the Kansas Dental Association, a prepaid dental care program contacted a dentist who offered to assist in enrolling other dentists in the program. This dentist contacted a few of his friends (none of whom were in direct competition with him) and then the prepaid dental care program closed enrollments. Other dentists were not allowed to participate in the program. As most of you will agree, going to a dentist can produce a great deal of anxiety. It can be assumed, however, that patients are better off if they are allowed to choose the provider who pleases them most. Again, the patient's concerns and preferences were not taken into account in this case.

While these are just two examples, the result of arbitrary exclusion of providers from health care plans is the establishment of a monopoly or oligopoly. Without competing health care providers, the monopoly has no incentive to offer a higher quality of service. Although restriction of freedom of choice is made in the name of cost savings, such a restriction is unnecessary. By setting low reimbursement rates, the health care plan administrator will discourage many providers from participating; therefore there is no need to restrict freedom of choice of providers directly. What has happened is that certain health care plans exclude providers in cases when cost is not a factor. This is often an attempt to form a monopoly by impairing the competition of health care providers based on the level of service.

THE SOLUTION

The State Associations representing chiropractors, dentists, optometrists, psychologists, and pharmacists are requesting a committee bill to resolve this problem. What will this bill do?

1. It will not require health care plans to cover chiropractic, dental, optometric, psychological, or pharmaceutical services. That decision will remain with the plan administrator.

2. However, if a decision is made to cover services that a chiropractor, dentist, optometrist, psychologist, or pharmacist may legally provide, then this legislation would enable individual practitioners to participate in the plan if (and only if) the provider agrees to the terms and conditions of the plan.

3. It will not result in higher cost services. The health care plan administrator will still establish a reimbursement rate which could be at the same rate which would have been offered on an exclusive contract basis.

4. It will encourage the competition among health care providers based upon the level of service. Since the cost to patients will be the same no matter which health care provider they select, it is likely that patients will select providers that offer better quality services and with whom they are more comfortable.

Mr. Chairman and members of the Committee, thank you for the time to describe this proposal. We feel that it is a very important measure and that it is for the public good. We hope that you will support this concept through the introduction of a committee bill. Thank you.

RS ____________________

House Bill No. ________

By the Public Health & Welfare Committee

AN ACT relating to physical therapy; concerning the practice there of by registered physical therapists; amending K.S.A. 1983 Supp. 65-2901 and K.S.A. 1983 Supp. 65-2912 and repealing the existing sections.

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

Section 1. K.S.A. 65-2901 is hereby amended to read as follows: 65-2901. (a) As used in this act, the term "physical therapy" means a health specialty concerned with the evaluation, treatment or instruction of human beings to assess, prevent and alleviate physical disability and pain. This includes the administration and evaluation of tests and measurements of bodily functions and structures in aid of treatment; the planning, administration, evaluation and modifications of treatment and instruction, including the use of physical measures, activities and devices for the prevention and therapeutic purposes; and the provision of consultative, educational and advisory services for the purpose of reducing the incidence and severity of physical disability and pain. The use of roentgen rays and radium for diagnostic and therapeutic purposes, the use of electricity for surgical purposes, including cauterization, and the practice of medicine and surgery are not authorized or included under the term "physical therapy' as used in this act.

(b) "Physical therapist" means a person who practices physical therapy as defined in this act and delegates selective forms of treatment to supportive personnel under the supervision of such person. Any person who successfully meets the requirements of K.S.A. 65-2906 and amendments thereto shall be known and designated as a physical therapist and may designate or describe oneself as a physical therapist, physiotherapist, registered physical therapist, P.T., Ph. T. or R.P.T. Physical therapists may evaluate patients without physician referral but may initiate treatment only after consultation with and approval by a physician licensed to practice medicine and surgery, a licensed doctor of chiropractic, a registered podiatrist or a licensed dentist in appropriately related cases.

(c) "Physical therapist assistant" means a person who works under the direction of a physical therapist, and who assists in the application of physical therapy, and whose activities require an understanding of physical therapy, but do not require professional or advanced training in the anatomical, biological and physical sciences involved in the practice of physical therapy. Any person who successfully meets the

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requirements of K.S.A. 65-2906 and amendments thereto shall be known and designated as a physical therapist assistant, and may designate or describe oneself as a physical therapist asistant, certified physical therapist assistant, P.T.A., C.P.T.A. or P.T. Asst.

Section 2. K.S.A. 1983 Supp. 65-2912 is hereby amended to read as follows: 65-2912. The board may refuse to grant a certificate of registration to any physical therapist or certificate to any physical therapist assistant, or may suspend or revoke the registration of any registered physical therapist or certificate of any certified physical therapist assistant for any of the following grounds:

(a) Habitual indulgence in the use of narcotic drugs or other habit-forming drugs;

(b) excessive indulgence in the use of alcoholic liquors;

(c) conviction of a felony;

(d) conviction of a crime involving moral turpitude;

(e) conviction for violating any municipal, state or federal narcotic law;

(f) procuring, aiding or abetting a criminal abortion;

(g) obtaining or attempting to obtain registration or certification by fraud or deception;

(h) finding by a court of competent jurisdiction that the physical therapist or physical therapist assistant is an incapacitated person and has not thereafter been restored to legal capacity;

(i) conduct unbecoming a person registered as a physical therapist or certified as a physical therapist assistant or detrimental to the best interests of the public while in the performance of professional duties;

(j) the treatment or attempt to treat ailments or other health conditions of human beings other than by physical therapy and as authorized by this act;

(k) failure to refer patients to other health care providers if symptoms are present for which physical therapy treatment is inadvisable or is symptoms indicate conditions for which treatment is outside the scope of knowledge of the registered physical therapist;

(l) initiating treatment without prior consultation and approval by a physician licensed to practice medicine and surgery, a licensed doctor of chiropractic, by a registered podiatrist or by a licensed dentist.

Section 3. K.S.A. 1983 Supp. 65-2912 and K.S.A. 1983 Supp. 65-2912 are hereby repealed.

Section 4. This act shall take effect and be in force from and after its publication in the statute book.