Approved 1-24-1985
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

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

1:30 a.m./p.m. on January 23, 1985 in room 423-S of the Capitol.

All members were present except:

Committee staff present:

Bill Wolff, Research
Sue Hill, Secy. to Committee

Conferees appearing before the committee:

Secy. Barbara Sabol, Health and Environment

See Visitor's register (Attachment No. 1.)

Chairman called meeting to order, and introduced Secy. Sabol.

Secy. Sabol introduced Dr. Joe Hollowell, Director of Div. of Health in the Ks. Department of Health and Environment, and Mr. Murphy, President of Ks. Association of Local Health Departments. There are also present today many Directors of Local Health Departments, and Secy. Sabol and Chairman both acknowledge their presence.

Secy. Sabol had several hand-outs for committee members, and key remarks were taken from, HEALTH STATUS, Problems, Programs & Issues. (See Attachment No. 2.). Stating, since the beginnings of Public Health in Kansas, the state department's programs have been implemented through the partnership of the local health departments and the State Dept. of Health and Environment.

Ms. Sabol spoke to health objectives, reviewed trends, long term care for the elderly, and noted that those who can and care to be, can remain in their own communities for care. She spoke to charts that indicated data using graphs in charting mortality rates, leading causes of death, alcohol related deaths, (see Attachment No. 3) for details. She spoke of growing concern about the abuse of alcohol, especially by those who drink and drive, concern about the relationship between lung cancer and smoking. She stated that smoking is considered the number one public health hazard. Further, the responsibility for addressing health care costs has shifted from government to the private sector, problems in rural hospitals, general programs being implemented and new programs being implemented, i.e., widespread use of asbestos and its potential hazard to public health.

Ms. Sabol then answered questions from committee in a wide range of topics. She noted also there are two other booklets presented this date that will serve to enlighten committee members. These are shown as (Attachments 4, and 5.)

Chair thanked Secy. Sabol for her remarks, and to those in attendance today from the Health Departments.

Meeting adjourned at 2:20 p.m.

Date: Jan 23, 85

GUEST REGISTER

HOUSE

PUBLIC HEALTH AND WELFARE

Please Print

NAME	ORGANIZATION	ADDRESS
Jacque Cantwell	KS Assn of local Health Depts	Riley Co - Manhattan Health Dept 219 S 6th Child's Rd. Manhattan, KS
Carolyn Shuman	"	McPherson County Health Dept. 119 N. Maple McPherson KS. 67460
Ruby Dennis	"	Montgomery County Health Dept 604 Union, Coffeyville, KS 67337
Pat Scott	"	N.E.K. Multi-Co. Health Dept. P.O Box 1822 Hiawatha Ks 66434
Terri Hyatt	"	Labette County Health Dept (316) 421-4350 Box 786 - Parsons, Ks 67357
Julianne Pottorf	"	Jefferson Co. Health Dept. 604 Liberty Box 324 Oskaloosa, Kansas 66066
Beverly GAINES	"	Bi-County Health Dept. Courthouse, El Dorado, K 67042
Lucy Calvin	"	Barton Co. Health Dept Barton Co. Courthouse Great Bend, Ks
P Habel	KDH&E	Topeka
J. Hollowell	KDH+E	Topeka
Linda Carol Woods	National Organization for Women	112 Woodlawn Topeka, KS. 66606
Michael J Symington	KS. assn for Blind and Visually Impaired	P.O. Box 292 Topeka 66601

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1-23-85

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Date: 1-23-85

GUEST REGISTER

HOUSE

PUBLIC HEALTH AND WELFARE

PLEASE PRINT

NAME	ORGANIZATION	ADDRESS
Fred E. Tosh, M.D.	Wichita-Sedgwick Co. Health Dept	1900 E. 9th Wichita, KS
BARBARA K. Hammond, RN, C	Ks. Assn. Local Health Dept Pawnee Co. Health Dept	Courthouse - Larned, Ks. 6750
Charles Murphy	Riley Co-Manhattan Health Dept	219 S. Seth Childs Manhattan, Ks.
Eileen Keating	Kansas Assoc. Homes for Aged (KAHA)	5th & Kansas, Topeka, Ks.
N. Campbell	Self	Kansas City, Ks 66102
Yvonne Ulrich	Self	Wichita, KS 67208
Lynell Kay	Ks State Nurses Assn	Topeka, Ks

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Attach #1
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HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

January 23, 1985

HEALTH STATUS

Problems, Programs and Issues

Barbara J. Sabol

Secretary

Kansas Department of Health and Environment

As we enter the centennial year of public health in Kansas, I will review some health trends 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) and when adjusted for age, the Kansas rate is significantly lower than the national rate. This indicates that Kansans are living longer and dying at an older age. The department's efforts over the past 100 years have dealt largely with infection control and sanitation, infant and maternal mortality, and attention to the qualify 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 now regularly extend into the 80's. None of these objectives can be achieved unless we maintain our commitment and efforts toward clean air, water and productive land.

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 improved health status 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 - 1983, just published, contains most of this information.

Attm #2
1-23-85

1. Problems Related to Decreasing Death Rates:

In 1900 only 4% of the population of the United 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

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 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 issues. As you can see the basis for this concern will not diminish. Our department has many interests and responsibilities 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, and healthy; 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 has studied the benefits and costs of having a licensed nurse on duty 24 hours a day for individuals living in adult care facilities. This year the Governor is supporting a requirement for licensed nurses 24 hours/day in adult care homes. We believe that this is extremely important to better assure quality care for the elderly and disabled in those homes. We will be taking additional steps to assure that complaint procedures are adequate and effective in dealing with problems in adult care facilities. Additional legislation will allow the department to assess fines more rapidly upon the discovery of infractions which jeopardize the health or safety of individuals in adult care facilities.

The department is studying ways to better use and modify the receivership statute so that the nursing home industry can be more helpful in that process. The administration of a receivership by the department takes valuable resources away from other regulatory activities. That committee has agreed to introduce legislation degisned to permit the courts to more easily assign the receivership responsibilities to entities other than the Secretary of Health and Environment.

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

I will address two, namely, the overall black mortality rate and the black infant mortality rate (see Figure 4). Blacks die when they are about 10 years younger than 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. In Wichita we began a program of high blood pressure detection and control to be run in the black community by the churches there. Next year, we can give you a report on the outcomes of this different approach.

The black infant mortality rate 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 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 identified 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. In Kansas City we are working directly with the Kansas Children's Service League Black Adoption Program in an attempt to influence the teenage pregnancy rate in that community. 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 premature death have changed. Infections and infant and maternal mortality have decreased; chronic disease and cancer are decreasing also, but violent deaths ("accidents") and suicide are increasing.

In the first example, Figure 7, auto vehicle deaths are equal to all other "accidental" deaths and victims are generally young males (Figure 8). Deaths are in great part alcohol related (Figure 9) and victims seldom use seat belts (Figure 10). 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 state programs relate to "accidents" and "accident" outcome. The Office of Emergency Medical Services is involved with the statewide system for the adequate treatment

of injuries after an "accident" occurred. Educational programs and legislation can increase the use of seat restraints which will reduce the risk of 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 on what are probably not "accidents" per se. 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 Governor shares the growing concern about the abuse of alcohol, especially by those who drink and drive. He has asked for enactment of tougher penalties for those who drive while impared by alcohol over use and for more resources for treatment. Yesterday we agreed to introduce a bill which would make it easier to penalize persons who do drink and drive. By making the certified blood alcohol report prima facie evidence of the facts of the report, court hearings on these matters can proceed expeditiously and defendants can not use the laboratorian's schedule conflicts resulting in nonappearance as a reason for dismissal of the case.

The second similar example is that of the relationship between lung cancer and smoking. Smoking is considered the number one public health hazard at this time. There is a clear causal relationship between smoking and lung cancer, chronic obstructive pulmonary disease, heart disease and other problems. 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. - about 3,000 of these are in Kansas), but the cost of health care associated with this morbidity and subsequent mortality is also extremely high. The nonsmoker is often not protected from the ambient pollution by those who do smoke. The annoyance and the risk to nonsmokers in terms of possibly cancer, allergies, chronic lung disease, eye, nose and throat irritation is significant. Our department strongly supports a policy of no smoking in the workplace and is working with other state agencies to provide workers with options for achieving no smoking in the workplace as well as other health promotion options.

For years there has been an active program for identification, control and treatment of tuberculosis. Over the years we have seen major changes in that program. Twenty years ago the tuberculosis hospitals were closed. The problem has continued to diminish. Last year there were only 76 active cases. For FY 1986, the Governor has recommended that the 3 local TB clinics be funded at one-half the previous amount. This will assure funds for those county health departments for the

remainder of their current fiscal year. In the meantime, this winter the U.S. Centers for Disease Control will conduct a study in Kansas and provide advice on TB control for our state.

4. Health Care Costs

The focus of responsibility for addressing health care costs has shifted from government to the private sector. The federal government initiated the effort through a prospective payment system for medicare providers. Kansas Blue Cross and Blue Shield has taken the lead, among its counterparts in the country, in implementing a prospective payment system for all its members. The direction of health care cost control clearly lies in changes in the health care market place. Government programs such as certificate of need are fast becoming obsolete in the face of the changing health care market.

Government needs to maintain and reaffirm its interest in assuring quality of services during this period of transition.

5. Rural Hospitals

Rural hospitals today are faced with a number of problems and issues that affect not only their financial viability and their very existence. The issues that are presently being addressed are the need to maintain high occupancy levels, the higher proportion of elderly and poor being served than urban hospitals, the difficulty of attracting and maintaining medical personnel, the limited ability they have in purchasing the equipment necessary to expand services necessary to attract physicians and changes in reimbursement for hospital services under Medicare (DRGs).

Regardless of these problems, rural hospitals do have options that would increase their chances for survival. Such options would include in-house long-range planning, marketing, diversification of services, corporate restructuring, innovative recruitment and staffing techniques, informal and formal multihospital arrangements.

The Department of Health and Environment is undergoing a medical facilities study to elucidate the issues and assist in planning for small rural hospitals.

6. General Programs

For the general health of Kansans, lifestyle factors are emerging, as major determinants for 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 for others. In FY 1985 the Governor established a Cabinet Sub-Committee on State Employees Health Promotion and Wellness to promote and implement the Kansas Employee Assistance and Health and Wellness Programs called "Health Promotion PLUS." Our department, along with SRS, is staffing that committee. The adoption of healthful lifestyles in the workplace will improve employee job satisfaction and performance and will reduce health care costs.

The Department of Health and Environment is taking an active role in the Cabinet Subcommittee on Preschool Handicapped Children as it plans for early identification, follow-along, development of services for infants and preschool children with high risk for handicapping conditions. To assist with this program the Governor has budgeted for the Crippled and Chronically Ill Children's Program to expand services to include seizures, severe visual impairments and cranio facial anomalies. We will be asking that legislation be introduced to require the screening at birth for phenylketonuria (PKU), congenital hypothyroidism and galactosemia to be done by the State Public Health Laboratory. This will ensure uniformity of testing measures, quality assurance and should improve the access of children with these problems to essential programs so that they are assured preventive therapy within the critical 30 days after birth.

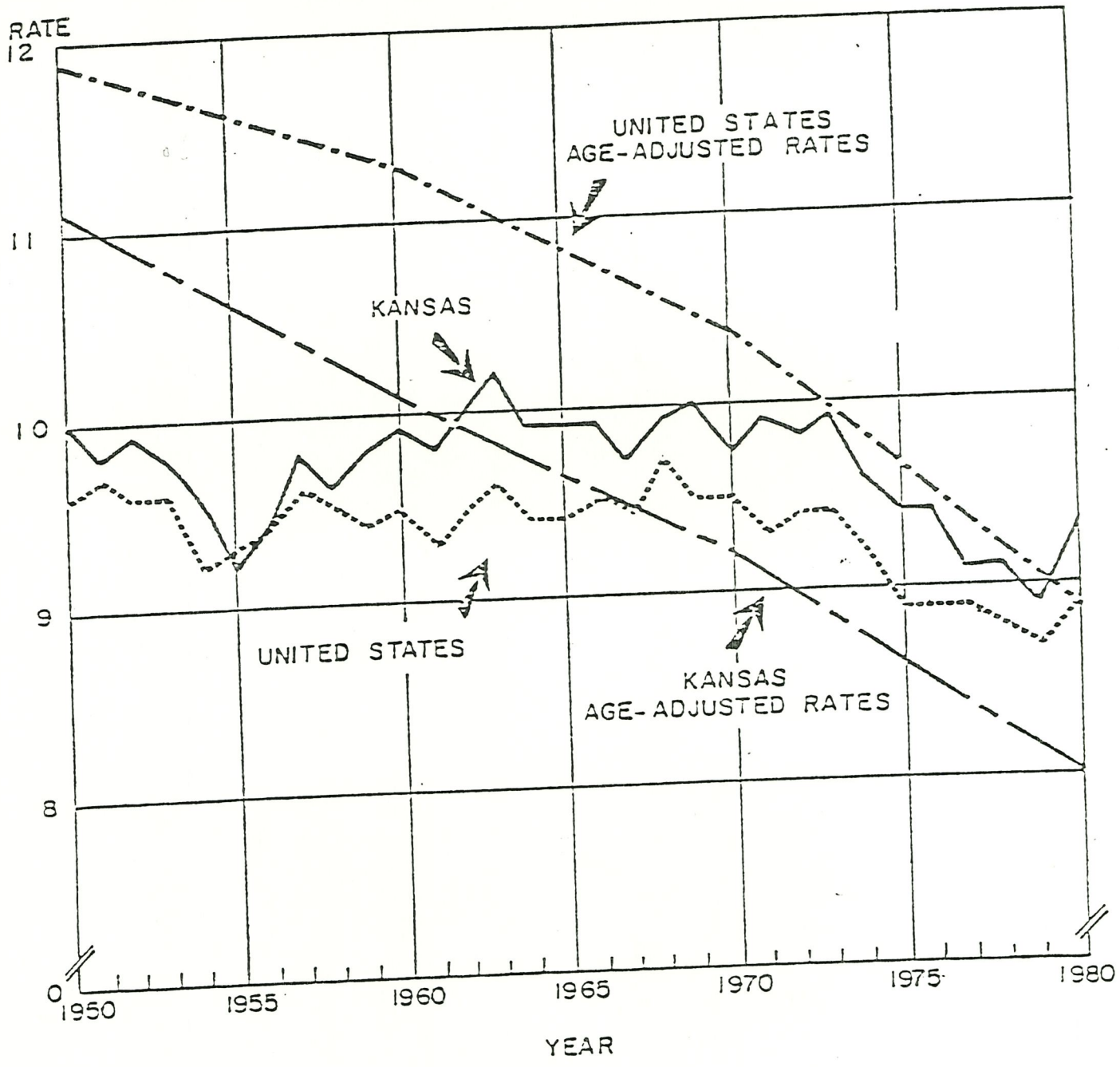
Because of the widespread use of asbestos and its potential hazard to public health, the Department of Health and Environment will take the lead working closely with the Departments of Human Resources and Education to deal with the problems and respond to school districts for inspections necessary to meet EPA requirements. In this fiscal year we are training two technicians on the identification of asbestos fibers and in 1986 the Governor has recommended 2 additional positions in Health and Environment to assist in the development of an effective Statewide Asbestos Control Program.

In Summary:

Health problems today are vastly different from those one hundred years ago 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.

Attm. #3
1-23-85

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

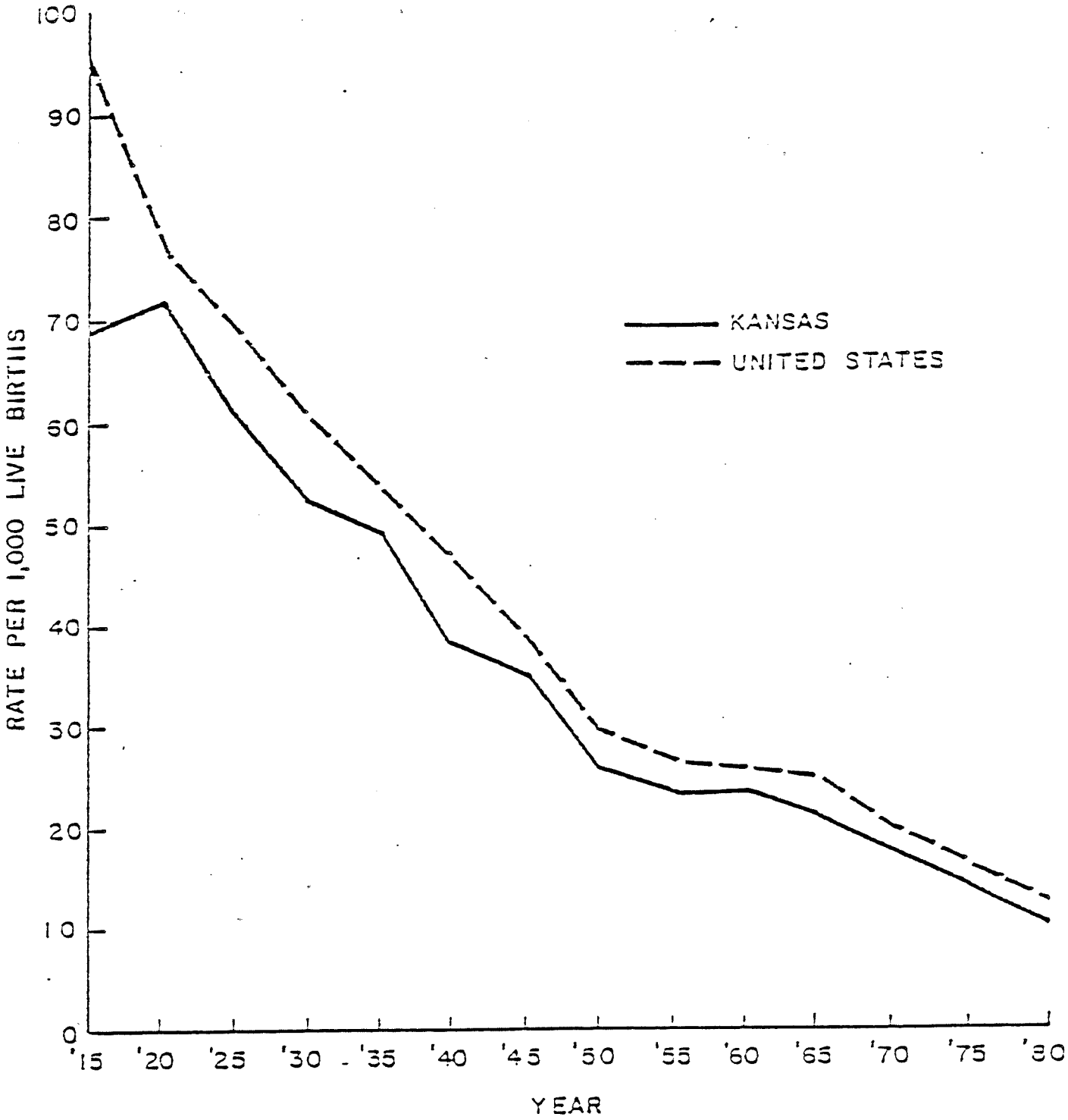


Residence data.
United States 1979 and 1980 rates are provisional.
The 1980 United States population was used as the standard for computing all age-adjusted death rates.

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

Attm. #3
1-23-85

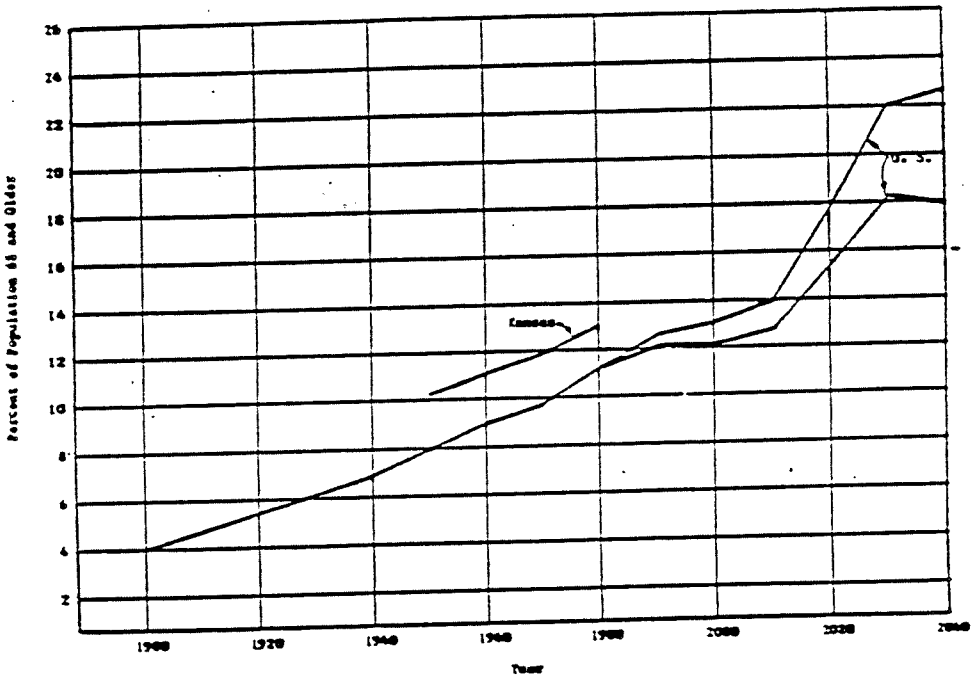
INFANT DEATH RATES
KANSAS AND THE UNITED STATES, 1915-1980



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

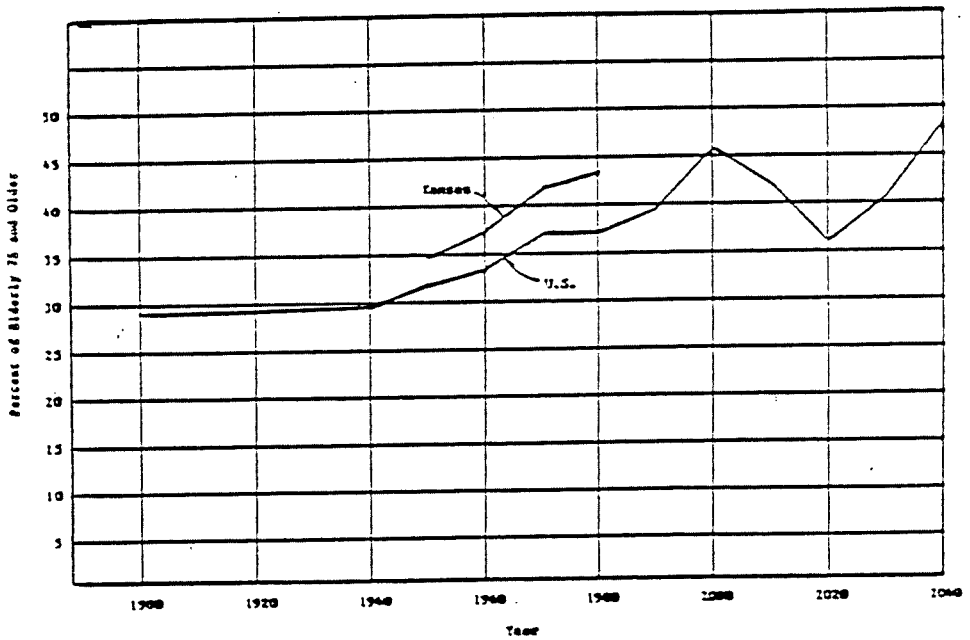
Population 65 and Older
Kansas and United States

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.

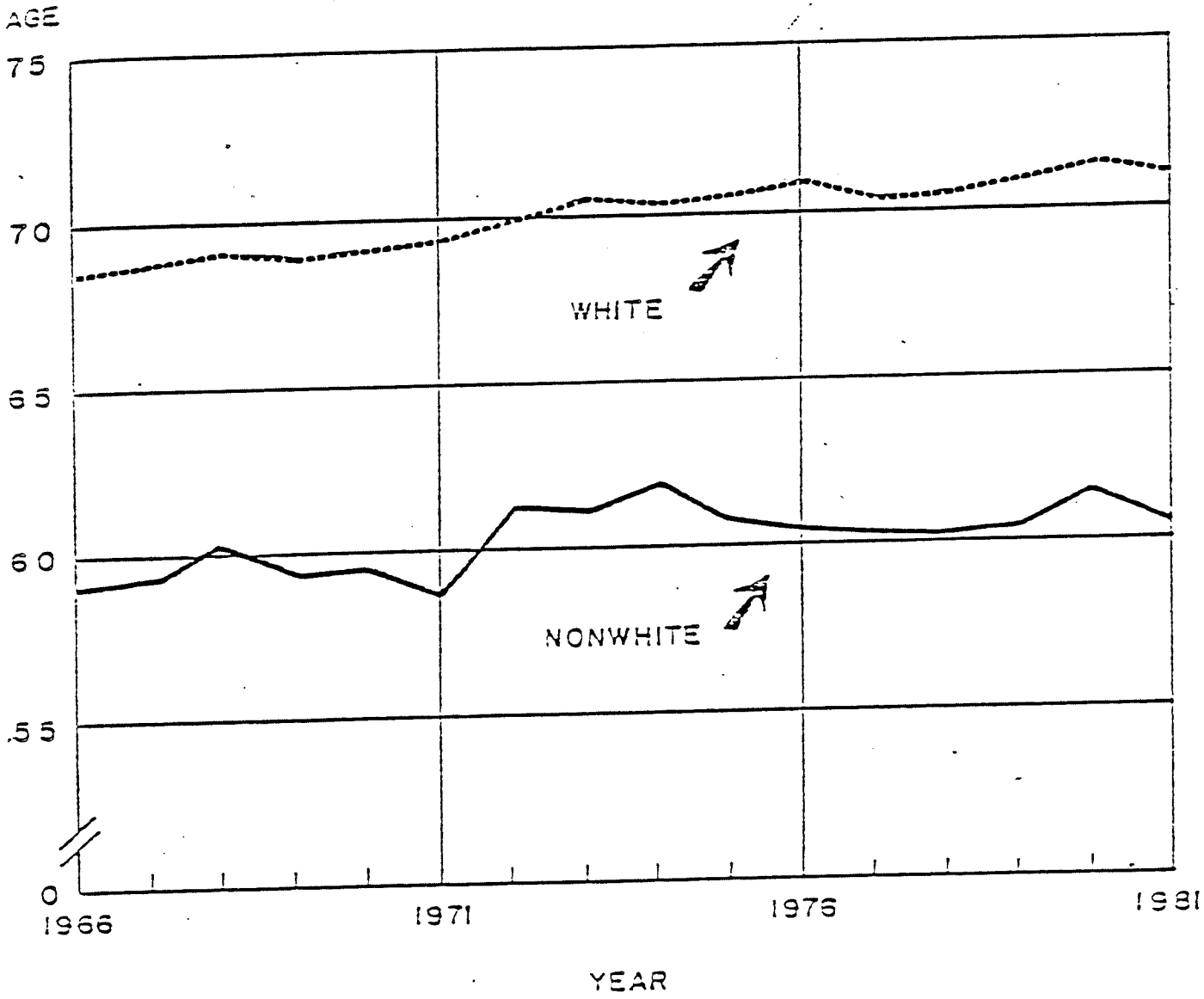
Population 75 and Older
Kansas and United States



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.

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

INFANT MORTALITY BY RACE

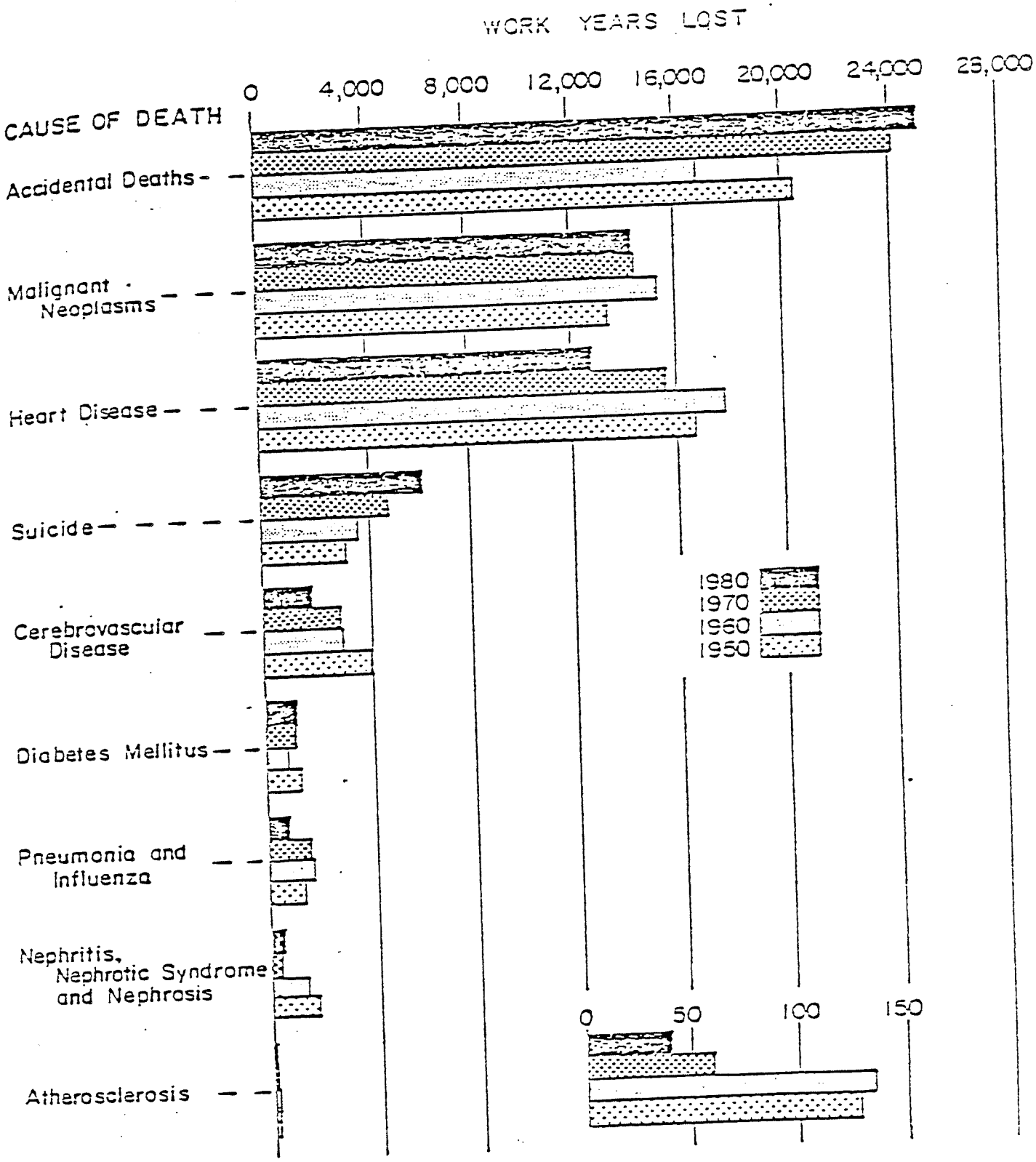
Ten Year Period

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
1983	16.8	9.6	10.1

FIGURE 6

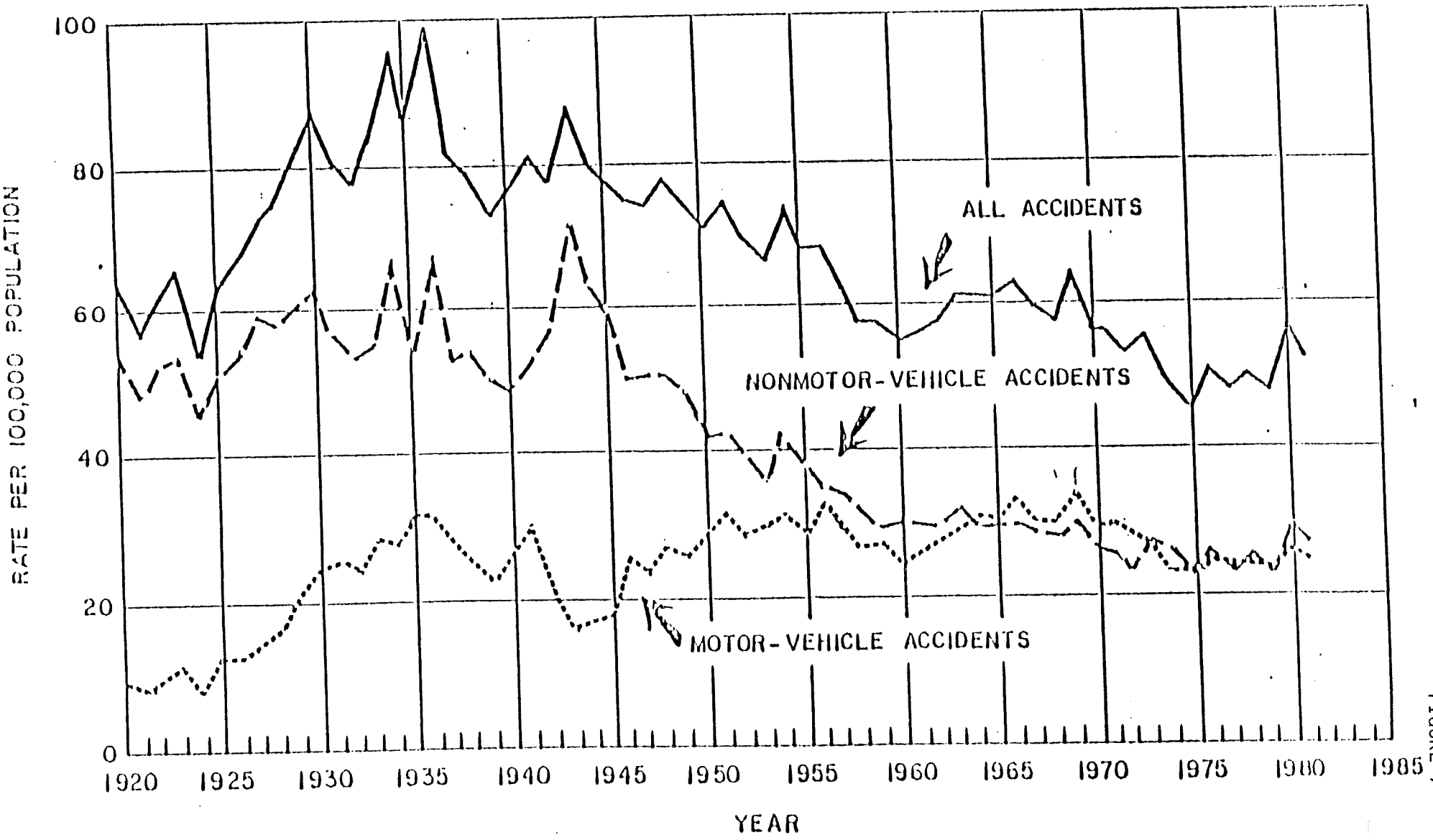
WORK YEARS LOST DUE TO THE LEADING CAUSES OF DEATH KANSAS, 1950, 1960, 1970, 1980



Residence data.

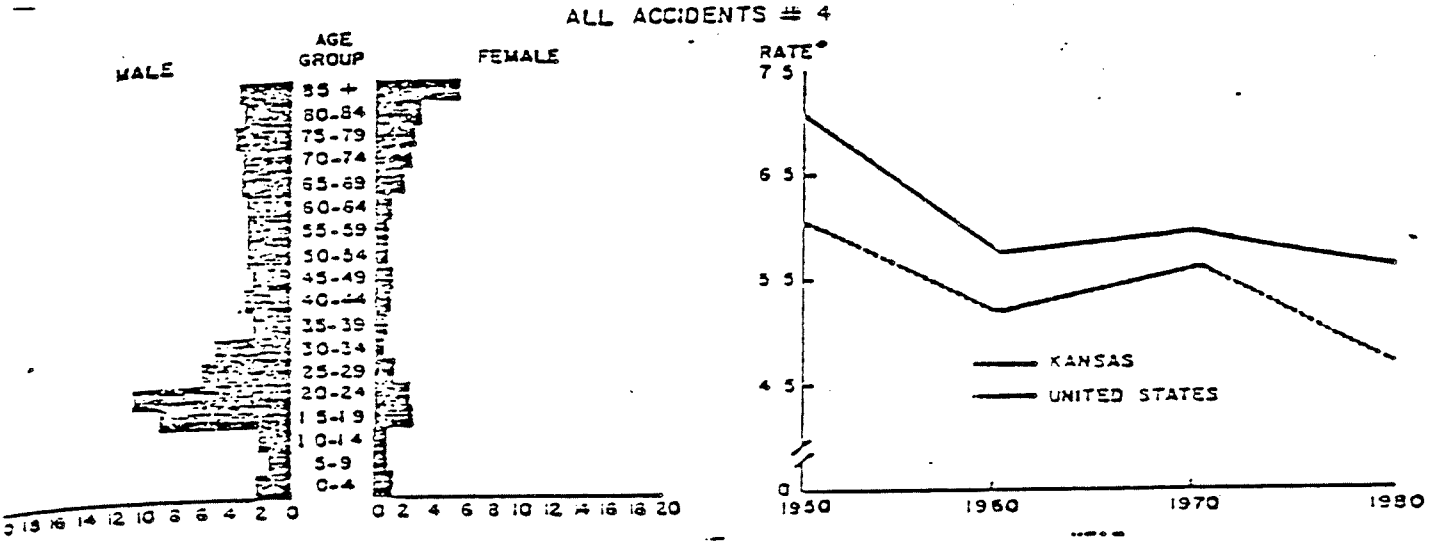
Source: Bureau of Registration and Health Statistics
Kansas Department of Health and Environment

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

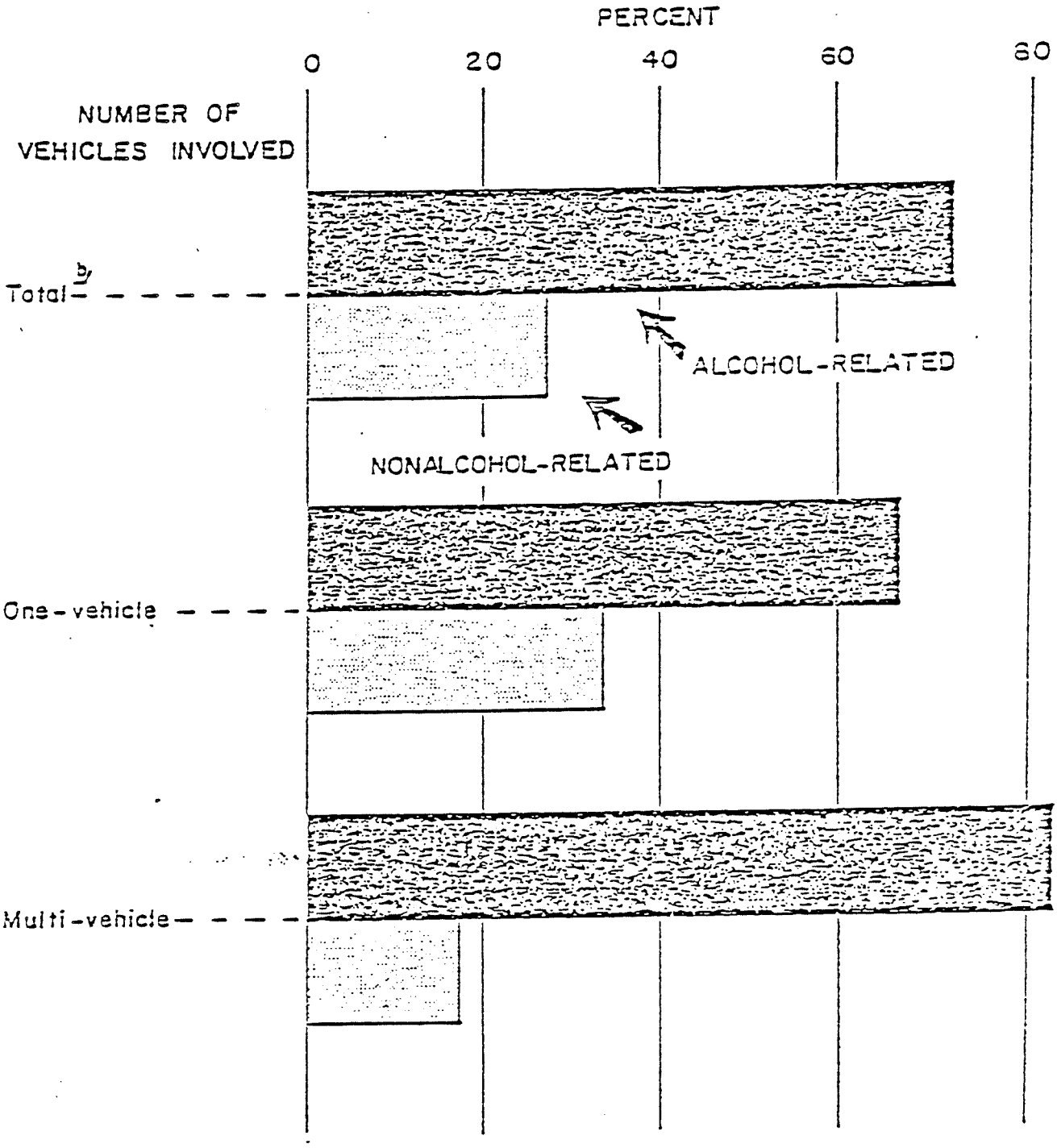


Source: Bureau of Registration and Health Statistics

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



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



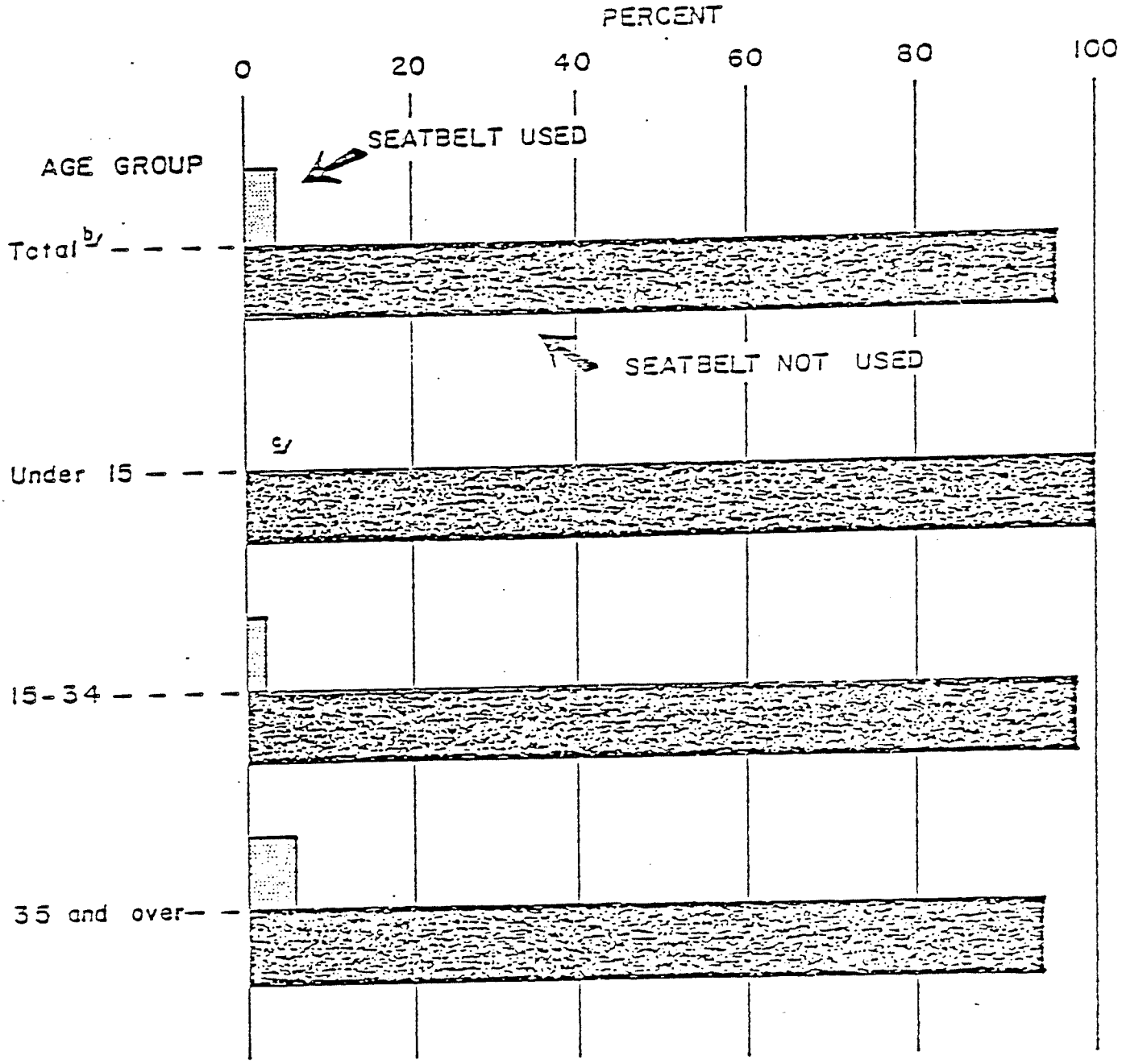
[a] Motor-vehicle accidents occurring in Kansas that 1) resulted in the death of a Kansas resident or 2) resulted in the death of a nonresident in Kansas.

[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

FIGURE 10

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



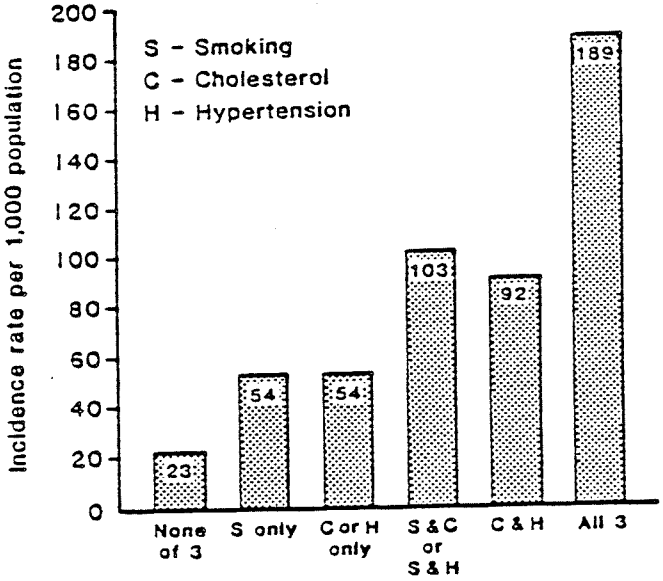
[a] Motor-vehicle accidents occurring in Kansas that 1) resulted in the death of a Kansas resident or 2) resulted in the death of a nonresident in Kansas.

[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

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.

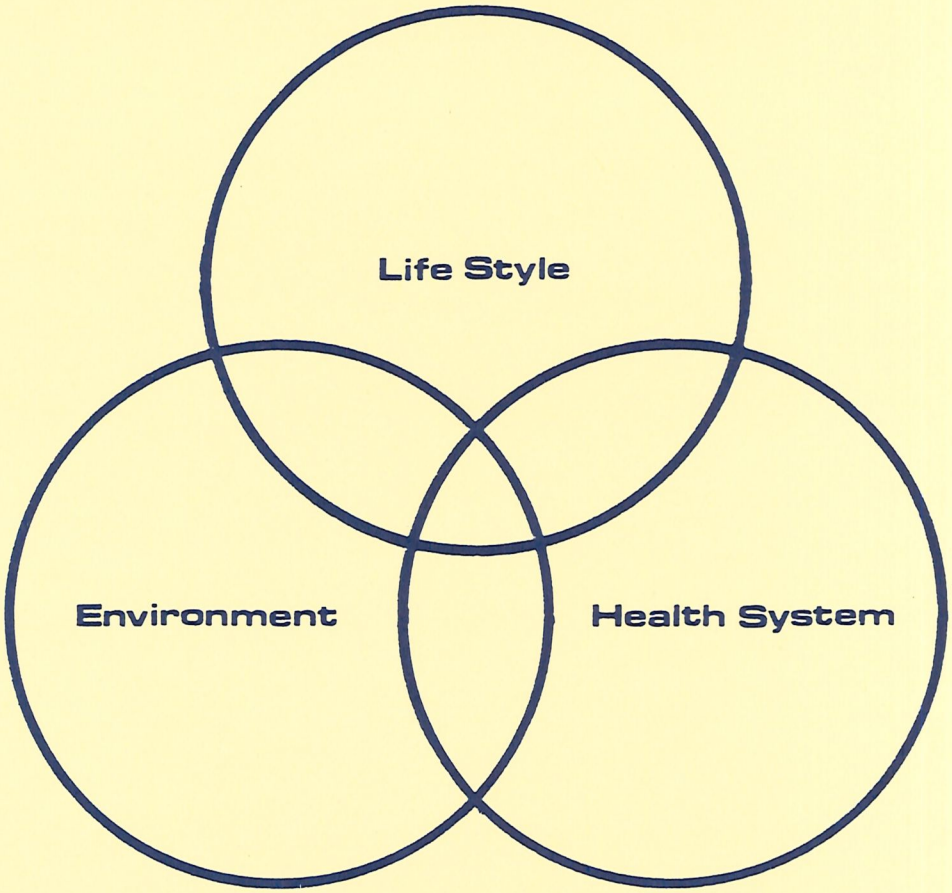
Source: National Pooling Project Study

atlm. #4
1-23-85

EXECUTIVE SUMMARY

The 1984 Plan for

The Health of Kansans



STATEWIDE HEALTH COORDINATING COUNCIL
AND
DEPARTMENT OF HEALTH AND ENVIRONMENT

atlm. #4
1-23-85

INTRODUCTION

The 1984 Plan for the Health of Kansans is part of an ongoing effort aimed at the development of a comprehensive health policy for Kansas. The State Health Plan is intended to be used as a guide for the Governor and the Kansas Legislature in health policy issues and in the development of state health programs. At the same time, the plan should be useful as a guide for private sector decisions concerning the development of health care resources. The State Health Plan is also used as the basis for reviewing applications for federal health funds and Certificates of Need for health facilities.

In this Executive Summary of the 1984 Plan for the Health of Kansans, policy issues and recommendations developed by the Statewide Health Coordinating Council in the following major health areas are highlighted:

HEALTH CARE COSTS
- Introduction
- Diagnostic Related Groups
- Health Maintenance Organizations
- Health Insurance Issues
- The Medicaid Program
- Wellness Promotion/Disease Prevention
- Accidental Injuries and Deaths
- Physicians and Health Care Costs
- Ambulatory Surgery

LONG-TERM CARE
ENVIRONMENTAL/HEALTH DATA
AVAILABILITY OF PRIMARY CARE
NURSING RESOURCES
ACUTE CARE HOSPITALS
MATERNAL AND INFANT CARE
COMPUTED TOMOGRAPHIC SCANNERS
MENTAL HEALTH SERVICES
SUBSTANCE ABUSE SERVICES

The Executive Summary is offered as a prelude to the State Health Plan, not as a replacement. It is designed to acquaint the reader with the general topic areas covered in the State Health Plan. The concluding section of the Executive Summary also highlights other activities in which the Statewide Health Coordinating Council and the Office of Health and Environmental Planning have been involved. These include studies of health care expenditures and medically underserved areas. The individual who seeks in-depth information on a particular topic is encouraged to request further information from:

Office of Health and Environmental Planning
Department of Health and Environment
6700 South Topeka Avenue - Building 321
Topeka, Kansas
(913) 862-9360, ext. 535

HEALTH CARE COSTS

Introduction

The cost of medical care in the United States has nearly doubled every five years since 1955. The average growth rate of the Gross National Product has been exceeded by the rate increase of health care expenditures by several percentage points for many years. In 1982, the GNP rose by 4.1 percent while health care costs increased by 12.5 percent. The cost of medical care is rising at a greater rate than that of any other major American goods or service. A total of $322.4 billion were spent on health care in the United States in 1982.

In Kansas, expenditures for health care services and supplies have increased every year from 1974 to 1982, with annual jumps of approximately $200 million. Health expenditures in the state in 1982 totaled $2,857 million, an increase of 12 percent over 1981's total expenditures. The health expenditure share of the 1982 Gross State Product was 9.0 percent, a significant increase over 1981's 8.5 percent share.

National personal health expenditures have consumed a greater share of personal income, increasing from 9.2 percent in 1975 to 11.1 percent in 1982. While the portion consumed has been less in Kansas, the trends are parallel. Kansas personal health expenditures were 8.3 percent of personal income in 1975, and increased to 9.5 percent in 1982. These trends provide some measure of the burden of health care spending on individuals.

In recognition of the growing concerns about the cost of health care, the Statewide Health Coordinating Council dedicated 1983 to a study of cost related issues. Analysis of eight specific topics resulted in the generation of numerous recommendations for health care cost containment through reimbursement issues and alternative services issues. These eight topics are now presented.

Diagnostic Related Groups

Effective October 1, 1983, Medicare, the federal health insurance program for the elderly and disabled, no longer reimburses hospitals for inpatient services under the traditional retrospective cost-based system. Development of a prospective payment proposal was called for in the Tax Equity and Fiscal Responsibility Act of 1982. The system required the establishment of prices in advance (i.e., prospectively) on a cost-per-case basis, using 467 categories of patient classification called diagnostic related groups (DRGs).

Rates were established for nine census divisions as well as for rural and urban areas within each division for every DRG. The program will be phased in over a four year period and will be fully implemented in Fiscal Year 1987.

Many questions are raised by the implementation of such a massive system change. The questions will likely not be answered until well into the operation of the prospective payment system, but nonetheless they are

repeatedly asked: What will be the system's impact on patient care?; How will the system affect hospitals?; Will the DRG payment rates be sufficient for rural hospitals?; and, most basic, How will the system work?

In addition to the federal Medicare program, Blue Cross and Blue Shield of Kansas is also basing their inpatient reimbursement system on DRGs. The Competitive Allowance Program (CAP) became effective January 1, 1984. All 137 acute-care hospitals in the state elected to participate in the program and agreed to accept the DRG rates as payment-in-full.

The Statewide Health Coordinating Council recommends that two actions be taken to restrain unnecessary increases in expenditures for health care services: 1) encourage prospective payments for all services; and 2) reduce unnecessary utilization.

1. Encourage prospective payments for all services. The performance of prospectively established health care payment systems and existing cost-containment programs must be monitored. The impact of diagnostic related group-based payment systems and preferred provider organizations on the availability, accessibility and quality of health care services is a primary concern, and must be monitored. Kansas State government should encourage prospective payments for health care services.

2. Reduce unnecessary utilization. The general concepts of utilization management contained in Medicare's and Kansas Blue Cross/Blue Shield's DRG systems should be extended to all health care services.

Health Maintenance Organizations

Health maintenance organizations (HMOs), are an example of alternative delivery systems designed to provide high-quality, comprehensive care at competitive prices. Insurance and financial functions are combined with the provision of health care in HMOs; the programs compete with traditional insurance plans and fee-for-service providers for their clientele.

In return for their members' prospective payments, HMOs provide a range of health maintenance and treatment services, either directly or by referral. The prepayment method creates incentives to provide efficient, high-quality and less costly care.

In 1983, there were 280 HMOs in the country, with a total enrollment of 11.6 million persons. As of April, 1984, there were six HMOs in Kansas serving persons in over ten counties.

The Statewide Health Coordinating Council recommends that actions be taken to contain increases in health care expenditures through the provision of appropriate and high-quality health services by the most cost-effective method possible. Policy recommendations are offered in two areas: 1) implement programs to reduce demand and utilization of services; and 2) encourage expansion of HMO services to targeted populations.

1. Implement programs to reduce demand and utilization of services. The development of prepaid alternative delivery systems should be evaluated and encouraged as appropriate.

2. Encourage expansion of HMO services to targeted populations. Health maintenance organization services should be expanded to Medicare and Medicaid beneficiaries. Kansas planning agencies should evaluate demonstration social/health maintenance organizations which are being developed in other areas of the country.

Health Insurance Issues

America's health insurance system has been identified as the "most popular culprit for the health care cost problem." The large third party payment system has insulated consumers from the true cost of health care; the result has been excessive utilization of health resources.

Because of the significant role played by insurance in the increasingly high cost of health care, federal and state governments, as well as private insurers, are analyzing more cost-effective delivery methods and various methods of restraining the use of services, while at the same time attempting to increase consumers' awareness of the issues. Some of these methods include cost-sharing, and cost containment efforts of Blue Cross and Blue Shield plans.

The Statewide Health Coordinating Council recommends that three actions be taken to restrain excessive increases in expenditures for health care services through insurance related methods: 1) implement programs to reduce demand for services; 2) increase public awareness of health care costs and cost containment; and 3) promote catastrophic medical coverage for all persons.

1. Implement programs to reduce demand for services. Health insurance carriers should offer comprehensive coverage including coverage for outpatient services as alternatives to inpatient care, deductibles, and copayment provisions; first-dollar coverage should be available as a separately priced benefit. Subrogation of insurance benefits should be studied to determine if it could reduce health care costs.

2. Increase public awareness of health care costs and cost containment. Education programs on group health insurance and health care costs for major purchasers and statewide business groups should be continued. The Kansas Insurancet Commissioner should develop and implement an education program for major purchasers to inform them about health cost issues related to group health plans. The program should also be used to promote cost consciousness with statewide business groups and consumer coalitions.

3. Promote catastrophic medical coverage for all persons. A study of catastrophic medical coverage, including long-term care and rehabilitation services, should be completed and such coverage should be promoted. The extent and specific causes of possible barriers to health care in Kansas should be determined.

The Medicaid Program

On July 30, 1965, Congress enacted Title XIX of the Social Security Act which established the Medicaid Program. The program was designed to provide medical assistance to certain low-income individuals and families whose resources and incomes were not adequate to pay for health care.

In 1968, Medicaid expenditures were $3.5 billion; for Fiscal Year 1983, state and Federal Medicaid payments were expected to total $37 billion. Medicaid has been called the "sleeper" of the Social Security Amendments; the program has grown at an unbelievable rate.

Two recent pieces of legislation have led to many changes in the Medicaid Program: The Omnibus Budget Reconciliation Act (OBRA) of 1981, and the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. The laws allowed the states more flexibility in program management which has led to some major reforms in their Medicaid programs. In Kansas, the Home and Community Based Services Program waiver, begun in 1982, and the Primary Care Network waiver, begun in 1984, were both implemented as a result of TEFRA.

The Statewide Health Coordinating Council recommends that actions be taken to provide cost-effective and quality services and care to the state's Medicaid population. Recommendations are offered to: 1) promote appropriate and cost-effective services; and 2) expand the Primary Care Network pilot project.

1. Promote appropriate services. All Kansas counties should have home health and other community-based noninstitutional services. The Kansas Legislature, as well as local government agencies and public/private agencies, should continue to make allocations for projects which promote primary and long-term care service coordination for all elderly regardless of income.

2. Expand the Primary Care Network pilot project. The Department of Social and Rehabilitation Services, the Department of Health and Environment, and the Department on Aging, in addition to providers and consumers participating in the Primary Care Network, should be involved in evaluating the program. The PCN should be monitored to determine if the program is effective in reducing utilization of and costs for health care, and to determine that continuity and quality of care are being maintained.

Wellness Promotion/Disease Prevention

Since the turn of the century, a remarkable change has occurred in the population's health status. There has been a steady decline in morbidity and mortality rates for a number of acute and infectious diseases such as rheumatic fever, meningitis, small pox, diphtheria, tetanus, poliomyelitis, and tuberculosis.

Conversely, there has been a steady increase in morbidity and mortality rates for chronic disorders such as cardiovascular disease, cancer, cerebrovascular disease, diabetes mellitus, and liver diseases. Evidence now indicates that

at least half of all chronic disease deaths are closely linked to life-style choices.

The Statewide Health Coordinating Council recommends that the population's health status be improved through modified life-styles and that a lower demand for costly health services be achieved by increasing the availability and accessibility of health promotion and disease prevention programs. Policy recommendations are offered in two areas: 1) develop a comprehensive approach for primary prevention programs; and 2) develop a comprehensive approach for risk-reduction programs.

1. Develop a comprehensive approach for primary prevention programs. Activities to increase public awareness of chronic ill health problems and causal factors should be engaged in. Kansas colleges and universities that train grade K-12 teachers should develop the curricula necessary to support the development and implementation of complete health promotion and education activities in the school system. Substance abuse prevention should be established as one of the highest priorities of school age prevention programs, and existing state agency efforts in this area should be coordinated under a single, unified system easily accessed by the general public as well as organized education/other institutions and agencies.

2. Develop a comprehensive approach for risk-reduction programs. The Department of Health and Environment's PLUS Program concept should be expanded by augmenting existing staff efforts with the Department's community health consultants; additionally, consideration should be given to program expansion to reach school age children and youth. The Department of Health and Environment should continue to work with public health departments and employers to promote the Project VOTE concept. The Kansas Legislature should consider mandating nonsmoking areas in all public places, in child day care facilities, in health facilities, in public conveyances, and in schools and work places of 20 or more employees. Kansas communities should assume responsibility for promoting health education and screening through programs such as Kansas Health Fairs. Technical assistance should be available from the Department of Health and Environment and local health departments.

Accidental Injuries and Deaths

The American Medical Association has called accidental injuries and deaths the neglected diseases of modern society. Currently, accidents are the fourth leading cause of death both in Kansas and the United States; further, accidents are the leading cause of death for persons age one to 44.

National data indicate that 25 to 30 percent of the population are accidentally injured each year; this yields one accident every three seconds. In Kansas during 1981, 1,243 people died as a result of accidents. This yielded a ratio of 52 accidental deaths per 100,000 population; the 1981 United States ratio was substantially lower at 43.7 per 100,000. In general, accidental

death rates for Kansas have exceeded the national rate since the 1930's, when both reached their peak.

To an extent, accidental injuries and deaths will always be a problem for society. However, many accidents are preventable and thus unnecessary injuries and premature deaths could be avoided. The savings to the health care system would be realized in both financial and emotional terms.

The Statewide Health Coordinating Council recommends actions to reduce health care expenditures and prevent unnecessary suffering by decreasing the incidence of accidental injuries and deaths in Kansas. Policy recommendations are offered in two areas: 1) by 1990, the motor vehicle accidental death rate should not exceed 18 deaths per 100,000 population; and 2) modify the health care system to better meet the needs of severely traumatized accident victims, particularly those with head or spinal cord injuries.

1. By 1990, the motor vehicle accidental death rate should not exceed 18 deaths per 100,000 population. The Kansas legislature should give serious consideration to increasing the severity of drunk driving penalties. Items which should be debated include: dram shop liability; limitations on alcohol consumed for a set price; felony convictions for vehicular homicide; and evaluations of effectiveness and consistency of diversion programs. The Department of Health and Environment should work with the Kansas Highway Patrol, Department of Transportation, and other concerned groups to continue media campaigns on the value of using seat belts and infant car seats. The Department of Health and Environment should work with the Commissioner of Insurance to study insurance practices which would enhance motor vehicle safety.

2. Modify the health care system to better meet the needs of severely traumatized accident victims, particularly those with head or spinal cord injuries. The Department of Health and Environment should study the needs of persons handicapped by spinal cord or head injuries and develop appropriate plans. The Emergency Medical Services Council of the Department of Health and Environment should be encouraged to complete their statewide communication system.

Physicians and Health Care Costs

In 1981, Kansans spent $469 million for physician services; this resulted in a per capita expenditure of $197. Nationally, $54.8 billion were spent for physician services, for a per capita expenditure of $234. Both in Kansas and the United States, physician services represent the second largest category of total personal health expenditures (exceeded only by hospital services) and have consistently consumed approximately 20 percent of all personal health care expenditures.

Whereas large scale forces such as general inflation and population growth influence the economic behavior of the health care system, the physician has the authority to make direct and indirect decisions about the use of the

majority of health care resources. Studies indicate that between 70 and 90 percent of all health care expenditures are initiated or controlled by physicians. Given the societal mandate to gain control of spiraling health care costs, physicians are finding themselves in the center of the financial challenge.

The Statewide Health Coordinating Council recommends that physician services in Kansas should be adequate to meet the population's need for quality, cost-effective care. Policy recommendations are offered in three areas: 1) strengthen the state's medical education system's efforts to address physician knowledge; 2) maintain medical reviews of service utilization to assure that appropriate care is provided; and 3) by 1990, increase the supply of primary care physicians to 73 per 100,000 population, and the supply of total physicians to 151.7 per 100,000 population.

1. Strengthen the state's medical education system's efforts to address physician knowledge. The University of Kansas School of Medicine should continue to work with the Long-Term Care Gerontology Center to provide medical students with geriatric education. The University of Kansas School of Medicine should develop and mandate education curricula for medical students which emphasizes medical economics and health care cost containment. The University of Kansas School of Medicine, the Kansas Medical Society, and the Kansas Osteopathic Association should increase efforts in primary care education. The Kansas Hospital Association, Kansas Medical Society, and professional laboratory/medical technologist organizations should work together to assist in redesigning hospital laboratory test order forms to stress problem-oriented utilization.

2. Maintain medical reviews of service utilization to assure that appropriate care is provided. All health insurers (private insurers, the Kansas Medicare intermediary, and the Kansas Medicaid program), should develop and/or maintain review procedures related to the utilization of ancillary services.

3. By 1990, increase the supply of primary care physicians to 73 per 100,000 population, and the supply of total physicians to 151.7 per 100,000 population. Physician practice in rural areas should be enhanced through maintenance of three area health education centers. The Kansas Medical Scholarship Program should make the majority of funds available to students who plan to enter primary care practice in underserved, rural areas of Kansas.

Ambulatory Surgery

The health care delivery system challenge of the 1980's is to provide high quality care in the most cost effective setting possible. To this end, attention is increasingly focused on various forms of ambulatory care as alternatives to inpatient hospital care. Ambulatory care, broadly defined, includes primary care, hospital outpatient care, ambulatory and neighborhood health clinics, emergency room services, and ambulatory surgery. Although

each type of ambulatory care has been studied during the last decade, ambulatory surgery proposals have perhaps generated the most interest.

It is widely recognized by the medical community today that a large percentage of surgical cases do not require hospitalization. Thus, ambulatory surgery is hailed as a viable cost containment proposal. However, to be of value, plans for expansion of any ambulatory service must be viewed as an integrated part of the health care system. Concerns also exist because of the potential for service duplication.

The Statewide Health Coordinating Council recommends that ambulatory surgery programs in a variety of settings be promoted to prevent expenditures related to unnecessary inpatient surgery and hospitalization. Policy recommendations are offered under the following objective: The development of new or expansion of any existing ambulatory surgical capacity, regardless of setting, should be covered by the Kansas Certificate of Need program.

Certificate of Need applications for the addition of any new surgical capacity regardless of setting in a service area should take into consideration: a) quality of existing and proposed services; b) utilization of all surgical capacity in the service area; c) a service area population of at least 75,000 people within 30 minutes traveltime; and d) short-term and long-term health care service availability and cost impacts of proposed projects. Ambulatory surgical capacity should be monitored on a yearly basis and the status of the program and its impact on inpatient surgery services should be evaluated.

LONG-TERM CARE

Long-term care refers to any professional or personal service required on a recurring or continuous basis by an individual because of chronic or permanent physical and/or mental impairments. Three population groups may generate substantial long-term care needs: the 65 and older population, which has grown from four percent of the population in 1900 to almost 13 percent in Kansas in 1980; the developmentally disabled; and the chronically mentally ill. The ultimate goal of the long-term care system is to promote optimal physical, social, and psychological functioning by assisting individuals to cope with disabilities and live as independently and normally as possible.

A variety or "continuum" of long-term care services are needed if the goal is to be realized. Services in the long-term care continuum should be available in a variety of settings (home, community agency, institution, and other), and may be delivered by a number of providers ranging from family and friends to paid professionals. An analysis of the long-term care continuum in Kansas indicates that three major problems exist.

- There are service gaps in the continuum. With the exception of intermediate nursing home care, few long-term care services are widely available across the state. A core set of services has been identified and described as being essential in the provision

of continuum services. The core services include: income programs, home health, homemaker services, meal programs, day care, transportation services, nursing home care, hospital care, alternative housing, and case management/service coordination mechanisms.

- Reimbursement for long-term care services has been biased in favor of medical/institutional care. Because competition for resources is increasing, service needs were examined by the urban/rural geography of Kansas to shift planning emphasis away from the medical bias toward a more comprehensive approach.

- Over 50 types of services are part of the long-term care continuum. Given the almost confusing array of services, a coordinating mechanism is needed to enhance access to services. Several elements of case management are described, including: client identification, evaluation, care plan development, and plan implementation.

The Statewide Health Coordinating Council proposes that actions be taken in three areas to assure the provision of a long-term care continuum in Kansas: 1) eliminate service gaps, 2) promote continuum quality, and 3) special population needs.

1. Eliminate Service Gaps. Kansas communities must assume responsibility for developing plans concerning their ability to provide formal and informal services. The Kansas Legislature, as well as local government agencies and public/private agencies, should help finance the development of core services in unserved areas, and should sponsor innovative projects which promote service coordination. State government agencies involved with long-term care should work together to develop statewide program implementation plans. Finally, the moratorium on nursing home construction or expansion should be continued to prevent undue emphasis on institutional resources.

2. Promote Continuum Quality. Increased knowledge and understanding offer the greatest potential for ensuring that the long-term care system functions in a high-quality manner. All health providers should have greater exposure to geriatric care concepts during training and through continuing education courses. Public information programs should also be directed at the general population.

3. Special Population Needs. Developmentally disabled and chronically mentally ill adults in need of general supervision should have access to facilities designed to meet their needs and should not be placed in facilities designed for the frail and ill elderly.

ENVIRONMENTAL/HEALTH DATA

In Kansas, and in the nation as a whole, citizens are becoming increasingly aware of the association between environmental contaminants and adverse health effects. Every year, Congress hears an increasing outcry for stricter

enforcement of air and water quality controls. There are now thousands of citizen claims being filed for compensation for health problems due to exposure to Agent Orange, diethlystilbesterol (DES), asbestos, formaldehyde, and other substances. A number of environmental health issues in Kansas have become increasingly evident in recent years.

- There are several areas around the state where surface water and/or groundwater supplies are contaminated with heavy metals, hazardous wastes, or salt. Approximately 80 percent of all Kansans rely on groundwater as their major source of water for all purposes; this is the highest population percentage in the nation. In some water-contaminated areas, high rates of tuberculosis, infant mortality, and lung cancer have been noted.

- As a state highly dependent on agriculture, pesticide usage is common. Although the health effects of the over 32,000 pesticide products are basically unknown, it is known that pesticides remain in the environment for many years and their impact may be latent and synergistic. In 1981, the Kansas Fish and Game Commission reported that eight fish kills (over 25,000 fish) were attributable to pesticides.

- Chronic occupational disease is becoming a major health problem in industrialized society. There are over 60,000 synthetic chemicals in production today, and each year 500 to 1,000 additional substances are produced. Absolute knowledge of their effects is often minimal because research cannot keep pace with the rapid introduction of chemicals into industrial settings and ultimately the environment. It is known, however, that certain occupations do have higher than normal cancer rates and pregnant women employed by specific industries are more at-risk than other population groups.

The Statewide Health Coordinating Council recommends that Kansas expand and improve its capacity to respond to environmental health conditions and to research the impact of environment on public health. Policy recommendations are offered in three areas: 1) toxics management data system, 2) toxicology, and 3) environmental health training.

1. Toxics Management Data System. To establish the data base needed, the Department of Health and Environment should help establish a statewide registry of toxic substances and a pesticide monitoring system, both of which should be integrated with health-related information. The system should ultimately serve as a source for evaluating existing and potential environmental health conditions, and provide awareness and protection for Kansans.

2. Toxicology. The Toxicology Unit of the Department of Health and Environment should work with other state agencies, state universities, federal agencies, and local health departments to identify and respond to environmental health conditions in the state.

3. Environmental Health Training. Health care practitioners, students, and any other professionals involved with human or animal life should be trained in identifying health problems due to environmental exposure. The cooperation of local health departments in this endeavor is encouraged.

AVAILABILITY OF PRIMARY CARE

Primary care is an essential set of health services, providing early detection and treatment for a majority of the health problems of the population. In recent years, Congress has identified the provision of primary care services, especially in medically underserved rural and economically depressed areas, as a priority issue to be addressed. One important element in the provision of primary care services is the availability of physician manpower (doctors of medicine and osteopathy).

- The supply of full-time primary care physicians in Kansas has increased by 13 percent in just four years; from 50.8 per 100,000 population in 1978 to 57.4 per 100,000 in 1982. By 1990, if present trends continue, Kansas will show an overall surplus of physicians and a deficit of full-time primary care physicians of just 2.4 per 100,000, or 3.3 percent. As supply rapidly improves, geographic maldistribution can be expected to remain the major issue regarding availability of primary care in Kansas.

- Over one-third of Kansas' counties fall below 36 full-time physicians per 100,000 population, a ratio just one-half the optimal rato of 73 per 100,000. Moreover, 28 counties are below 33.3 per 100,000 (one physician per 3,000 people), a threshold indicating severe need for primary care physicians.

The Statewide Health Coordinating Council has set a target of 73 full-time primary care physicians per 100,000 population by 1990. In 1982, there were 57.4 primary care physicians per 100,000 population. To achieve this objective, three areas for action are identified: 1) physician recruitment, placement, and retention; 2) rural professional enhancement; and 3) physician residency guides. In developing its recommendations, the Council recognizes the role performed by physician assistants and nurse practitioners in providing primary care, especially in underserved areas.

1. Physician Recruitment, Placement, and Retention. The University of Kansas College of Health Sciences, Department of Health and Environment, and Department of Economic Development have worked cooperatively for several years to provide technical assistance to local community and professional organizations seeking to recruit physicians. Since the program's inception in 1978, over 100 physicians have been recruited and placed in more than 75 Kansas communities. This program should be maintained and strengthened.

The Kansas Medical Scholarship program, the similar Board of Regents Scholarship Program, and the Medi-Serve Program now have the capability to add 75 to 100 physicians per year to underserved areas in Kansas over the next seven years. Approximately 30 such physicians now are practicing in Kansas.

2. Rural Professional Enhancement. The University of Kansas College of Health Sciences has worked with the communities of Hays, Chanute, and Garden City to establish area health education centers to provide professional support for rural health care providers. This decentralized approach to health science education should be maintained as it provides needed professional linkages for recruitment of new providers and supports efforts to geographically integrate and coordinate services.

3. Physician Residency Guides. To prevent an increasing oversupply of secondary and tertiary care specialists, demonstrated need for these practitioners should be used as a guide for the number of residency opportunities.

NURSING RESOURCES

Registered nurses and licensed practical nurses play major roles in the health care system, as half of all health care personnel provide nursing-related services. Both nationally and in Kansas, many health worksites have a difficult time recruiting and retaining qualified nursing personnel. In extreme cases, health facilities have closed portions of existing facilities and/or delayed opening new facilities. The health consumer/patient may be adversely affected if timely and emotionally supportive care are delayed due to personnel shortages, and to the extent that facility charges are increased to cover nurse recruitment costs. There appear to be several reasons for the difficulties in recruiting and retaining nurses.

- A growing body of nurses are vocalizing dissatisfaction with their careers. Issues cited include: misuse of professional time by physicians and health facility administrators who do not understand the assessment, treatment, and patient education roles nurses are trained to assume; hours of work which are incompatible with social and family life; salaries which are below many nonprofessional occupations; overwork due to staff shortages and increasing paper work requirements; lack of career mobility; and "burn-out" due to physical and mental stresses of the job.

- The supply of full-time equivalent, active nurses fell short of meeting the health care needs of Kansans by over 2,880 registered nurses and 820 practical nurses in 1981. By 1985, the statewide shortage only will decline slightly. Hospitals and nursing homes experience the most acute shortages; this is a result of the increased utilization of hospital care, greater emphasis on outpatient care, a growing population age 65 and older, and the institutional 24-hour per day responsibility in these worksites. The supply of nursing personnel in rural areas is also short.

Despite claims that nurses are leaving their profession in great numbers, this does not appear to be occurring in Kansas. Almost 80 percent of the licensed registered nurses in Kansas are actively employed, as compared with 77 percent nationwide. Further, the activity status for nurses exceeds the work status for most allied health professions and for college educated women. The Statewide Health Coordinating Council recommends that actions be taken in three areas to ensure that the Kansas population's need for nursing services is adequately met: 1) maintenance of 80 percent activity status, 2) enhancement of geriatric and rural health care, and 3) student support.

1. Maintenance of 80 Percent Activity Status. Health sector employers and nurses in Kansas must assume the responsibility for working together to retain active nursing personnel. Options which should be explored include: part-time, flexible scheduling; improved communication and decision-making processes; attaining and retaining adequate salary schedules and fringe benefit packages; developing career mobility pathways; cooperative recruitment; more appropriate utilization; and improvements in the nursing media image. Further, efforts should be made to organize and coordinate refresher programs for inactive nurses, as well as continuing education programs for active nurses. Innovative projects which will provide further information on the profession are encouraged.

2. Enhancement of Geriatric and Rural Health Care. The supply of nursing personnel in rural areas is critically short, and statistics indicate that few nursing graduates enter nursing homes. Nursing school curriculum requirements should be reevaluated to increase content and practical opportunities in these areas. Teaching nursing homes are encouraged.

3. Student Support. Declines in the number of high school graduates, federal Nurse Training Act funds, and other programs which help finance nursing education have played some role in declines being experienced in nursing school admissions. A state-sponsored loan forgiveness program should be established to encourage students to enter the nursing field and to seek employment in Kansas hospitals and nursing homes. The private sector is also encouraged to provide loans and scholarships to students. Special consideration should be given to licensed practical nurses who are interested in becoming registered nurses.

ACUTE CARE HOSPITALS

The hospital industry in Kansas is a large and significant part of the Kansas economy. Expenditures for care in nonfederal, short-term hospitals amounted to 3.5 percent of the Gross State Product in 1981; over 36,500 full-time equivalent personnel were employed by the hospitals. There are several reasons why hospitals warrant study as a health planning issue.

- Total expenditures for hospital care in Kansas equaled $1.17 billion in 1981, a substantial increase over the $151 million expended in 1966. Spending for hospital services made up 48 percent of all personal health care expenditures in 1981, compared to 40 percent in 1966. The increased expenditures were caused by general economy price increases, new and additional services provided to inpatients, and increased service utilization by the total population.

- Because hospitals which serve the same population do not necessarily coordinate the services they offer, duplicate services may exist in some communities while other service needs go unmet. In part, this is caused by a lack of economic pressures for efficiency, and social factors such as physician influence on hospitals and community pride in being "medically self-sufficient."

- There is an apparent excess of over 1,350 hospital beds in Kansas. The oversupply can lead to increased costs because of low facility utilization or to unnecessary utilization encouraged by available capacity.

- In 1981, the average expense per hospital admission in Kansas was $2,243. It is thought that at this level of expense, some persons will not seek and will not receive needed hospital care because they do not have the personal resources or a third-party policy which will be responsible for their hospital expenses.

In order to prevent unnecessary increases in hospital costs while assuring that appropriate, high-quality services are provided to the population, the Statewide Health Coordinating Council has made policy recommendations in three areas: 1) cost-effectiveness, 2) service utilization, and 3) service planning.

1. Cost-Effectiveness. The performance of existing cost-containment programs should be monitored, and recommendations for necessary changes or refinements should be made.

2. Service Utilization. As discussed in the Health Care Costs Section of the State Health Plan, the general concepts of admissions review, concurrent review, and medical care evaluation studies should be extended to all acute care hospital patients regardless of their source of payment. Further, programs which may help reduce the need for and utilization of costly inpatient hospital services should be encouraged; examples include health promotion programs, prepaid alternative delivery systems, and appropriate outpatient services. Studies should also be directed toward determining the extent and possible causes of barriers to hospital care for some Kansans.

3. Service Planning. Institutional and interinstitutional planning activities are encouraged in order to avoid duplicative and unnecessary development of hospital facilities and services. Health planning actions should also be directed toward developing incentives to reduce the apparent excess of hospital beds, including exploration of regulations, legislation, and/or procedures which would encourage alternate uses of hospital facilities.

MATERNAL AND INFANT CARE

In order to assure optimal pregnancy outcomes, the provision of timely, appropriate, and high-quality services for the mother and infant are essential. During the 20th Century, it is apparent that great gains have been

made in this area. Infant death rates in Kansas have declined from approximately 65 deaths per 1,000 live births in 1926 to 11.0 deaths per 1,000 live births in 1981; nationally, the infant death rate was slightly higher in 1981, at 11.7 deaths per 1,000 live births. Maternal death rates have also declined from approximately 65 deaths per 10,000 live births in 1926 to virtually none in recent years. While these trends are impressive, there are still further improvements which can be made among high-risk populations.

- Appropriate prenatal care is essential. This includes maintenance of a nutritional diet and avoidence of substances potentially harmful to the fetus. Prenatal care may also serve to identify potentially high-risk patients. The absence of proper prenatal care is associated with the delivery of low birth weight infants, which in turn correlates with higher fetal mortality. Other characteristics which correlate with potentially at-risk cases include: racial/ethnic minority identity, age, marital status, and geographic residence of the mother; and factors such as previous history of pregnancy loss, short gestation period, and inter-pregnancy interval of under six months.

- Care received during and after delivery is also a determinant in pregnancy outcomes. National experts recommend a system of regionalized care; three hospital obstetrical levels are prop sed, with Level I providing routine care and Levels II and III providing for complicated cases. All facilities and professionals involved with maternal and infant care must be integrated into the system to assure appropriate pregnancy management. This is especially important given the often random and nonscheduled timing of obstetric admissions and fluctuations in the numbers of births.

- The popularity of family-centered maternity and newborn care has grown in recent years. More fathers are present at deliveries and the importance of early parent-child bonding is emphasized. Hospitals are attempting to change regulations so that the care provided is more acceptable to the family unit.

The Statewide Health Coordinating Council proposes that pregnancy outcomes may be improved by addressing: 1) access to prenatal care, 2) regional perinatal care, and 3) acceptability of care.

1. Access to Prenatal Care. Federal and state dollars for prenatal care programs should be directed toward high-risk black populations in urban areas, high-risk populations in geographically underserved areas, and adolescent populations. Health education in the schools and public and private agencies should emphasize the importance of prenatal care. The supply of physicians should be monitored to evaluate access to primary care and obstetrical doctors, and continuing education for physicians, as well as all other health providers should emphasize recognition and management of high-risk pregnancies.

2. Regional Perinatal Care. To promote appropriate utilization of hospital services, Level II centers should achieve a minimum of 65 percent

occupancy with 500 deliveries annually, and Level III centers should achieve 75 percent occupancy with 1,500 deliveries annually.

3. Acceptability of Care. The Kansas Department of Health and Environment should continue to consult with hospitals to provide family-centered care, when safe for the mother and child.

COMPUTED TOMOGRAPHIC SCANNERS

Computed tomographic (CT) scanning combines X-ray equipment with computers to produce cross-sectional images of the head or body. The first CT scanner in the United States was installed in 1973 and had only head scanning capabilities. Since that time, CT scanners have changed substantially and now have full-body scanning capabilities as well as shorter scanning times. Although the potential of body scanners is still being explored, the CT scanner has established itself as a diagnostic device of remarkable usefulness by providing accurate diagnoses of some conditions and improving the safety and comfort of patients when used in place of older, invasive diagnostic methods.

The policy direction for CT scanners, both nationally and in Kansas, has been to ensure the availability of medically necessary scanning services at the lowest possible resource commitment. Several factors, however, complicate the situation.

- Nationwide and in Kansas, there has been a strong desire to acquire CT scanners. In 1982, the Department of Health and Environment reviewed eight Certificate of Need requests for CT scanners; six were approved. The number of CT scanners in Kansas now equals 24. A potential for underutilization exists and is a concern since much of CT scanning costs are fixed; the cost per procedure is affected by the total number of procedures performed by each scanner.

- CT scanning services have not been consistently or systematically monitored to ensure that only medically necessary and appropriate usage is occurring. The appropriateness of CT services is difficult to define and evaluate. Unnecessary utilization can lead to false assumptions that additional capacity is needed, and it can delay necessary and timely access to the service for some patients. Information on the current utilization of existing scanners, whether based in or out of hospitals, is also necessary to assist in determining the need for future scanning services, as well as information on the clients served by CT scanners.

- Quality and continuity standards are fundamental to the provision of CT scanning services. As CT scanning availability expands from tertiary to secondary care service areas, standards are needed to ensure that appropriate staffing, facilities, and support services are in place.

The Statewide Health Coordinating Council recommends that actions be taken in three areas to ensure the appropriate provision of CT services in Kansas: 1) scanner supply guidelines; 2) continuity, quality, and efficient utilization; and 3) necessary data collection.

1. Scanner Supply Guidelines. Community need for CT scanning services should be documented through the Certificate of Need Program. Scanners should operate at a minimum of 4,000 HECT scans per year for the second year of operation and thereafter, or before additions or replacements occur in a service area. Exceptions may be allowed for areas with a high proportion of medically underserved elderly, pediatric, or trauma patients who require scanning, or in rural areas where travel time is a serious hardship.

2. Continuity, Quality, and Efficient Utilization. Facilities offering the service must have existing medical capabilities, including professional and paraprofessional personnel, which complement the CT service. Utilization review for CT services should occur for all patients regardless of the source of payment. Professional education should emphasize the importance of efficacy, effectiveness, and efficiency considerations in CT medical practice.

3. Necessary Data Collection. Data collectors in Kansas should explore the specifics of developing the ability to retrieve information on the use of all CT scanners, and the demographic and diagnostic characteristics of CT patients.

MENTAL HEALTH SERVICES

Mental health represents a continuum. At one end is a state of wellness in which an individual is able to achieve a balance between the positive and negative forces that are in play in all aspects of life. At the other end is a state of mental disorder or illness which leaves individuals unable to function effectively and relate to others in a meaningful way. Concern for the widespread impact and high cost, both personally and financially, of mental health problems which affect an estimated 15 percent of the population has made mental health services a priority issue at the federal, state, and local levels. Given a body of increasing knowledge about the dynamics of mental health, a movement toward deinstitutionalization of chronic mentally ill persons, and concerns for treatment in the least restrictive setting, the current service delivery system has been found to be insufficient.

- Public and private insurance reimbursement policies have traditionally favored inpatient care and do not promote prevention, early identification, or noninstitutional alternatives. One result is that Kansas appears to have a more than adequate supply of psychiatric inpatient beds.

- The special needs of the chronically mentally ill, elderly, young people, racial and ethnic minorities, and victims of family and sexual abuse are sometimes not met by the current service system.

- Coordination between mental health services, and between medical, legal, and social services is often weak. Given that many persons fear the stigma associated with admitting and seeking help for a mental health problem, the lack of coordination among services may frustrate many persons in need of care and treatment.

- Basic data to monitor and evaluate the performance of the mental health delivery system are not available.

With the goal of providing a coordinated continuum of appropriate social, psychological, and medical services for mental health clients, the Statewide Health Coordinating Council recommends: 1) development of a model delivery system, and 2) improvement of the mental health system data base. Given federal and state fiscal policies which will ultimately reduce the amount of funds available for mental health care, the need to improve the efficiency of the mental health delivery system is evident.

1. Development of a Model Delivery System. A model service delivery system for the severely mentally ill should be developed. The system should: a) conduct an assessment of the client's total needs, including but not limited to, needs for treatment, shelter, food, education, personal support networks, employment, income, and recreation; b) determine the most appropriate means for meeting the client's total needs; and c) develop an individualized service program including arrangements for service delivery and progress monitoring. The current Partnership Agreement for the Continuity of Treatment (PACT) Program may serve as the vehicle for implementing the model system. The Department of Social and Rehabilitation Services and interested psychiatrists, psychologists, social workers, the Kansas Hospital Association, and others should be involved. Once the model system is in place for the severely mentally ill, it should be expanded to include all mental health clients.

   Undue emphasis on inpatient/institutional care should be avoided. The Certificate of Need Program should review applications for psychiatric inpatient beds taking into account: beds available, occupancy of existing beds, and other mental health continuum services available.

2. Improvement of the Mental Health System Data Base. To eliminate gaps in the mental health system data base, epidemiologic studies should be conducted to determine the nature and extent of mental health problems in the state. Special emphasis should be placed on behavioral evaluations which would help determine the need for community-based facilities which would serve as alternatives to institutional care.

SUBSTANCE ABUSE SERVICES

Substance abuse is the nonmedical use of any drug or alcohol in such a way that it adversely affects some aspect of the user's life. The abuse may be intentional or unintentional; it may involve legal or illegal substances. There are estimated to be 142,000 problem drinkers and 110,000 high-risk drug abusers in Kansas. The personal and financial costs of substance abuse can be substantial. Many traffic fatalities, suicides, homicides, and fatal accidents are related to substance abuse. Lost productivity through absenteeism, unemployment, and death amounts to billions of dollars annually. Children are also innocent victims of abuse and neglect related to familial substance abuse.

When substance abuse was first recognized as a serious social problem, the service response to the needs of the abusers was neither planned nor orderly.

Substance abusers were often removed from their natural environment and placed in highly structured environments for treatment. In recent years, emphasis has been placed on a continuum of care which encompasses prevention and treatment services, and utilizes outpatient services as the focal point of the system. Although admissions to substance abuse programs are increasing, barriers do exist which restrict the development and utilization of a full range of services.

- Substance abuse services are provided by a wide range of agencies and facilities, including hospitals, mental health centers, state psychiatric facilities, freestanding programs, self-help groups, and others. Lack of coordination due to philosophical differences, geographic location, and funding sources all contribute to problems for the client in need of coordinated services, which may also include job training and social services.

- Social stigmas still prevent many persons from seeking help. This may be due to feelings of failure, fear for personal reputation, and use of illegal substances.

- Service needs of special populations, including young people, the elderly, women, and racial/ethnic minorities are frequently not recognized.

- Private insurance policies do not address substance abuse service needs in a comprehensive manner.

With the goal to reduce the personally destructive and socially disruptive effects of substance abuse, the Statewide Health Coordinating Council made recommendations regarding: 1) continuum of care, 2) funding, and 3) service provider education.

1. Continuum of Care. Prevention/education programs are encouraged as a vital part of the substance abuse continuum because they act as a means of intervention before more costly treatment services are needed. Outpatient services also are stressed so that clients may remain in the family, community, and/or work setting while receiving treatment. Inpatient services are a part of the continuum where Certificate of Need reviews are needed to prevent unwarranted growth.

2. Funding. At the federal level, funding for alcohol and drug abuse services has been combined in a block grant with mental health services. The Kansas Legislature is encouraged to eliminate the separation between state funds for alcohol and drug abuse services, to permit more flexibility in funding allocations of scarce treatment resources.

3. Service Provider Education. Substance abuse identification, intervention, and referral training programs for medical and social service providers should be expanded. Training programs should also be developed for substance abuse and other service providers to ensure that the prevention, early identification, and treatment needs of young people, the elderly, women, and racial/ethnic minorities are adequately met.

OTHER STATEWIDE HEALTH COORDINATING COUNCIL AND OFFICE OF HEALTH AND ENVIRONMENTAL PLANNING ACTIVITIES

HEALTH CARE EXPENDITURES IN KANSAS

Rising health care expenditures are a major cause of concern in Kansas and the nation. The Office of Health Planning, Kansas Department of Health and Environment, annually produces a document which is designed to monitor trends in health care expenditures for Kansas and the United States. Some of the data items contained in the documents include total outlays and per capita expenditures for health services and supplies, major categorical distributions of the expenditures, and sources of health care funding. Because data are available beginning with Fiscal Year 1966, it is possible to examine changes in health care spending since passage of Medicare and Medicaid legislation.

The following highlights, taken from the 1982 Health Care Expenditures Report, underscore the importance of this topic.

- Kansans spent $2.9 billion in 1982 for all health services and supplies, up 12 percent from 1981. This amounted to $1,186 per capita.

- 1982 health care spending contributed 9.0 percent of the Gross State Product, an increase over the 1981 share of 8.5 percent.

- Kansans spent $1,096 per capita for personal health care services in 1982, compared to $1,216 nationally. Per capita spending is now 90 percent of the United States level compared to 92 percent in 1981.

- Kansans spent $540 per capita for hospital care in 1982, compared to $574 nationally. Hospital care accounted for the largest share, 49 percent, of 1982 personal health care spending in Kansas. Since 1975, the rate of spending for hospital services has grown faster in Kansas than the national rate.

- Since 1966, nursing homes have shown the most growth in health care expenditures nationally and in Kansas. Per capita spending in Kansas increased from $5.55 in 1966 to $108 in 1982.

- In 1982, $1,061 million were spent for personal health services under public programs in Kansas. The Medicare Program contributed the largest share of public spending in Kansas amounting to $512 million in 1982. The Medicaid Program contributed the second largest share of public funds amounting to $268 million in 1982.

- The federal government funded nearly 30 percent of all personal health care services nationally and in Kansas in 1982, compared to only about ten percent in 1966. The federal government funded 40 percent of all hospital care nationally and 44 percent in Kansas in 1982.

- In 1982, out-of-pocket spending by consumers accounted for about one-third of all outlays for personal health care nationally and in

Kansas, a notable decrease from the half contributed by consumers in 1966.

Many changes are taking place in federal policies which will affect health care programs in the future. The changes include a movement toward block grant programs with greater state control, and reduced funding levels. It will be important to continue to monitor and analyze the impact of these initiatives on health care expenditures.

KANSAS MEDICALLY UNDERSERVED AREAS

As part of the Medical Scholarship Program enacted by the 1978 Kansas Legislature, the Secretary of the Department of Health and Environment is directed to prepare annually a list of areas in the state which are medically underserved with regard to doctors of medicine and osteopathy. As part of the report, the availability of primary care physicians, 11 categories of secondary physician specialists, and six categories of tertiary physician specialists in the state are compared with optimal physician-to-population ratios. The resulting designation of areas where the current availability is substantially below the optimal ratio serves as a guide in determining where scholarship physicians may fulfill their service commitments. In 1982, both critically underserved areas, as well as underserved areas, were designated, as required by legislative changes intended to show which areas in Kansas have severe needs for physicians.

The following information is summarized from the 1983 edition of the Kansas Medically Underserved Areas Report, the sixth annual document in this series.

- In 1983, Kansas showed a total of 3,083 full-time equivalent practicing, nonfederal physicians, a .98 percent increase from 1982. The greatest gain, as in past years, was in tertiary and secondary specialities. The tertiary speciality increased by six percent and the secondary speciality increased by .75 percent. The primary speciality decreased by less than one percent (.21). Thirty-seven counties were designated as underserved in primary care, compared to 36 in 1982. Thirty-three counties are considered critically underserved. Seventy-six secondary areas in 11 specialities were designated as underserved, 49 as critically underserved. In the six tertiary specialities, four areas were designated as underserved, three critically.

- Overall, Kansas shows about 130 full-time equivalent physicians per 100,000 population, about 535 full-time equivalent's short of the optimum of 151.7 per 100,000. During the rest of this decade, present trends indicate that the need for primary care physicians will continue but that the secondary and tertiary specialties will show surpluses. Disparities in distribution of physicians, particularly in primary care, persist, despite modest improvement in Kansas' smaller counties. To achieve further improvement will depend on appropriate distribution of scholarship recipients committed to underserved areas.

- As of June 30, 1983, 2,759 scholarships have been awarded to 1,584 recipients. Current projections show that fewer than 90 physicians per year are needed to reach optimum levels, with 31 per year needed in underserved areas and 15 per year in primary care. Thus, enough scholarships already have been given to have a substantial impact on physician supply and distribution in Kansas.

The preparation of this plan was financially aided through a federal grant from the Department of Health and Human Services.

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PROGRAMS AND SERVICES

Kansas Department of Health and Environment

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT 1974

Attm #5
1-23-85

PROGRAMS AND SERVICES

John Carlin, Governor

Barbara J. Sabol
Secretary of Health and Environment

Compiled by
the Division of Policy and Planning
and
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INTRODUCTION

In 1885, the Kansas State Board of Health and local boards of health were established by the Kansas Legislature. The first full-time executive secretary, Dr. Samuel Crumbine of Dodge City, was appointed in 1904. His total annual budget for the first year was $3,080 and the legislature imposed a ceiling of $5,000 on expenditures for the newly formed department. Dr. Crumbine was an innovative, imaginative and tireless public health worker. Many of the sanitation, pure food, and drug laws first enacted in Kansas to control the spread of contagious diseases were later adopted by the federal government and other states.

In 1906, Dr. Crumbine launched a campaign against the housefly and its spread of disease. He invented the fly swatter and promoted its use through an extensive public education campaign. This was immediately followed with Dr. Crumbine's "Bat the Rat" campaign.

To educate the public about the spread of tuberculosis, Dr. Crumbine persuaded a brick manufacturer to produce paving bricks with the admonition, "Don't spit on the sidewalk." Among other steps for controlling tuberculosis, Kansas passed a law in 1907 requiring physicians to report cases of tuberculosis within 24 hours of diagnosis. In 1908, the legislature appropriated $20,000 to hire six nurses and to carry on a statewide educational campaign against tuberculosis.

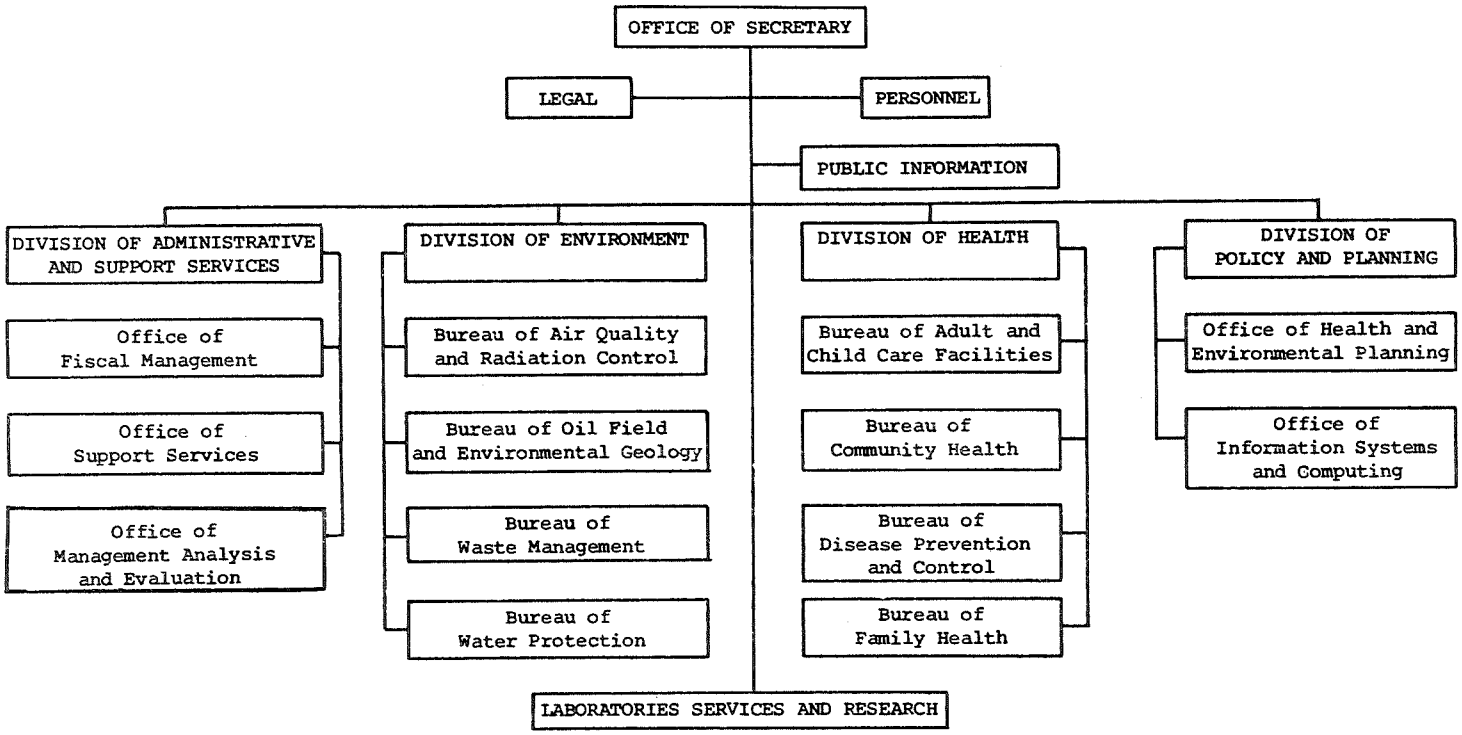
Dr. Crumbine was also noted for his campaign against food adulteration. A food and drug law was passed by the state legislature in 1907. Four inspectors were hired to enforce the law, collect samples, and make inspections of food premises.

Over the years, the Board of Health grew in its responsibilities, staff and budget resources. The new responsibilities of the Board included environmental health. In 1907, amendments to the water and sewage laws gave the State Board of Health jurisdiction over operation of all water plants and sewage systems. In addition, the Board was authorized to investigate stream pollution produced by industrial wastes. A plan for remedial action to abate the heavy pollution of the Neosho and Verdigris Rivers was launched in 1911, and a year later funds were requested for research on treating industrial wastes.

Sixty-three years later, during the 1974 session, an Executive Order was issued by Governor Robert Docking which created the Kansas Department of Health and Environment (KDHE) to take over responsibilities of the Board of Health. The order was approved by the legislature and the new department became operational on July 1, 1974. Created within KDHE were a Division of Health and a Division of Environment. In addition, an Office of Laboratories was established to serve both divisions. The agency is headed by a cabinet-level secretary who serves at the pleasure of the Governor.

In 1983, Secretary Barbara Sabol reorganized the agency to enhance the department's ability to effectively and efficiently serve Kansans. The reorganization resulted in minimizing unnecessary layers of management by consolidating 18 bureaus into eight bureaus. The following chart illustrates the organizational structure of KDHE. Presently, KDHE has a staff of 582 employees representing several professional fields, and an operating budget of $37 million; $23 million in federal funds and $14 million in state general revenue funds.

ORGANIZATIONAL CHART



This booklet provides brief descriptions of programs and services provided by the Division of Administrative and Support Services, the Division of Environment, the Division of Health, Laboratories Services and Research, the Division of Policy and Planning, the Public Information Office, the Legal Unit and the Personnel Office. Legislative authority for the various programs and services appear in many sections of Kansas statutes. The mission of the department is to protect and maintain the health and welfare of Kansans and the quality of the environment.

DIVISION OF ADMINISTRATIVE AND SUPPORT SERVICES

The Division of Administrative and Support Services provides a variety of administrative, fiscal and technical support services to all KDHE programs. The Division is responsible for: 1) coordinating the preparation of the agency's annual budget, 2) managing the expenditure of all funds according to state and federal law as well as accepted accounting procedures, 3) providing financial and statistical data required for the operation of the agency, 4) maintaining optimal working conditions for the staff within the limits of the funds available, and 5) conducting performance audits on KDHE programs. Facility management and maintenance services for the main offices in Topeka, six district offices throughout the state and the health and migrant office are coordinated through this division in conjunction with activities of the Kansas Department of Administration. The Division is organized into three offices: the Office of Fiscal Management, the Office of Support Services and the Office of Management Analysis and Evaluation.

THE OFFICE OF FISCAL MANAGEMENT

This office is responsible for coordinating the preparation of the annual operating budget document, providing fiscal management for funds received through federal and other grant sources, and accounting for receipts and disbursements. Additional duties include supplying financial information to the Secretary, division directors, and bureau and office managers.

THE OFFICE OF SUPPORT SERVICES

The Office of Support Services is responsible for the management of all agency purchasing. This includes contractual services, commodities and equipment. The office manages the central mailroom and supply operations, the central communications network, duplicating operations, inventory control and buildings and grounds maintenance.

OFFICE OF MANAGEMENT ANALYSIS AND EVALUATION

The Office of Management Analysis and Evaluation is primarily responsible for conducting performance audits on KDHE programs and projects as requested by the Secretary, the Director of Policy and Planning and/or program managers. Audits are to determine legislative compliance, determine efficiency and effectiveness of programs, recommend improvement measures and monitor progress in achieving improvements. This staff also assists managers by identifying and devising methods to resolve problems; forecasting effective program implementation techniques; and periodically assessing organizational climate through staff and climate surveys.

DIVISION OF ENVIRONMENT

The mission of the Division of Environment is to provide comprehensive management of the interrelated land, air and water environments of the state in order to protect the public health and welfare of Kansans. To achieve this mission the division is organized into four bureaus. Each bureau represents one of the four major areas of environmental regulation: Bureau of Air Quality and Radiation Control, Bureau of Oil Field and Environmental Geology, Bureau of Waste Management, and Bureau of Water Protection.

BUREAU OF AIR QUALITY AND RADIATION CONTROL

This bureau is responsible for air quality conservation, pollution control, radiation control, and environmental toxicology. Air quality conservation activities involve the review, approval, and regular inspection of all air contaminant emission sources. These activities are conducted to ensure that proper emission control is present and in accordance with federal and state air quality standards. Statewide assessments provide an up-to-date inventory of the amount and nature of contaminant emissions. Long-term atmospheric air sampling of the Wichita, Kansas City and Topeka areas are provided by local health agencies in cooperation with KDHE. Routine monitoring through portable sampling equipment is used to investigate special, localized air pollution problems and to identify changes in air quality.

The bureau also is responsible for the inspection and control of all radiation sources. (Radiation sources are radioactive materials or equipment which produce radiation.) Radioactive materials are used in medicine, research, and industry and occur naturally in the environment. The radiation control program includes: annual registration of x-ray devices; biennial licensing of radioactive materials; enforcement of state regulations pertaining to the storage, transfer, disposal and handling of radiation sources; and inspections and investigations of radiation sources. This bureau is also responsible for monitoring

the Wolf Creek Nuclear generating facility and the surrounding environment. As part of the State Emergency Response Program, the staff provides technical assistance for the development of emergency plans and assistance during any type of radiological emergency.

The bureau's environmental toxicology program, in conjunction with the health toxicology program, investigates and evaluates reports of potential adverse human health effects from exposures to hazardous chemicals and other environmental agents. For example, the program has examined levels and sources of formaldehyde in buildings, indoor air quality of private residences, and commercial buildings and home environment pesticide exposures.

BUREAU OF OIL FIELD AND ENVIRONMENTAL GEOLOGY

Oil field pollution control and pollution hydrogeology are the two program areas in this bureau. These programs regulate oil and gas operations which could result in saltwater pollution of fresh and usable waters. The oil field pollution control program includes the underground injection control which involves the review of oil field brine or enhanced recovery injection well applications, evaluation of oil field pollution control equipment on leases and taking enforcement action when violations are found. All oil field pollution control activities are coordinated with the Kansas Corporation Commission (KCC) through the joint oil and gas regulatory program. (Specific permitting authority for different classes of oil and gas pollution control facilities rests officially with either the KCC or KDHE, depending on the statutory authority.)

The pollution hydrogeology program involves enforcement of groundwater pollution control regulations related to buried petroleum storage tanks, liquid waste injection wells, LPG storage wells, salt solution mining wells, and water well construction. In addition, the program provides geological expertise and technical assistance related to proposed landfills, hazardous waste sites, and industrial

wastewater lagoons. This program involves assessing the potential for groundwater pollution from faulty facility design or misdirected operation and abandoned wells.

Most permit activities involve both state and operator monitoring and site performance evaluations to ensure groundwater quality. Staff provides technical assistance, coordinates statewide response, and provides on-site supervision of pollution spill incidents. Technical assistance is also provided to groundwater management districts, other water agencies and to the Mined Land Conservation and Reclamation Board.

BUREAU OF WASTE MANAGEMENT

Each day, the average Kansan discards 3.5 pounds of solid waste or 1,400 pounds per year. Added to this is a special category of waste called hazardous wastes which are generated in the production of commercial and industrial products, or are hazardous materials used and discarded. In 1982, Kansas industries generated an estimated three million tons of hazardous wastes.

The Bureau of Waste Management is divided into two program areas: solid waste management and hazardous waste management. The hazardous waste management program regulates the generation, transportation, storage, treatment and disposal of hazardous wastes in accordance with state and federal regulations. The hazardous waste management program administers a permit program for persons who store, treat or dispose of hazardous wastes. Generators of hazardous wastes are regularly inspected by staff, who supply technical assistance to the regulated community to better achieve compliance with standards and regulations. Staff is currently engaged in the identification, investigation, and cleanup of sites where past solid or hazardous waste disposal practices may pose a hazard to health or environment. Currently, more than two hundred sites are targeted for investigation. KDHE will implement cleanup or other remedial action if determined necessary by the investigation. Additional sites are expected to be added as the investigations continue.

The solid waste management program regulates the storage, collection, and transportation of the non-hazardous solid wastes. In Kansas, county units of government have the primary responsibility for the management of solid wastes. Each county must have a solid waste management plan. The bureau reviews solid waste management plans and assists in the development and implementation of such plans. In addition, the bureau reviews applications and issues permits for sanitary landfills, industrial landfills, tree and brush disposal sites and other solid waste facilities. Bureau personnel inspect landfills and other facilities periodically to insure that these are being operated in compliance with applicable standards and regulations.

Solid wastes are a potential source of energy and materials; the bureau encourages the recovery and reclamation of solid wastes. Staff conducts periodic education seminars on solid and hazardous waste management.

BUREAU OF WATER PROTECTION

This bureau administers two major programs: water pollution control and regulation of public drinking water sources. These programs are designed to prevent water pollution and provide safe potable public water supplies.

The bureau provides engineering and laboratory surveillance of community and noncommunity water supplies and wastewater facilities; reviews engineering reports, plans, and specifications for the pretreatment and/or treatment of drinking water and wastewater; carries out a compliance program; and issues permits for new or extended systems.

KDHE has an extensive surveillance system whereby samples are collected and analyzed to determine the presence or absence of pollutants. The system is based on approximately 103 stream water quality stations, 58 stream biological stations, and special lake biological studies.

The control of discharged pollutants from waste treatment facilities (municipal, industrial, commercial and feedlot) is obtained through a system of permits adopted under federal and state statutes. Under this system each operator of a treatment plant must meet specified design reports.

In addition, bureau staff administers the water and wastewater operator's training and certification program, provides technical assistance, and carries out special water quality studies. The bureau maintains a water-use inventory; determines minimum flows needed to maintain surface water quality; maintains listings of critical water quality management areas; and develops designs for water emergencies, droughts, and alternative water supplies.

LABORATORIES SERVICES AND RESEARCH

The programs in Laboratories Services and Research include both public health and environmental laboratory activities. The current staff of 72 chemists, microbiologists, technical and support staff produce 260,000 test reports annually, using state-of-the-art analytical chemistry and microbiological techniques. The primary mission of these programs is to provide reliable, quality laboratory support for public health and environmental activities in Kansas.

Additional responsibilities include participation in the planning, development, and implementation of environmental and health programs initiated by KDHE; and provision of analytical support to Kansas physicians, hospitals, clinics and law enforcement agencies. These efforts reflect both statutory responsibilities and administrative policies that are designed to protect the environment in Kansas and the health of its citizens.

Major efforts are made to maintain and improve the quality of laboratory services provided by other laboratories in Kansas through training, consultation activities, and certification and proficiency programs. Additional and new laboratory methods and services are developed and evaluated to provide the best possible data for these vital public health and environmental programs.

RECORDS AND REPORTS

The records and reports program provides for the acquisition, transmission and retention of the two hundred sixty thousand laboratory reports produced by the state laboratory each year. These laboratory reports are transmitted to physicians, hospitals, law enforcement agencies, local health departments, clinical laboratories, environmental programs, governmental agencies and private citizens in Kansas. This technical information is provided to these client groups to prevent and control disease and to insure a safe environment.

The program is also responsible for the long term storage and retrieval of analytical data produced by the State Public Health Laboratory in conjunction with the automated laboratory data reporting system.

CHEMISTRY

The chemistry program provides detailed chemical analyses of approximately 50,000 samples and specimens each year. This chemical data is used to assess and prevent environmental pollution, to enforce Kansas statutes and regulations, and to prevent and/or treat diseases resulting from chemical exposures.

The chemistry program is comprised of five units which include Environmental Radiation Chemistry, Environmental Organic Chemistry, Air Quality/Environmental Toxicology, Environmental Inorganic Chemistry and Health Chemistry. This program utilizes approximately one million dollars worth of sophisticated laboratory instrumentation which is not generally available elsewhere in the state. This instrumentation allows the analyst to identify and quantify chemical species to the part per billion concentration level. (One part per billion is equivalent to one inch in 16,000 miles.) Reporting and retrieval of data is performed using the automated laboratory reporting system.

MICROBIOLOGY

The microbiology program examines approximately 210,000 specimens each year to provide specific information required for the timely diagnosis, treatment, control and prevention of infectious diseases. This program is composed of three activity units which include Health Microbiology, Virology/Serology and Environmental Microbiology. Some specific examples of public health issues which require microbiological analyses include sexually transmitted diseases such as gonorrhea and syphilis; foodborne and intestinal diseases; tuberculosis; and the examination of public drinking waters to insure biological safety.

LABORATORY CERTIFICATION AND IMPROVEMENT

The laboratory improvement and certification program works with chemical, environmental and law enforcement laboratories throughout the State to maintain and improve the quality of the analyses performed in these laboratories. This goal is reached through technical training, consultation, proficiency test programs and on-site evaluations. Activities associated with the approximately 160 Kansas clinical laboratories are part of larger programs of Kansas hospital licensure, Medicare, syphilis serology laboratory regulation and federal CLIA-67 laboratory certification programs.

The environmental laboratory activity unit works with 120 Kansas environmental laboratories which produce technical data used in relation to public drinking water supply permits, wastewater discharge permits and hazardous waste evaluations.

The law enforcement activity provides breath alcohol instrument training, operator proficiency test programs and on-site evaluations to assist law enforcement agencies in the detection and prosecution of individuals driving under the influence of alcohol.

DIVISION OF HEALTH

The mission of the Division of Health is to promote an optimal level of health in Kansas citizens by: 1) reducing the incidence of morbidity and mortality; 2) assuring access to quality health services; 3) preventing, detecting and treating disease; 4) detecting and correcting conditions which can cause disease; 5) promoting consumer safety; 6) encouraging and providing risk-reducing health promotion services; 7) developing and maintaining health services either directly or indirectly through technical and financial assistance; 8) maintaining a statewide registration and vital records system; 9) establishing health standards; 10) regulating health and child care facilities, and 11) regulating food, drug and lodging facilities and services.

The division is divided into four bureaus: the Bureau of Adult and Child Care Facilities, the Bureau of Community Health, the Bureau of Disease Prevention and Control, and the Bureau of Family Health.

The Kansas Department of Health and Environment provides some direct health services however, a majority of the services are administered by the department through funds distributed to health departments and other agencies.

BUREAU OF ADULT AND CHILD CARE FACILITIES

The Bureau of Adult and Child Care Facilities is responsible for child care facility licensure and registration and health facility licensure and certification.

The child care licensing and registration program is mandated by Kansas statutes to assure that out-of-home care for children will not be exploitive, unsafe or unhealthy. Foster homes, group homes, maternity care homes, detention centers, certain day-care homes, child-care centers, and child-placing agencies all require a license to operate. Family day-care homes are registered with the program.

Licensing inspections are made by county health department staff; enforcement action is a KDHE responsibility.

The health facility licensure and certification program regulates adult-care homes and medical-care facilities. Specially trained registered nurses and sanitarians monitor health facilities programs, investigate complaints and provide the information for licensure and certification determinations. The health facilities licensure and certification program ensures that health care providers follow licensure regulations designed to provide a safe, sanitary and functionally adequate environment. Adult-care home administrator licensure, nurse aide training and certification, recertification of medication aides and home health aide training and certification are also responsibilities of the program.

BUREAU OF COMMUNITY HEALTH

The Bureau of Community Health provides administration, consultation, education and support services to community health programs with an emphasis on prevention and risk-reducing health promotion services. The bureau is divided into two offices: the Office of Health Promotion and the Office of Vital Statistics.

The Office of Health Promotion oversees the following primary prevention/risk reduction programs: healthy start home visitor, hearing conservation, school health, prenatal risk reduction, primary prevention/health promotion, family planning training, hypertension screening and intervention, health screening, and independent living. Another emphasis of the office is health information and resource development. A lending library of approximately 2,500 films, slide/tapes, film strips and videotapes related to health and environmental issues is available to local organizations and individuals at no cost other than return postage.

The office is also responsible for coordinating the state employee health and wellness program such as the Health Promotion PLUS, and

VOTE (no smoking). PLUS is a comprehensive education and intervention effort to promote healthy lifestyles in order to reduce premature death and disability. VOTE provides information and support for the promotion of smoke-free environments.

The community liaison section of the office provides consultation and education for the development of programs on the local level. Staff coordinates programs in which the state and local agencies are partners.

The Office of Vital Statistics is charged with the collection and transmission of birth and death certificates, marriage records, records of marriage dissolution or annulment and the issuance of certified copies of these records upon request. The state registrar makes an annual report of these records to the Secretary of KDHE.

BUREAU OF DISEASE PREVENTION AND CONTROL

The Bureau of Disease Prevention and Control is responsible for several programs directed at the control of communicable diseases and the protection of the public health and safety. The bureau contains three program categories: epidemiology; health toxicology; and food, drug, and lodging.

The epidemiology programs maintain a continuous surveillance on all infectious or communicable diseases, provide vaccines for the control of tuberculosis, and provide immunizations required by law for all children in school. Additionally, all venereal disease control activities in Kansas are coordinated by this bureau.

The health toxicology program, in conjunction with the environmental toxicology program, coordinates multidisciplinary investigation, assessment and management of health risks caused by exposure to environmental toxic agents. The program maintains a registry of birth defects and a registry of cancer cases through the cancer data service of the Kansas University Medical Center.

Staff of the food, drug and lodging arm of the bureau inspect sanitation and safety of food and food service establishments, lodging establishments, and pharmacies. Detection of adulteration and misbranding of food products is a part of inspection activities. Each food service or lodging establishment must obtain an appropriate license from the Secretary to conduct business in Kansas. Facilities found by inspection not to be in compliance with regulations are subject to suspension, revocation or denial of licenses, or denial of applications for licenses. Facilities inspected, but not required to pay fees or obtain licenses, include: retail food stores, food wholesalers, food manufacturers and repackers, pharmacies, flour mills, variety stores, bakeries and bottling plants. The staff is responsible for conducting investigations of consumer complaints concerning all regulated establishments. Occurrences of foodborne illness are investigated and are considered as a first priority by the staff.

BUREAU OF FAMILY HEALTH

The Bureau of Family Health plans, develops, and coordinates health resources and programs to meet the health needs of Kansas families. Included within the bureau are programs directed toward family health, health of migrants and refugees, nutrition and health, and crippled and chronically ill children.

The well family health program focuses on programs and services that support the health of the family through prevention of illness and access to health care. The program monitors the quality of health services to mothers, infants and children; collects and analyzes health data; coordinates programs at the local and state level regarding public health; and provides basic essential health services. Specific program activities include: maternal health care, care for high-risk pregnant women and newborns, outpatient medical services for children (birth to 21 years), physical exams and family planning.

The nutrition and health program provides nutrition education

and consultation, as well as administering the federal women, infant and children supplemental food program (WIC) in Kansas. WIC provides medical and nutritional screening, counseling and education for prenatal and postnatal care of women and children under five years.

Programs are also targeted to migrants, refugees and other low-income persons. In southwest Kansas, migrant health services provide preventive and primary health care to migrant and seasonal farm workers. Health assessments, well child care, health and nutritional counseling, outreach, home visits, and referrals to health care providers are handled by migrant health staff. The refugee health assessment program evaluates the health of newly-arrived refugees, in order to address significant public health problems.

The crippled and chronically ill children's program is responsible for the planning, development and promotion of specialty health care for the handicapped youth of Kansas. Diagnostic services are available to those under the age of 21 who are suspected of having a severe handicap, disability, or chronic disease. Treatment services include special medical care, surgery, outpatient care and hospitalization. Other services include genetic clinics and newborn screening.

DIVISION OF POLICY AND PLANNING

The Division of Policy and Planning ensures comprehensive policy development and implementation, as well as program research and evaluation; provides information and documentation regarding laws and regulations affecting KDHE; coordinates comprehensive state health and environmental planning; provides a sound basis for agency budget priorities, operations, program planning and evaluation; provides data processing and word processing services to agency staff; and develops and maintains sound management and organizational practices. To meet this mission this division is divided into two offices: the Office of Health and Environmental Planning and the Office of Information Systems and Computing.

OFFICE OF HEALTH AND ENVIRONMENTAL PLANNING

The Office of Health and Environmental Planning is responsible for compiling and analyzing data on health and environmental problems in Kansas and proposing corrective actions. This office is responsible for administering the certificate of need program, the medically underserved program, the credentialing program, the Health Facilities Plan, and the Environmental Policy Plan.

The certificate of need program reviews applications for specific health care projects such as the construction, development or establishment of new health facilities, as specified by state statutes. The primary purpose of the program is to prevent unnecessary duplication of expensive health care facilities and technological services.

The credentialing program provides a thorough analysis and recommendations to the Kansas Legislature concerning health occupation groups seeking to be licensed or registered.

The medically underserved program designates areas of the state as medically underserved according to physician specialities to be used

for policy decisions. This office is also responsible for the development of the state's Health Facilities Plan which is to be used as a guide by local, state and federal governments and private industry in making decisions to assure efficient and appropriate health care delivery systems which address needs at a reasonable cost.

The office, in conjunction with the Statewide Coordinating Council, develops The Plan for the Health of Kansans. This plan is intended to be used as a guide in health policy issues and the development of state health programs. The state health plan is also used as the basis for reviewing applications for federal health funds and certificates of need application.

The Environmental Policy Plan consists of studying and revising existing statutes and regulations and developing a Kansas environmental atlas. The environmental planners also provide staff support to the Environment Awareness Council.

OFFICE OF INFORMATION SYSTEMS AND COMPUTING

The Office of Information Systems and Computing coordinates the collection, analysis, and dissemination of the KDHE health and environmental data. Statistical support services are provided to program managers, local health departments and other state and local health data users and providers. This office is also responsible for the data processing and word processing sections.

PUBLIC INFORMATION OFFICE

The mission of the Public Information Office is to provide accurate, timely information regarding the Kansas Department of Health and Environment to the public. Information is provided about agency plans and activities to news media, federal and local units of government and members of the general public. This is accomplished through news releases, public service announcements and other informational materials on matters which affect Kansans' health and/or environment.

LEGAL UNIT

The mission of the Legal Unit is to provide full legal services to the Secretary of Health and Environment and agency staff in order to carry out their official duties. These services generally include giving timely and appropriate legal counsel and advice to agency personnel and the representation of the agency and its employees in both administrative and judicial proceedings.

OFFICE OF PERSONNEL AND EMPLOYMENT SERVICES

The mission of the Office of Personnel and Employment Services is to provide technical support in the development and maintenance of an effective personnel management program. The personnel staff is responsible for programs in the areas of employee recruitment; training and staff development; classification, examination and certification of qualified candidates; Equal Employment Opportunity and Affirmative Action, employee relations and technical personnel consultation to managers and administrators.

CONTACT PERSONS

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Advisory Commission on Environment
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Advisory Commission on Health
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Environment Awareness Council
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Statewide Health Coordinating Council
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OTHER IMPORTANT CONTACTS

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Ext. 468

24-Hour Emergency/Spill Response..... (913) 862-9360

Vital Statistics (birth, death, divorce, and
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Ext. 557
or 558