Approved 1-28, 1991
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Carol H. Sader at
Chairperson

1:30 a.m./p.m. on January 23, 19 91 in room 423-S of the Capitol.

All members were present except:

Representative Theo Cribbs, Representative Ann Cozine, both excused absences.

Committee staff present:

Bill Wolff, Research
Norman Furse, Revisor
Sue Hill, Committee Secretary

Conferees appearing before the committee:

Orville Voth, Silver Haired Legislator
Dr. Stanley Grant, Secretary Department Health/Environment
Charles Konigsberg, Director of Health/Department of Health/Environment
Steve McDowell, Director of Rural Health/Department of Health/Environment
Esther Wolf, Secretary of Department on Aging

Chairperson Sader called meeting to order welcoming all present, she entertained a motion for approval of minutes. Motions to approve minutes from January 17, 1991 made by Representative Scott, seconded by Rep. Bishop, motion carried.

Chair announced procedures in regard to attendance at committee meetings by members. It will be required that Representatives call the office of Chairperson by 10:30 a.m. prior to meeting if they plan not to attend the meeting. If this notification is not received, their absence will be recorded as unexcused.

Mr. Orville Voth, Silver Haired Legislator, offered a Resolution and asked that it be introduced as a committee bill. (See Attachment No. 1) Mr. Voth detailed the Resolution urging the legislature to support national legislation providing a comprehensive national health plan that would cover all Americans.

Mr. Furse noted if it is to go through both the House and Senate, it will need to be filed as a Concurrent Resolution. Mr. Voth ageed.

Chair entertained motion in regard to this request. Rep. Love moved this Resolution be introduced as a committee bill, seconded by Rep. Bishop, motion carried.

Chair recognized Bill Wolff, Research.

Mr. Wolff offered background information to members, i.e., Proposal No. 30-- Registration of Marriage and Family Therapists. Attachment No. 2. He gave background material in regard to the credentialing. All health care providers in Kansas have the opportunity to present their request for credentialing for state registration under existing state law. Current law requires a Technical Committee to make a recommendation on the credentialing of a particular applicant group. The Secretary of the Department of Health/Environment makes the decision on the application and the Legislature makes the final decision on whether or not the group is credentialed and at what level.

In 1986 the Legislature completely re-wrote the credentialing laws. Thus, the group of American Family Therapists has been through both sets of legal procedures. Mr. Wolff detailed explanations of levels of credentialing i.e., Registration, whereby the law protects use of the title; Licenseure, whereby the law protects both the use of Title, and the defined scope of practice. If the Family Therapists are Registered, it would hold them out and apart from the clergy, psychologists and others that practice unless these other groups would join their American Therapists Group, pay dues, etc. The bill that comes out of Proposal No. 30, **HB 2017,** asks for Registration of Family Therapist. He then answered numerous questions.

Mr. Wolff then gave a comprehensive report on the end stage renal disease program that is detailed in the Interim Report, (Not recorded as an attachment). He noted this disease is the only disease that allows the patient to become eligible for Medicare reimbursement for treatments 60 days after being diagnosed by a physician. This eligibility is available to all end stage renal disease patients regardless of their age. Fiscal impact would be significant. A policy issue to consider in regard to this legislation is that there are 1500 Kansans currently eligible and the fiscal note for this program is 3.2 million dollars and will grow. Some testimony offered during Interim noted a broader view that would cover more of the population for the dollar benefit. He answered numerous questions.

Chair recognized Dr. Stanley Grant, Secretary Department of Health/ Environment.

Secretary Grant introduced numerous staff members and gave some background information on his Department. The management philosophy is to try to deal in a proactive stance rather than a reactive stance; work with an educational, rather than a regulatory, program; work with long-range planning wherever possible rather than short range; more local citizen involvement in decision-making rather than state-level involvement, and even less at the Federal level; like to work with preventive rather than remedial structures wherever possible. He outlined the organizational levels of the Department. He noted the Agency is funded in excess of 100 Million Dollars annually, most of most of this funding is Federal and is direct pass-through. Not money to be used internally, but to be sent to local units of government where it has been allocated.

Dr. Charles Konigsberg, Director of Health then offered his portion of presentation. He noted hand-out materials, Attachment No. 3, Kansas Health Status/Health Policy Issues, Attachment No. 4, Programs and Services of Ks. Department of Health/Environment, Attachment No. 5, National Health Objectives for the Year 2000.

Dr. Konigsberg then gave a brief overview of the health status of Kansans, noting there has been a shift in this century with the main causes of death now being cancer and heart disease. Unfortunately, he said we do not have a vaccine for those diseases. Challenges for the future, i.e., disease control; health care access;charitable health care provider bill implementation; rural health care; nursing home reform; quality child care.

Steve McDowell, Director of Rural Health/ Department of Health/Environment spoke to members noting his comments taken from Attachment No.3, pages 23 through 33. He highlighted priorities, indicated Rural Health Policy for the 90's; spoke of Essential Access Community Hospital Program. He detailed E.A.C.H. (Essential Access Community Hospitals) and PCH (Primary Care Hospitals).

Secretary Esther Wolf, Department on Aging thanked Chair for the opportunity to present an overview of the Department on Aging's priorities and challenges that must be met. She introduced her staff members, and Directors of Area Agencies on Aging.

She drew attention to handouts, (Attachment No. 6, Who's Who in Aging, Attachment No 7. Priorities, Attachment No.8., Senior Care Act, Attachment No. 9, her printed remarks. She highlighted hand-outs, then discussed priorities, both federal and state and how drastically changes are taking place. She noted that after one year evaluation of the Senior Care act indicates in-home services are a critical factor in keeping Kansans independent in their own homes. She discussed how vital nutrition programs are. Attachment 10

Ms. Wolf spoke of an on-going agenda. She would like to see a 14th month study in regard to redesigning. She offered to return to the committee to discuss their program further. She answered questions.

Mr. Myron Donavan explained office of Ombudsman and answered questions in that regard.

Chair thanked all Agency people for their comments.

Chair recommended members bring their Interim Report with them to committee as there will be more briefings on that report.

Meeting adjourned.

VISITOR REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

DATE Jan. 23, 1991

NAME	ORGANIZATION	ADDRESS
Annice D. White	JoCo AAA	301 A S Clairborne Olathe, KS
JAN BUEKER	KANSAS CHAPTER NASW	817 S.W. SIXTH TOPEKA
Lynda Doren	KDOR	Topeka
Jeff Montague	Budget	
Jan Barnes	SW KS Nutrition	Great Bend
~~Ralph Bridges~~	~~AARP~~	EC, KS
Paul Showalter	KDOA	TOPEKA
DAVID M TRASTER	KDHE	Topeka
Esther O Wolf	KDOA	Topeka
Norma Nichols	Ks Senior Center Director Assn	Baxter Springs
Charles Konigsberg	KDHE	Topeka
Michelle Lieston	John Peterson & Associates	Topeka
Marty Kennedy	DOB	"
Jack Keeler	KDHE	
Paula F Massoth	KDHE	Topeka
Deborah Taylor	KDHE	Topeka
Richard Morrissey	KDHE	"
Myron Dunavan	LTC Ombudsman	Topeka
Kristy Koscielny	Governors Office	TOPEKA
KEITH R LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS	"
David Hanzlick	KS Dental Ass'n	
Steve McDowell	KDHE	"
Stan Grant	KDHE	"

Mary Lou Waner

Susan M. Hamilton

Nancy Klostermeyer

Retired Senior Vol. Progs

1101 Kansas Great Bend, Kans 67530

Retired Senior Volunteer Program

111 South 3rd Marysville

Retired Senior Volunteer Prog. 236 N 7th, Suite B

(RSVP) Salina, KS 67401

Mr. Voth

SHL

(As Amended by SHL Committee on Public Health and Welfare A)

SILVER HAIRED LEGISLATURE RESOLUTION NO. 711

By PSA 1 and PSA 5

A RESOLUTION urging the Kansas state legislature to support national legislation providing a comprehensive national health plan that would cover all Americans.

WHEREAS, Assuring access to basic health services is not solely the responsibility of state government, but the joint responsibility of state, federal and local governments; providers; employers; insurers; and the private sector; and

WHEREAS, Health care must be provided equally, without discrimination to all members of our society; and

WHEREAS, Those in need of health care should not be penalized due to financial condition; and

WHEREAS, Medicare and medicaid have failed to meet the mandates of protecting the elderly, the disabled and poor; and

WHEREAS, Medicaid covers only 40% of the low-income population and critical home care and long-term care services remain uncovered; and

WHEREAS, Access to health care is limited to those having health insurance, but over 37 million Americans have no insurance coverage; one-third of those are children, two million are chronically ill and cannot obtain insurance and three-fourths are full-time workers and their dependents;

WHEREAS, A nationalized system of health care can be a step toward containing escalating health care: Now, therefore,

Be it resolved by the Silver Haired Legislature of the State of Kansas: That the Silver Haired Legislature urges the Kansas legislature to pass a resolution to support efforts in the United States Congress to pass legislation providing a comprehensive national health plan that would cover all Americans.

Attm # 1
PASSED
1-23-91

MEMORANDUM

Kansas Legislative Research Department

Room 545-N – Statehouse
Topeka, Kansas 66612-1586
(913) 296-3181

July 13, 1990

To: Special Committee on Public Health and Welfare

From: Bill Wolff, Principal Analyst

Re: Proposal No. 30 -- Registration of Marriage and Family Therapists

Proposal No. 30 -- Registration of Marriage and Family Therapists directs the Special Committee on Public Health and Welfare to:

> consider the desirability of creating a regulatory system under which marriage and family therapists who meet certain requirements could be registered by an agency of the state, including a review of the credentialing study conducted pursuant to the Kansas Act on Credentialing, identification of the number of individuals practicing as marriage and family therapists who are currently credentialed under other acts, and the effect of any regulation on persons who provide similar services.

Background

On February 1, 1983, representatives of the Kansas Association of Marriage and Family Therapists, filed a notice of intent to file an application seeking credentialing (licensure) with the Secretary of Health and Environment in accordance with the Kansas statutes applicable to health care personnel. The Secretary found that marriage and family therapists were "health care personnel" as defined in the statute and the petitioning group was invited to continue with its application for credentialing.

On September 7, 1987, a revised application for licensure was submitted by the marriage and family therapists to the Secretary for consideration. In accordance with the Kansas Act on Credentialing (Act) and the policies of the Department, a technical committee was appointed and was scheduled to meet ten times in the period October, 1987, through June, 1988. In her memorandum to the members of the technical committee, Cathy Rooney, Health Project Reviewer, Department of Health and Environment, noted that the statutes governing the credentialing of health care personnel had been revised significantly by the 1986 Legislature. Among the changes she noted was the inclusion of nine criteria in the Act pertaining to the issues of whether a need for protection from the unregulated occupation exists and what effects might credentialing of the occupation have on society. She also pointed out that the Act dictated the conditions that must be met in order to determine the appropriate action (licensure or registration) required to protect the public. Copies of the criteria were provided to the technical committee members at the outset of their deliberations.

House PHW
attm. # 2
1-23-91

Following meetings throughout the fall and winter months, the technical committee submitted its final report and recommendations to the Secretary of Health and Environment. In summary:

> The first section of this report is a summary of the findings, conclusions, and recommendations of the seven-member technical committee whose responsibility is to determine whether the statutory criteria on the need for credentialing of marriage and family therapist (MFTs) have been met. **The technical committee found all of the criteria on the need for credentialing met if the applicant agrees to change its definition of scope of practice. The technical committee found that the need for credentialing exists.**
>
> The second section of this report is an analysis of the various levels of credentialing that could be used to protect the public from the documented harm. **In summary, the technical committee concluded that licensure was not the appropriate level of credentialing; however, identification of properly educated and trained persons in marriage and family therapy is needed. Hence, the technical committee recommended registration of MFTs and that the registration law include a provision to mandate the distribution by MFTs to clients, prior to treatment, educational information referred to as a "client bill of rights."**

On June 9, 1988, the Secretary of Health and Environment, in accordance with the Act, submitted his findings and recommendations on the application seeking to license marriage and family therapists. In the executive summary of the Secretary's report, he said:

> I concur with the technical committee that all statutory criteria are met. However, I disagree with the technical committee's conclusion that there is a need to credential marriage and family therapists in order to protect the public from the documented harm. Therefore, I recommend that the application be denied since protection of the public can be improved without credentialing the occupation.
>
> The technical committee found that the only documented case of potential harm was due to sexual exploitation of clients by psychotherapists . . . . I agree with the findings and the conclusions made by the technical committee. However, I conclude that since regulation would not reduce the incidence of sexual exploitation, there is no need to credential marriage and family therapists. It appears that harm caused by sexual exploitation is not generated by a lack of specialized training but from ethical or moral failures. Credentialing protects the public by setting minimum standards of education and training in order to practice. Therefore, credentialing in this case would not address the issue of harm.

1989 Interim Study

The Secretary went on in the report to recommend that the Legislature consider enacting legislation similar to the Minnesota Client Protection System to offer the public protection from sexual exploitation by psychotherapists. That recommendation resulted in a 1989 interim study. Proposal No. 18 -- Mental Health Professionals, directed the Special Committee on Corrections/Mental Health to examine alternatives for recourse and redress available to consumers who are victims of sexual exploitation by mental health and counseling professionals.

PHCW
1-23-91

attm 2-2

In the course of the 1989 study, the Secretary of Health and Environment recommended four bills for consideration modeled after the Minnesota Client Protection System. After hearing from several groups, including the marriage and family therapists who testified in support of full licensure of all therapista, including marriage and family therapists, the Committee recommended one of the bills drafted by the Secretary. 1990 S.B. 425 would have incorporated into existing criminal law a new class E felony for commission of "sexual exploitation" as the term was defined, and a new class D felony, "aggravated sexual exploitation" as that term was defined. The interim committee did not recommend credentialing of any health care personnel and the 1990 Legislature did not act on S.B. 425.

1989 S.B. 257

In 1989, S.B. 257 was drafted and introduced at the request of the Kansas Association For Marriage and Family Therapy. No action was taken that year, but hearings were held before the Senate Committee on Public Health and Welfare. The Committee amended the bill and recommended its passage. S.B. 257 was further amended by the Senate Committee of the Whole and passed as amended on a vote of 40 to 0. In the House of Representatives, the bill was referred to the House Committee on Governmental Organization where hearings were held on April 3, 1990. Following the hearing and Committee discussion, the subject matter of S.B. 257 was recommended for interim study.

Kansas Act on Credentialing

The task of this interim committee is not to work S.B. 257. Rather, the charge is clear that you are to consider the desirability creating a regulatory system under which marriage and family therapists could be registered (credentialed?) by an agency of the state. In light of this charge, it seems appropriate to review the Kansas Act on Credentialing to reacquaint you with the statutory findings necessary to recommend credentialing, and the findings necessary to recommend the appropriate level of credentialing. (See attachment.)

The Kansas Act on Credentialing was enacted in 1980 following two interim committee studies and a study requested by the Legislature carried out by the Statewide Health Coordinating Council. The studies were done because the Public Health and Welfare committees were faced with a number of bills that would have resulted in licensing various groups of health care providers, and numerous studies had shown that licensing, registration, or certification of health care providers may have unintended results, among which are increasing the cost of health care, decreasing the pool of people who are available to provide the health care service, raising the educational level required to enter the field of health care resulting in persons who may be well qualified to carry out a health procedure being disqualified from doing so, and restricting the practice of persons who are already providing health care although under another title or authorization. The Kansas Act was the third in the nation to be enacted.

The statutes enacted in 1980 were extensively amended in 1986, to set out a procedure for a precredentialing review by a group of Kansans appointed by the Secretary of Health and Environment after the group seeking to be credentialed has submitted an application signed by at least 100 Kansans requesting a review of the need for licensure, registration, or some other form of state recognition. The seven-member technical committee, which may include no more than three health care providers, follows the procedures set out in the Act, including conducting hearings that are open to the public on issues outlined in the law. In order to recommend that a provider group be licensed, registered, or otherwise recognized by the state through legislative action, the technical committee must find that the applicant group meets each one of nine criteria set out in the law. If the technical

PHall
1-23-91
Attm # 2-3

committee recommends some form of credentialing, it must also recommend the appropriate level of credentialing. After the technical committee has submitted its findings and recommendations to the Secretary of Health and Environment, the Secretary must carry out his or her own review, based upon the record submitted by the technical committee, and make recommendations to the Legislature. Both the findings and recommendations of the technical committee and the Secretary are submitted to the Legislature, along with the record created during the credentialing review.

Pttee
1-23-91
attm 2-4

[redacted]

Attorney General's Opinions:
Practice of optometry; opticians fitting contact lenses. 88-169.

65-5001. Credentialing health care personnel; definitions. As used in this act unless the context requires otherwise, the following words and phrases shall have the meanings respectively ascribed to them herein:

(a) "Credentialing" or "credentialed" means the formal recognition of professional or technical competence through the process of registration, licensure or other statutory regulation.

(b) "Certification" means the process by which a nongovernmental agency or association or the federal government grants recognition to an individual who has met certain predetermined qualifications specified by the nongovernmental agency or association or the federal government.

(c) "Registration" means the process by which the state identifies and lists on an official roster those persons who meet predetermined qualifications and who will be the only persons permitted to use a designated title.

(d) "Licensure" means a method of regulation by which the state grants permission to persons who meet predetermined qualifications to engage in an occupation or profession, and that to engage in such occupation or profession without a license is unlawful.

(e) "Health care personnel" means those persons whose principal functions, customarily performed for remuneration, are to render services, directly or indirectly, to individuals for the purpose of:

(1) Preventing physical, mental or emotional illness;

(2) detecting, diagnosing and treating illness;

(3) facilitating recovery from illness; or

(4) providing rehabilitative or continuing care following illness; and who are qualified by training, education or experience to do so.

(f) "Provider of health care" means an individual:

(1) Who is a direct provider of health care (including but not limited to a person licensed to practice medicine and surgery, licensed dentist, registered professional nurse, licensed practical nurse, licensed podiatrist, or physician's assistant) in that the individual's primary current activity is the provision of health care to individuals or the administration of facilities or institutions (including medical care facilities, long-term care facilities, outpatient facilities, and health maintenance organizations) in which such care is provided and, when required by state law, the individual has received professional training in the provision of such care or in such administration and is licensed or certified for such provision or administration;

(2) who holds a fiduciary position with, or has a fiduciary interest in, any entity described in subsection (f)(3)(B) or subsection (f)(3)(D) other than an entity described in either such subsection which is also an entity described in section 501(c)(3) of the internal revenue code of 1954, as amended and supplemented, and which does not have as its primary purpose the delivery of health care, the conduct of research, the conduct of instruction for health professionals or the production of drugs or articles described in subsection (f)(3)(C);

(3) who receives, either directly or through a spouse, more than 1/5 of such person's gross annual income from any one or combination of the following:

(A) Fees or other compensation for research into or instruction in the provision of health care;

(B) entities engaged in the provision of health care or in such research or instruction;

(C) producing or supplying drugs or other articles for individuals or entities for use in the provision of or in research into or instruction in the provision of health care; or

(D) entities engaged in producing drugs or such other articles;

(4) who is a member of the immediate family of an individual described in subsection (f)(1), (f)(2) or (f)(3); or

(5) who is engaged in issuing any policy or contract of individual or group health insurance or hospital or medical service benefits. An individual shall not be considered a provider of health care solely because the individual is a member of the governing board of an entity described in subsection (f)(3)(B) or subsection (f)(3)(D).

(g) "Consumer of health care" means an individual who is not a provider of health care.

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

History: L. 1980, ch. 181, § 1; L. 1986, ch. 246, § 1; L. 1987, ch. 232, § 2; L. 1988, ch. 246, § 22; July 1.

PH+W
1-23-91
Attm # 2-5

65-5002. Same; credentialing applications; fees. (a) Health care personnel seeking to be credentialed by the state shall submit a credentialing application to the secretary upon forms approved by the secretary. The application shall be accompanied by an application fee of $1,000. The secretary shall not accept a credentialing application unless such application is accompanied by the application fee and is signed by 100 or more Kansas resident proponents of credentialing the health care occupation or profession seeking to be credentialed. All credentialing applications accepted by the secretary shall be referred to the technical committee for review and recommendation in accordance with the provisions of this act and rules and regulations adopted by the secretary. The application fee established under this subsection (a) shall apply to every group of health care personnel which submits a credentialing application to the secretary on and after the effective date of this act and to every group of health care personnel which has not filed both a notice of intention and a fully answered application before the effective date of this act.

(b) The secretary shall remit all moneys received from fees under this section to the state treasurer at least monthly. Upon receipt of each such remittance, the state treasurer shall deposit the entire amount thereof in the state treasury to the credit of the state general fund.

History: L. 1980, ch. 181, § 2; L. 1986, ch. 246, § 2; L. 1987, ch. 232, § 3; July 1.

PH&W
1-23-91
attn 2-6

65-5003. Same; appointment of technical committee; hearings; evidence; criteria; findings; recommendations and report. (a) A technical committee shall be appointed by the secretary to examine and investigate each credentialing application referred by the secretary. Seven persons shall be appointed to each technical committee and such persons shall be appointed for a term of one year. Within 120 days after the expiration of such term, the secretary shall appoint a successor to fill such vacancy. The chairperson of the technical committee shall be designated by the secretary. Three members of the technical committee shall be health care personnel currently credentialed under the laws of this state. Four members of the technical committee shall be consumers of health care who are not also providers of health care. No member of the technical committee shall have a direct economic or personal interest in the credentialing or noncredentialing of health care personnel whose application for credentialing will be reviewed by the technical committee. If a member of the technical committee has a direct economic or personal interest in the credentialing or noncredentialing of health care personnel whose application for credentialing will be reviewed by the technical committee or otherwise has a conflict of interest concerning the credentialing or noncredentialing of health care personnel whose application for credentialing will be reviewed by the technical committee, the secretary shall replace such member on the technical committee by appointing a new member to the technical committee. The new member shall serve for the remainder of the term of the original member. A vacancy on the technical committee shall be filled by appointment within 120 days after such vacancy by the secretary for the remainder of the unexpired term of the vacant position.

(b) Each technical committee, as soon as possible after appointment of the members thereof, shall organize and review any credentialing application assigned to such committee by the secretary. The technical committee shall conduct fact-finding hearings and shall otherwise investigate the credentialing application.

(c) The technical committee shall attempt to obtain evidence and testimony from persons in support of the application and from persons opposed to the application, but evidence and testimony shall not be limited only to such persons. All interested persons shall have an opportunity to give evidence and testimony subject to such reasonable conditions as may be established by the technical committee in the conduct of the hearing and subject to applicable rules and regulations established under this act. A notice of all meetings of the technical committee shall be published in the Kansas register at least 30 days prior to the day of the meeting. The notice shall state the time and place of the meeting.

(d) The technical committee shall make findings in an objective, unbiased manner based on the criteria established in K.S.A. 65-5006 and amendments thereto. Credentialing applicants shall have the burden of bringing forth evidence upon which findings may be made and shall have the burden of proving by clear and convincing evidence that the health care provider occupation or profession should be credentialed by the state. The evidence required to sustain this burden of proof shall be more than hypothetical examples or testimonials. The technical committee shall detail its findings in a report and shall file the report with the secretary. The technical committee shall complete hearings and shall file a report for any applicant group of health care personnel that has begun the process.

(e) If the technical committee determines after consideration of the evidence and testimony that all the criteria established by law or by rules and regulations for credentialing have not been met and that credentialing is not appropriate, the technical committee shall recommend that an application for credentialing be denied. If the technical committee determines after consideration of the evidence and testimony that clear and convincing evidence has been presented that an occupational or professional group of health care personnel has met all the criteria established by law or by rules and regulations for credentialing and that credentialing by the state is appropriate, the technical committee shall recommend the application for credentialing be approved. If the technical committee recommends that the application for credentialing be approved, there shall be included in the committee's report a recommendation of the level or levels of credentialing, and such recommendation shall be based upon a finding by the technical committee, stated in the report, that all criteria established by law or by rules and regulations for the recommended level or levels of credentialing have been met. This recommendation shall be based on the criteria established in K.S.A. 65-5007 and amendments thereto.

History: L. 1980, ch. 181, § 3; L. 1986, ch. 246, § 3; L. 1987, ch. 232, § 4; July 1.

65-5004.

History: L. 1980, ch. 181, § 4; L. 1986, ch. 246, § 4; Repealed, L. 1987, ch. 232, § 11; July 1.

Rptd
1-23-91

Attn # 2-7

65-5005. Same; review of reports by secretary; recommendations of secretary; final report to legislature. (a) Within 120 days after receiving the report and recommendations of the technical committee relating to a credentialing application, the secretary shall prepare a final report for the legislature. In preparing the final report, the secretary shall apply the criteria established by K.S.A. 65-5006 and 65-5007 and amendments to these sections. The final report shall be submitted to the speaker of the house of representatives, to the president of the senate and to the chairpersons of the committees on public health and welfare for consideration by their respective committees. The secretary shall include the report of the technical committee in the final report prepared for submission to the legislature. The secretary need not be bound by the recommendations of a technical committee.

(b) If the secretary determines after consideration of the report of the technical committee and the evidence and testimony presented to the technical committee that all criteria established by law or by rules and regulations for credentialing have not been met and that credentialing is not appropriate, the secretary shall recommend that no legislative action be taken on a credentialing application. If the secretary determines that clear and convincing evidence which was more than hypothetical examples or testimonials was presented to the technical committee that the applicant occupational or professional group of health care personnel should be credentialed by the state, that the applicant occupational or professional group of health care personnel has met all the criteria established by law or by rules and regulations for credentialing and that credentialing by the state is appropriate, the secretary shall recommend that the occupational or professional group of health care personnel be credentialed. If the secretary recommends that an occupational or professional group of health care personnel be credentialed, the secretary shall recommend: (1) The level or levels of credentialing, and such recommendation shall be based upon a finding by the secretary, stated in the report, that all criteria established by law or by rules and regulations concerning the recommended level or levels of credentialing have been met; (2) an agency to be responsible for the credentialing process and the level or levels of credentialing; and (3) such matters as the secretary deems appropriate for possible inclusion in legislation relating to the recommendation for credentialing.

(c) No group of health care personnel shall be credentialed except by an act of the legislature. The final report of the secretary and the report and recommendations of the technical committee shall constitute recommendations to the legislature and shall not be binding upon the legislature. The legislature may dispose of such recommendations and reports as it deems appropriate.

History: L. 1980, ch. 181, § 5; L. 1986, ch. 246, § 5; L. 1987, ch. 232, § 5; July 1.

PH&W
1-23-91
Attm #
2-8

65-5006. Same; credentialing criteria. (a) The technical committee appointed pursuant to K.S.A. 65-5003 and amendments thereto and the secretary shall apply the following criteria to each credentialing application:

(1) The unregulated practice of the occupation or profession can harm or endanger the health, safety or welfare of the public and the potential for such harm is recognizable and not remote;

(2) the practice of the occupation or profession requires an identifiable body of knowledge or proficiency in procedures, or both, acquired through a formal period of advanced study or training, and the public needs and will benefit by assurances of initial and continuing occupational or professional ability;

(3) if the practice of the occupation or profession is performed, for the most part, under the direction of other health care personnel or inpatient facilities providing health care services, such arrangement is not adequate to protect the public from persons performing noncredentialed functions and procedures;

(4) the public is not effectively protected from harm by certification of members of the occupation or profession or by means other than credentialing;

(5) the effect of credentialing of the occupation or profession on the cost of health care to the public is minimal;

(6) the effect of credentialing of the occupation or profession on the availability of health care personnel providing services provided by such occupation or profession is minimal;

(7) the scope of practice of the occupation or profession is identifiable;

(8) the effect of credentialing of the occupation or profession on the scope of practice of other health care personnel, whether or not credentialed under state law, is minimal; and

(9) nationally recognized standards of education or training exist for the practice of the occupation or profession and are identifiable.

(b) Reports of the technical committee, and the secretary shall include specific findings on the criteria set forth in subsection (a). No report of the technical committee or the secretary shall recommend credentialing of any occupational or professional group of health care personnel unless all the criteria set forth in subsection (a) have been met.

History: L. 1980, ch. 181, § 6; L. 1986, ch. 246, § 6; L. 1987, ch. 232, § 6; July 1.

PH+a)
1-23-91
attm. # 2-9

65-5007. Same: criteria applicable to levels of credentialing regulation. (a) All recommendations of the technical committee and the secretary which relate to the level or levels of credentialing regulation of a particular group of health care personnel shall be consistent with the policy that the least regulatory means of assuring the protection of the public is preferred and shall be based on alternatives which include, from least regulatory to most regulatory, the following:

(1) Statutory regulation, other than registration or licensure, by the creation or extension of statutory causes of civil action, the creation or extension of criminal prohibitions or the creation or extension of injunctive remedies is the appropriate level when this level will adequately protect the public's health, safety or welfare.

(2) Registration is the appropriate level when statutory regulation under paragraph a)(1) is not adequate to protect the public's health, safety or welfare and when registration will adequately protect the public health, safety or welfare by identifying practitioners who possess certain minimum occupational or professional skills so that members of the public may have a substantial basis for relying on the services of such practitioners.

(3) Licensure is the appropriate level when statutory regulation under paragraph (a)(1) and registration under paragraph (a)(2) is not adequate to protect the public's health, safety or welfare and when the occupational or professional groups of health care personnel to be licensed perform functions not ordinarily performed by persons in other occupations or professions.

(b) Reports of the technical committee and the secretary shall include specific findings on the criteria set forth in subsection (a). No report of the technical committee or the secretary shall recommend the level or levels of credentialing of any occupational or professional group of health care personnel unless all the criteria set forth in subsection (a) for the recommended level or levels of credentialing have been met.

History: L. 1980, ch. 181, § 7; L. 1986, ch. 246, § 7; L. 1987, ch. 232, § 7; July 1.

Phred 1-23-91 # Attm 2-10

65-5008. Same; periodic review of credentialing status of health care personnel. The secretary shall periodically schedule for review the credentialing status of health care personnel who are credentialed pursuant to existing laws. The procedures to be followed, the criteria to be applied and the reports to be submitted for credentialing applications filed pursuant to K.S.A. 65-5002 and amendments thereto shall apply to credentialing reviews conducted pursuant to this section.

History: L. 1980, ch. 181, § 8; L. 1987, ch. 232, § 8; July 1.

65-5009. Same; records; duties of secretary; rules and regulations; compensation of members of technical committee. (a) The secretary shall provide all necessary professional and clerical services to the technical committee. Records of all official actions and minutes of all business coming before the technical committee shall be kept. The secretary shall be the custodian of all records, documents and other property of the technical committee.

(b) The secretary shall adopt rules and regulations necessary to implement the provisions of this act including, but not limited to, rules and regulations establishing the policies and procedures to be followed by the technical committee in the consideration of credentialing applications under this act.

(c) Members of the technical committee appointed pursuant to K.S.A. 65-5003 and amendments thereto shall be paid subsistence allowances, mileage and other expenses as provided in K.S.A. 75-3223 and amendments thereto when in attendance at a meeting of the technical committee authorized by the secretary.

History: L. 1980, ch. 181, § 9; L. 1986, ch. 246, § 8; L. 1987, ch. 232, § 9; July 1.

65-5010. Same; title of act. This act shall be known and may be cited as the Kansas act on credentialing.

History: L. 1980, ch. 181, § 10; July 1.

65-5011. Application of act to certain credentialing applications. Except as otherwise provided in this act, the review of an application for credentialing commenced prior to the effective date of this act shall be governed by the provisions of this act which apply to that part of the review of such application which was not completed prior to the effective date of this act. The secretary shall authorize an original application for credentialing filed prior to the effective date of this act, to be amended to address the standards and criteria established under this act. Nothing in this section shall be construed to require the filing of a new application with the secretary.

History: L. 1986, ch. 246, § 9; April 24.

PA&CJ
1-23-91
Attm 2-11

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

Division of Health

Briefing for House Committee on Public Health and Welfare

Kansas Health Status and Health Policy Issues

January 23, 1991

PH&W
Attm. #3.
1-23-91

Kansas Health Status
and
Health Policy Issues
Table of Contents

PH&W
attm. #3
1-23-91
3-2

INTRODUCTION

The mission of the Division of Health is to protect and promote the health of Kansans through a variety of public health service delivery and regulatory programs. These programs are designed to: protect Kansans from communicable disease; ensure healthy and safe adult and child care facilities; assure proper sanitation in food services; assess environmental health risks; improve access to medical care for low income Kansans and pregnant women, children, and families who are at risk for poor health; and combat chronic disease by promoting healthy lifestyles.

There is a strong partnership between State and local health departments in the delivery of public health services. The role of the Kansas Department of Health and Environment (KDHE) is to assure services through: the provision of funding assistance to local agencies; establishing statewide policies and procedures; and program consultation, planning, implementation and evaluation. With some exceptions, local health departments are the service delivery component of the partnership.

Program activities of the Division of Health are carried out by staff assigned to six bureaus and offices. (Attachment 1)

I. HEALTH STATUS OF KANSANS

Throughout the past decades, the profile of the health status of Kansans has changed. The reduction in incidence of infectious diseases is perhaps the most significant public health achievement of the past 100 years. Improvements in basic hygiene, food production and food handling and water treatment as well as the development and widespread use of vaccines have contributed to this accomplishment. Major declines in death rates for three of the leading causes of death among Americans; heart disease, stroke, and motor vehicle crashes, have occurred. Infant mortality has decreased and some childhood infectious diseases have been nearly eliminated.
While the thrust of public health disease control efforts has been the control of communicable diseases, today's public health agenda focuses increasingly on health promotion and disease prevention. Chronic diseases and injuries dominate the list of leading causes of death in Kansas (Attachment 2) and are responsible for the greatest number of years of potential life lost (Attachment 3).

Cardiovascular diseases cause nearly half of all deaths in Kansas, yet, much of coronary artery disease is preventable. Clinical trials have demonstrated repeatedly that reductions in major risk factors--high blood pressure, high blood cholesterol and smoking--have a significant impact on cardiovascular mortality and morbidity.

Cancer accounts for about one of every five deaths in Kansas. Nearly one in three Kansans now living will eventually have cancer. This risk can be significantly reduced when adequate preventive measures are taken. For example, tobacco has been estimated to account for 30% of cancers and epidemiological research suggests that diets relatively low in fat and higher in foods containing fiber may help prevent colon, rectal, breast, prostate and other cancers.

Stroke caused 1,607 deaths in Kansas in 1989. Black men have the highest

rate of stroke among all population groups, with a death rate from stroke about twice that of white men and a substantially higher rate than for black women. This can be attributed to the fact that people with uncontrolled high blood pressure experience seven times the risk of developing a stroke as those with normal blood pressure. Overall, blacks have a higher prevalence of high blood pressure than whites (38 percent versus 29 percent).

Unintentional injuries were the fifth leading cause of death among Kansans in 1989. They pose an even greater threat to Kansas' younger population, as they are the number one cause of death for Kansans age 1-44. The total cost of injuries to our state is enormous; in 1985 it was estimated to be $1.6 billion per year with direct expenditures of $448 million per year. State funds bear the cost of approximately seven percent of the direct expenditures for injury treatment and rehabilitation by way of Medicaid and other expenditures.

Violent and abusive behaviors are another cause of injury-related death and long-term disability, particularly in the 15-24 age group. Suicide was the second leading cause of death among people in that age group in 1989.

Despite the impressive progress in the area of communicable diseases, pneumonia and influenza rank as the sixth leading cause of death in Kansas.

Diabetes, in addition to being the seventh leading cause of death in Kansas, is accountable for 30% of kidney failure cases, is the second leading cause of blindness in aged 45-74, causes half of all non-traumatic amputations, and causes a threefold increase in risk for congenital malformations and perinatal mortality among babies of diabetic mothers.

Atherosclerosis was the ninth leading cause of death in Kansas in 1989, followed by nephritis as the tenth leading cause of death.

Age Groups

The health profile of Kansas children has shifted markedly in the past 40 years. Once dominated by the threat of major infectious disease, such as polio, diphtheria, scarlet fever, pneumonia, measles and whooping cough, today, widespread immunization has virtually eliminated many of these diseases. Unintentional injuries have replaced infectious diseases as the leading cause of death and cause of greatest concern for the health of children in the 1-14 year age group (Attachment 4).

The years from 15-24 are a time of changing health hazards. The dominant preventable health problems of adolescents and young adults fall into two major categories: injuries and violence that kill and disable many before they reach age 25, and emerging lifestyles that affect their health many years later.

In the 25-34 age group, the increasing public health burden of AIDS becomes apparent. AIDS was responsible for 35 deaths in Kansas in 1989. There were 101 new Kansas AIDS cases reported in 1989; 135 new cases in 1990, which represents an increase of 35%. Hemophiliacs, minorities, women, children and heterosexuals made up the populations which experienced the greatest increases.

AIDS does not yet appear as a leading cause of death in the 35-44 year age group, but the number of new cases of AIDS in this age group increased by five percent from 1989 to 1990. The increasing trend is expected to continue and accelerate.

Perhaps more than any other age group, adults have the opportunity to assume personal responsibility for their health. Many of the leading causes of death for people between the ages of 25 and 65 are preventable through changes in lifestyle. As deaths from heart disease have declined, cancer has become the leading cause of death for people aged 25-64. (Attachment 5) To better assess the health risk behaviors of Kansans, the KDHE has recently conducted a randomly dialed telephone survey of 820 Kansas residents. The

survey is part of a national surveillance system developed by the CDC and includes questions on fitness, dietary habits, smoking, seat-belt use and other factors that have an impact on health. This health status data, when combined with Kansas' mortality and morbidity statistics, will enable public health officials to establish priorities and develop health promotion and educational strategies specific to the needs of Kansas.

As the population of Kansas grows older, the problems posed by chronic and disabling conditions increasingly demand attention. Compared with other states, Kansas has a disproportionately high percentage of elderly residents (those over 65 years of age). The state ranks 32nd in terms of total residents, but 11th in terms of proportion of elderly to the total population. By the year 2000, the aged will represent 14.2% of the population.

Chronic Disabling Conditions

Preventing unnecessary deaths is only one item on the public health agenda for chronic disease and injury. The preservation of physical and mental function is also essential. Quality, not merely quantity, of life has become the issue.

Roughly 33 million Americans have physical or mental impairments that limit their activity, and more than 9 million have functional limitations so severe that they cannot work, attend school, or maintain a household.

KDHE staff have played a key role in the development of the Kansas Prevention Plan for reduction of developmental disabilities in our state. The plan addresses women's preconceptual health status, school health programs, prenatal care, maternal and child nutrition, drugs and pregnancy, adolescent pregnancy, children's health, unintentional injury, identification of and early intervention with children at risk for a developmental disability, child abuse and the reproductive status and parenting skills of adolescents and adults with cognitive disabilities.

II. HEALTH POLICY ISSUES

A. Disease Control

Public health measures and improved living standards have been effective during this century in controlling most of the dreaded communicable diseases of the past. Even so, control of communicable diseases is an ongoing process. Lapses in vigilance and effort will result in new outbreaks as evidenced in recent outbreaks in this nation of measles, tuberculosis and syphilis. In addition, a new infectious disease, AIDS, has presented challenges to this nation to an extent exceeding any other infectious disease in a generation.

One measure of the effectiveness of the public health system is the success in controlling vaccine preventable diseases, such as measles, mumps, rubella, poliomyelitis, diphtheria and others. Unfortunately, outbreaks of mumps and measles, including outbreaks here in Kansas, have been occurring during the past several years. The major causes of these outbreaks primarily relates to failure in immunizing our preschool children and, and to a lesser extent, failures of the vaccine. A second measles, mumps and rubella (MMR) immunization coupled with intensified efforts of delivering vaccine to the children by both the public and private sectors is crucial to once again control these entirely preventable diseases. New vaccines for Hemophilus Influenza disease are now available. It is possible that a varicella (chickenpox) vaccine will be available in the near future. New vaccines, expanded indications for vaccines and major price increases have caused federal funds for vaccines to fall short of actual costs to the state.

While the great killers of the early part of this century were communicable diseases, the major killers and cripplers of more recent years are the chronic diseases and injuries. Heart disease, cancers and strokes continue to be the top three killers with accidents and diabetes major concerns as well. Unfortunately, these diseases do not lend themselves to such direct solutions as immunizations or dramatic cures with antibiotics. These diseases are best

dealt with by preventing them or at least their complications. These preventive interventions must be aimed at lifestyle changes over long periods of time.

B. Health Care Access Problems

Skyrocketing health care costs continue to dominate the concerns surrounding health care in Kansas. While an obvious problem, it is but one of the pressing issues jeopardizing Kansans' health. **Limited access, physician shortages,** and **rapidly changing health delivery systems** are equally critical problems in our state, all demanding effective solutions. There are predictions of more hospital closures in rural Kansas. 375,000 Kansans are reported to be without a means to pay for health care. Health manpower shortages plague both rural and urban areas of the state. There are increasing pressures on the public health delivery system brought about by increased technology and the growing population of medically indigent in Kansas.

The Office of Local and Rural Health Systems was created to develop an integrated approach to dealing with these complex issues. (Attachment 6) The goals of the Office of Local and Rural Health Systems are threefold:

- **develop systems to coordinate existing state, federal and private initiatives,**
- **coordinate funding strategies for maximum efficiency, and**
- **facilitate delivery system changes where needed.**

Rural Health

The **Rural Health Program** focuses on problems of access to and delivery of health services in Kansas. (Attachments 7, 8, 9, 10) Extensive meetings have been held around the State to determine health care needs and expectations. The Program provides community education and technical assistance to support the development of quality health centers in small Kansas

communities. It also coordinates efforts to alleviate shortages of physicians and other health professionals in rural areas. Additionally, this Program is the site for a joint grant with the Kansas Hospital Association and the Board of Emergency Medical Services aimed at studying and implementing the Essential Access Community Hospital (EACH) pilot project. (Attachments 11, 12) This project focuses on assuring access to primary care throughout Kansas by developing self-supporting community health systems using existing small hospitals as the hub.

Local Health

With few exceptions, the delivery system for public health services in Kansas has historically been one autonomous health department per county. Given the challenges of the modern health care market, it is generally recognized that this is an inefficient model for the development and delivery of a full range of preventive services. The **Local Public Health Program** is encouraging small health departments to join together to provide complete services. A unified Public Health Information System is being developed to aid in the collection of important service data. In addition to the regular preventive health services, local departments are being swamped with requests for primary medical care from citizens unable to pay. The Local Public Health Program, in conjunction with the Primary Care Program, is working to educate the public on the difference between public health services and primary care services, and to coordinate services from primary care providers in indigent care clinics in Kansas. Because of a deep concern with the public health services delivery system in Kansas, a study of the system, commissioned jointly by the Kansas Public Health Association, the Association of Local Health Departments and the Kansas Department of Health and Environment, was begun in January, 1990. A report reflecting the findings of that study will be available by April, 1991, and will include policy recommendations regarding the role, organization, and financing of public health programs at both the state and local levels in Kansas.

Primary Care

The **Primary Care Program** grew out of the need to coordinate efforts to assure health care access. The Primary Care Program has begun to assess the primary care needs of the medically indigent, coordinate recruitment and retention of health manpower in underserved areas, facilitate the development of indigent care clinics in the state and coordinate them with public health efforts where appropriate. (Attachment 13) The Program directs the Primary Care Cooperative Agreement, Migrant Health and Refugee Health activities. The Program also oversees the Charitable Health Provider activities. Charitable Health Provider rules and regulations have been written and applications for providers to participate in the program are now being accepted. In addition the Program has worked on the development of Primary Care Demonstration Projects for local health departments. This concept grew out of the Commission on Medically Indigent and the Homeless, and proposes to enhance the capability of local health departments so that they might provide both public health and primary care services in one coordinated effort.

Infant Mortality/Prenatal Care

Infant mortality rates are a leading indicator of perinatal care. Kansas met the 1990 Objectives for the nation in overall infant mortality with a rate of 7.9/1000 live births in 1988. There has been a steady decline in Kansas' infant mortality since 1984 except for racial/ethnic groups. Like the national rates the disparity between white and racial/ethnic rates is striking. The infant mortality rate for blacks of 16/1000 live births in Kansas is more than double that for whites. While the rate for other ethnic groups was 50% higher than for whites.

The Kansas Department of Health and Environment is actively involved in improving access to health care for pregnant women and their children. The agency promotes participation in early and continuous prenatal care which is the key to preventing low birth weight and infant mortality. A special focus

is placed on women who are uninsured or have other health care access barriers.

A significant investment in prenatal care for women in Kansas was made when the 1990 legislature committed an additional $1.0 million SGF for the Maternal and Infant (M&I) Program, to increase the number of pregnant women who receive adequate prenatal care. These funds brought to $2.3 million the total in program funding being committed to facilitating access to prenatal care. Prior to the 1990 funding increase, there were 21 M&I projects in 46 counties. In FY 1991, there are 23 projects in 69 counties. Local agencies estimate that approximately 2,100 additional pregnant women will be served with the additional funding. Given the disparity in infant mortality rates between racial/ethnic groups and whites a significant portion of the new funds has been targeted to assessment of barriers to access and to providing additional outreach activities for minority populations. Increasing access to health care addresses four issues: removal of financial barriers; removal of geographic and administrative barriers; removal of social and cultural barriers; and, provision of early, high-quality care.

Acquired Immune Deficiency Syndrome (AIDS)

AIDS and Human immunodeficiency Virus (HIV) infection will become more of an issue with respect to health care delivery issues in Kansas as the number of cases increases and the therapeutic interventions become more effective. At present 442 Kansans have been diagnosed with fullblown AIDS, but this figure understates the impact on the health care and social care systems. Additional cases of AIDS diagnosed elsewhere come home to Kansas. In addition, it is estimated that several thousand Kansans are infected with HIV, many of whom will require early intervention with followup and drugs to delay the progression of late stage HIV infection, including AIDS. While Kansas expects to receive some new funds from the Ryan White AIDS Care Act and some continuing funds for AZT, these funds will fall short of what will actually be needed to provide care and drugs for individuals with AIDS and for early intervention for the infected.

The Kansas Department of Health and Environment (KDHE) has developed a **Seven Point AIDS/HIV Prevention and Intervention Plan** to serve as a guide in properly planning and implementing statewide prevention/intervention techniques. Recommendations of the 1987 Task Force on AIDS have been made a part of the Plan.

There can only be speculation regarding the dollar cost of dealing with the AIDs problem in the future. It is generally accepted that substantial federal dollars will continue to be committed to the AIDS Program. However, the form and substance that funding might take is uncertain, although recent allocation of funds for the Ryan White bill has expanded the scope of the federal program.

Although, AIDS is known to have affected 442 Kansans, what is not known is the number, estimated to be in the thousands, who are HIV positive, who may unknowingly be infecting others, and who will require medical care in the future as they convert to disease status. KDHE, as a part of the Seven Point Plan, has begun implementing a Care Coordination Program designed to assure the provision of medical, psycho-social and behavior modification services while recognizing that public health's first and foremost responsibility should be primary prevention by halting the transmission of HIV infection.

C. Health Planning

Year 2000 Health Objectives

Clearly there are challenges ahead for public health in Kansas. The achievements in reducing infectious diseases and improving health status of Americans via effective vaccines and antibiotics have influenced today's national health agenda which focusses increasingly on health promotion and disease prevention. The KDHE is preparing to implement a process to develop Year 2000 health objectives specific to Kansas and compatible with the Year 2000 health objectives for the Nation. There were recently

developed by a consortium of national health organizations and state health departments. The development of Kansas Health Promotion and Disease Prevention Objectives will initiate an organized, decade-long effort to achieve the objectives. The campaign will be called Healthy Kansans 2000 and will parallel the national Healthy People 2000 campaign. The objectives adopted for Healthy Kansans 2000 will reflect the consensus of public health agencies, voluntary health organizations, private health foundation, health provider trade and professional association, private industry, and other groups interested in health affairs and health care costs. While the national objectives are inclusive and comprise some 290 objectives grouped in 21 priority areas. The Kansas Objectives will focus on only the highest priority objectives.

Healthy Kansans 2000 will offer the opportunity for state government to provide needed leadership to establish a consensus on priority areas for investment of both public and private resources to achieve desired improvements in health status; and, to maximize the potential for health promotion and disease prevention efforts to restrain future increases in health care costs. In addition, future federal support for health programs will be keyed to achieving established Year 2000 Objectives.

Health Data Systems

Virtually every board, task force, commission and committee that has looked at a major health policy issue in Kansas in recent years has recognized the basic problem of the lack of relevant data on which to base policy judgments. This last summer, the Special Committee on Public Health and Welfare considered a proposal to establish a specific health data program for the state. The Department is supportive of the recommendations of the Special Committee and recognizes the need to design a system that will produce information relevant to the highest priority health policy issues facing the state. The Department will pursue the possibility that grant funds may be available through the Kellogg Foundation to support development of such a system.

D. Environmental Health Risk

During the past two decades, federal and state governments have made major investments in environmental protection. Relatively little emphasis has been given to setting priorities based on human health and ecological risks. Federal and state approaches to environmental protection have been mainly regulatory and reactive, often responding to public and political pressures. The scientific body of knowledge regarding health risks is inadequate in many cases. The Environmental Protection Agency (EPA) is moving toward a new approach to environmental protection based on the recommendations of their Scientific Advisory Board. The Board recommends that EPA target environmental protection efforts based on the opportunities for greatest risk reduction; that EPA should reflect risk-based priorities in its strategic planning processes; that EPA should reflect risk-based priorities in its budget process; and, that pollution prevention should be the preferred option for reducing risk.

KDHE has recognized the need for developing risk assessment capacities to help set environmental priorities and as a basis for communicating with citizens. With the exception of a federally funded project for Galena, Kansas, the department has as yet been unable to fund and implement environmental risk assessment on a statewide basis. We believe that such a capacity is essential for the department and the state to effectively carry out environmental protection strategies as outlined by EPA.

E. Quality of Child Care

The health and safety of children in out of home care is an ever increasing concern in Kansas as in the nation. The Child Care Licensing and Registration Program regulates nearly 11,000 day care centers, family day care homes, and other facilities providing care for children. (Attachment 14) Inspections and investigations of complaints are carried out by local health departments through contract with KDHE. Growth in the number of

facilities regulated and the numbers of children in care has far outstripped the available regulatory resources. The program in KDHE is understaffed and operates with an inefficient manual record system. Reimbursement to local health departments is less than the cost they incur. Several health departments have been forced to discontinue their inspection contracts because of this discrepancy and it is likely that several more may do so in the near future.

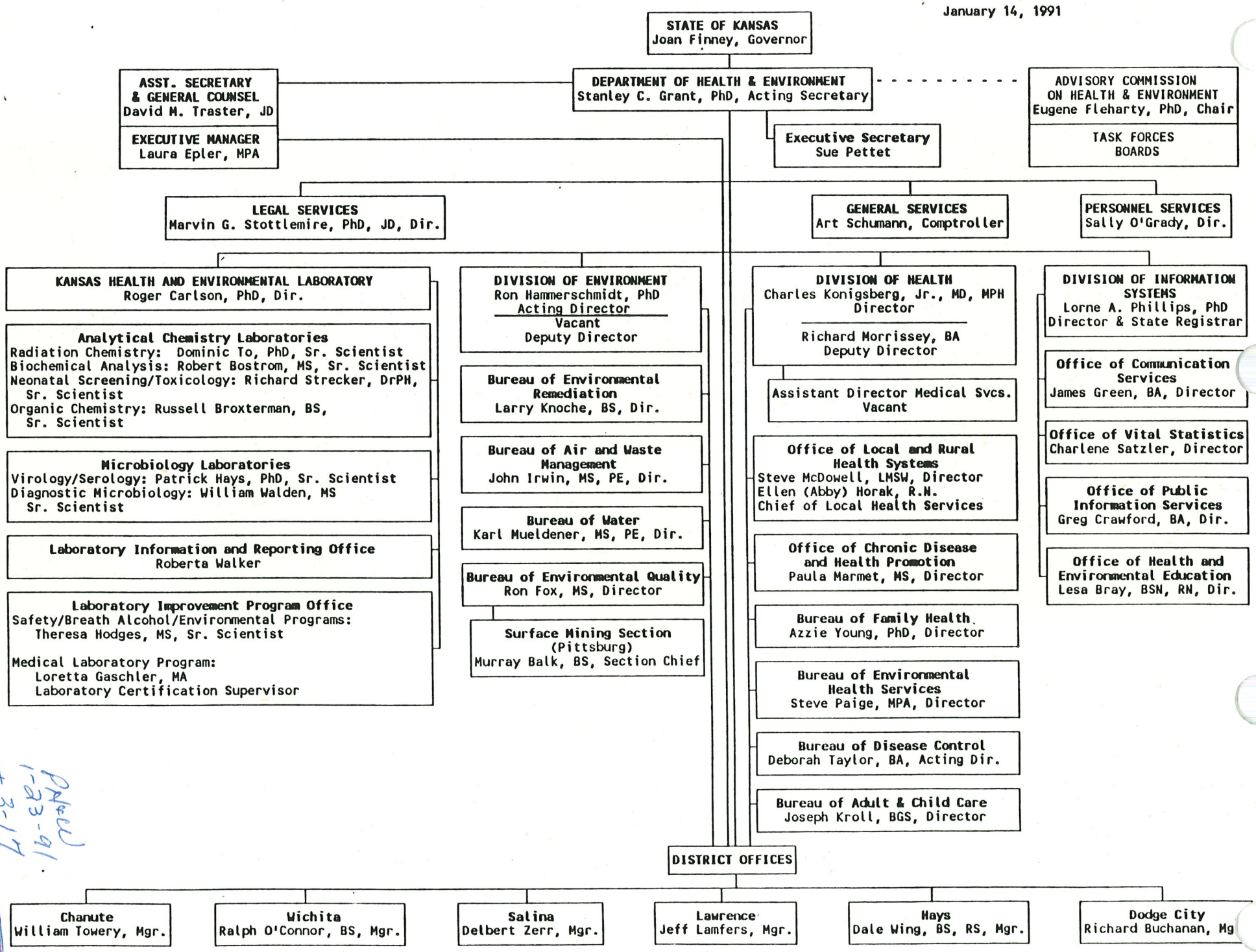
The FY 91 Federal budget makes available new funding for child care programs through the Child Care and Development Block Grant. Some of this new funding can be used for quality assurance and licensing and registration program support. Because the Block Grant will be administered by the Department of Social and Rehabilitation Services, close coordination will be required to assure that quality and regulatory needs are considered in allocating the Block Grant funds.

F. Nursing Home Reform

The Nursing Home Reform Act of 1987 initiated many significant changes in federal nursing home regulatory programs administered by the states. KDHE requested 22 new positions in FY 1991 to implement new survey requirements effective on October 1, 1990. The legislature approved 10 of the 22 requested positions, expecting that the issue would arise again in the FY 1992 budget. Governor Finney has recommended 10 new positions in her proposed FY 1992 Budget.

Now that the new survey and certification procedures are in place, it is clear that additional positions are needed to maintain the basic survey schedule. Timely certification is necessary to prevent the loss of Medicaid payments for clients in those facilities. Also the Federal government may, at their discretion, levy large financial penalties by withholding Medicaid payments for failure to carry out specific survey and certification procedures.

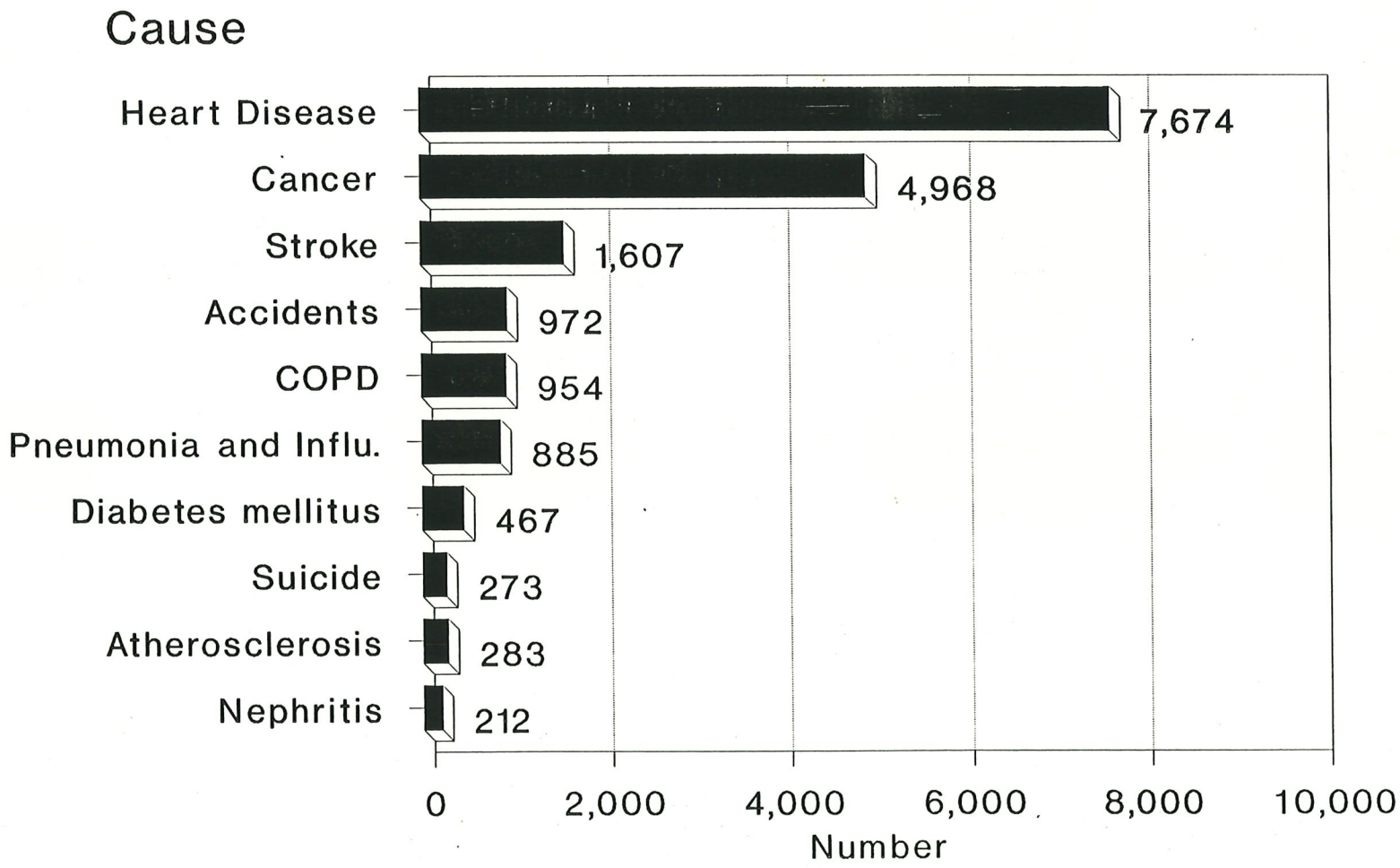
January 14, 1991



Attachment 1

Attn #3-14 Pdew 1-23-91

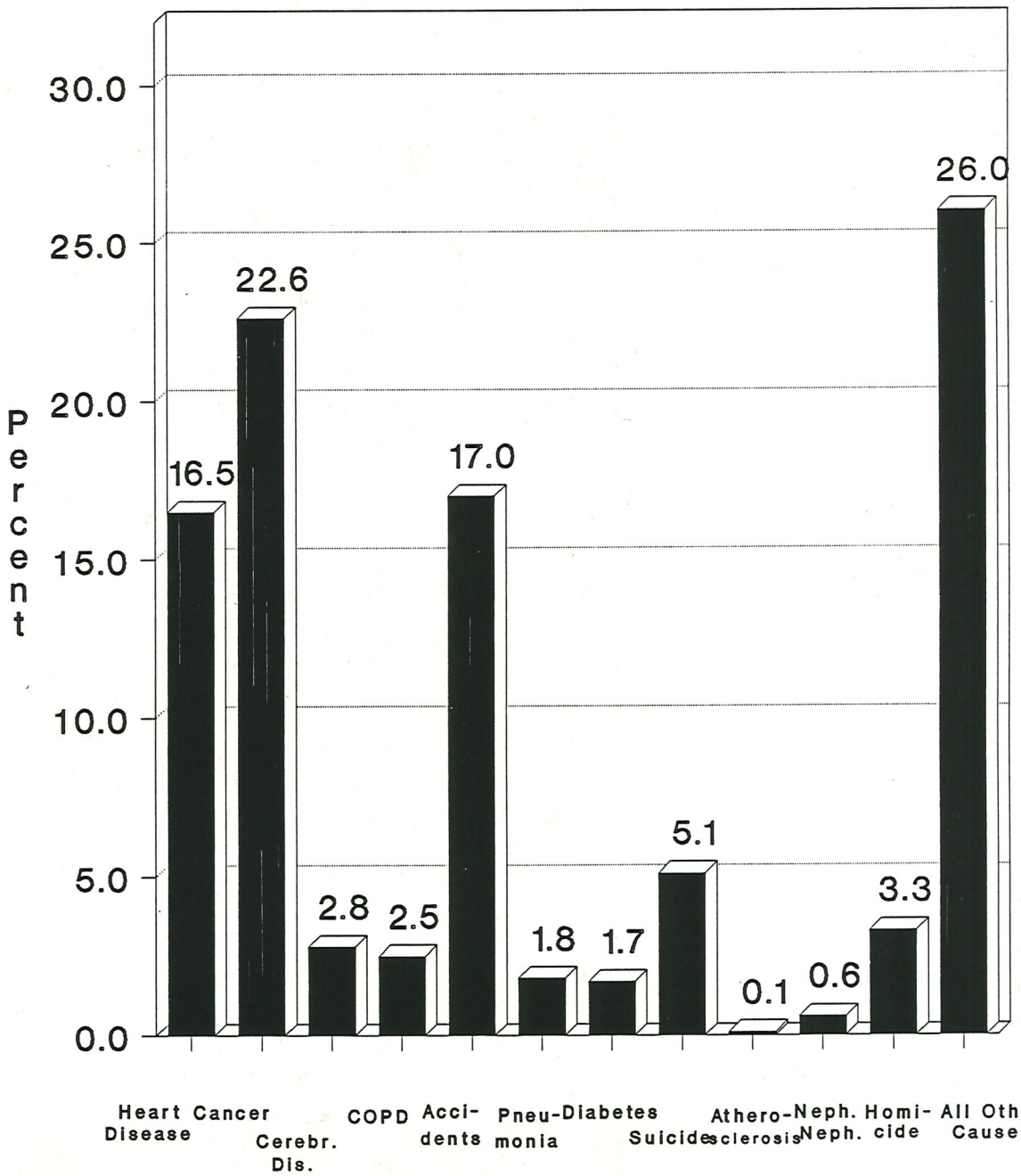
Ten Leading Causes of Death
Kansas, 1989



Attachment 2

PMHC 1-23-91 Attmt # 3-18

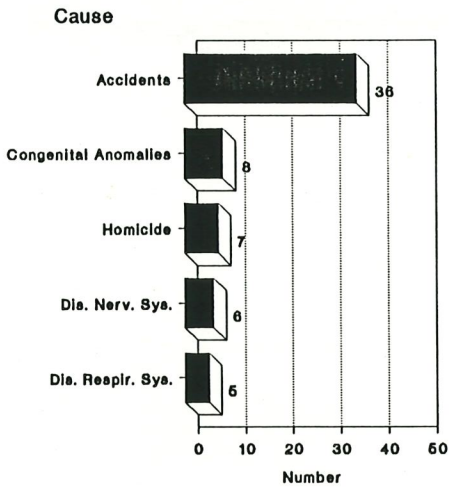
Percent Years of Potential Life Lost
By Selected Causes of Death
Kansas, 1989



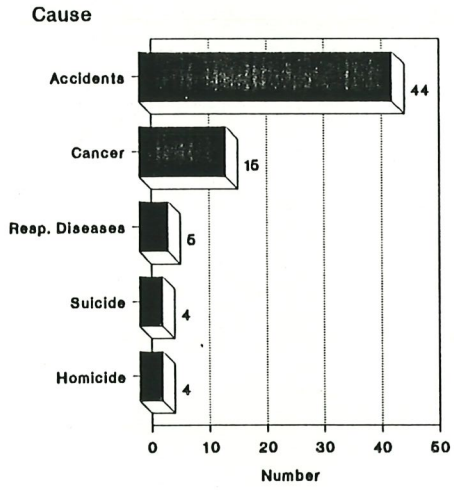
Attachment
1-23-91

Attmt. # 3-19

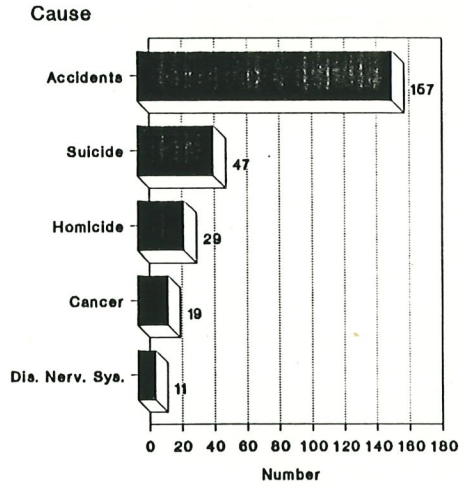
Leading Causes of Death
1-4 Age-Group
Kansas, 1989



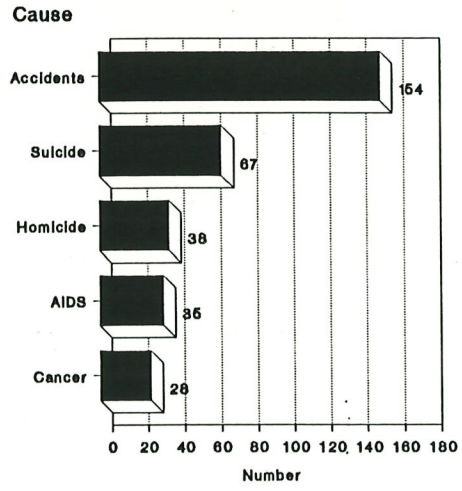
Leading Causes of Death
5-14 Age-Group
Kansas, 1989



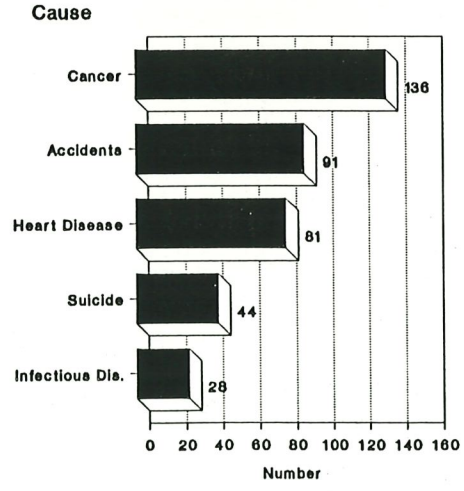
Leading Causes of Death
15-24 Age-Group
Kansas, 1989



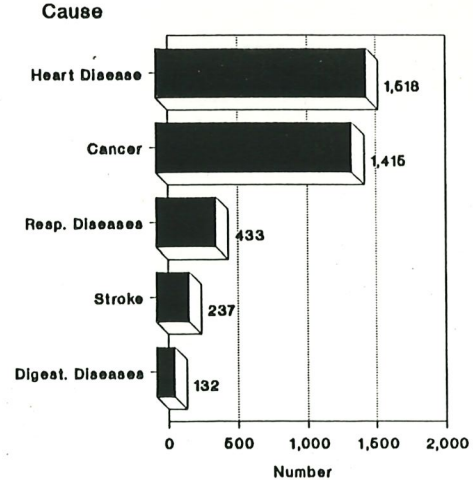
Leading Causes of Death
25-34 Age-Group
Kansas, 1989



Leading Causes of Death
35-44 Age-Group
Kansas, 1989



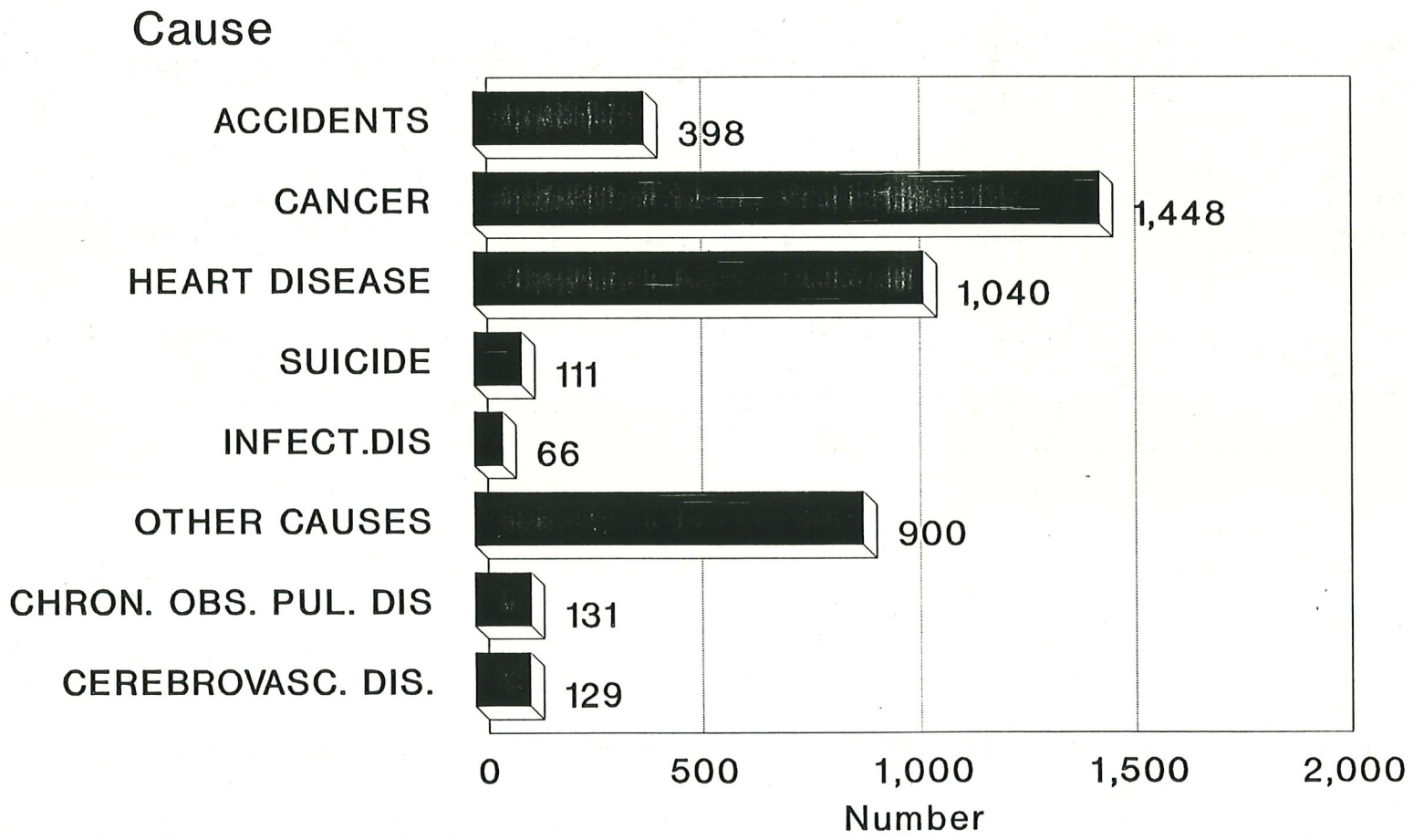
Leading Causes of Death
65-74 Age-Group
Kansas, 1989



Attachment 4

Dyrew
1-23-91
Attm. 3-20

Leading Causes of Death
25-64 Age-Group
Kansas, 1989



Attachment 5

1-23-91
Attn # 3-21

Costs of Treatment for Selected Preventable Conditions

Condition	Avoidable intervention[1]	Cost per patient[2]
Heart disease	Coronary bypass surgery	$30,000
Cancer	Lung cancer treatment	$29,000
	Cervical cancer treatment	$28,000
Stroke	Hemiplegia treatment and rehabilitation	$22,000
Injuries	Quadriplegia treatment and rehabilitation	$570,000 (lifetime)
	Hip fracture treatment	$40,000
	Severe head injury treatment and rehabilitation	$310,000
HIV infection	AIDS treatment	$75,000 (lifetime)
Alcoholism	Liver transplant	$250,000
Drug abuse	Treatment of cocaine exposed baby	$66,000 (5 years)
Low birth weight baby	Neonatal intensive care for LBWB	$10,000
Inadequate immunization	Congenital rubella syndrome treatment	$354,000 (lifetime)

[1] Examples (other interventions may apply).
[2] Representative first-year costs, except as noted. Not indicated are nonmedical costs, such as lost productivity to society.

SOURCE: Healthy People 2000

P&W
1-23-91

Attm# 3-22

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
DEPARTMENT OF HEALTH

OFFICE OF LOCAL AND RURAL HEALTH SYSTEMS

The office of Local and Rural Health Systems was created to develop an integrated approach to dealing with the complex issues related to health care delivery. The goals of the Office of Local and Rural Health Systems are threefold: (1) develop systems to coordinate existing state, federal and private initiatives; (2) coordinate funding strategies for maximum efficiency; and (3) facilitate delivery system changes where needed.

Steve McDonnell

LOCAL HEALTH

1. Administer Aid-to-Local Grant Program
2. Analyze community health needs and make recommendations for intervention
3. Administer Kansas Public Health Data System
4. Establish and maintain standards for public health service delivery
5. Provide regular reports and analysis of the public health delivery system
6. Analyze policy affecting local public health service delivery
7. Assess training needs and develop training programs
8. Manage Preventive Health Block Grant

RURAL HEALTH

1. Provide technical assistance to rural communities in developing new models for integrated rural health systems
2. Analyze rural health policies with recommendations of those that will help assure access to quality care
3. Operate a clearing house for rural health information
4. Administer Federal Rural Health Grant
5. Participate jointly with Kansas Hospital Association and Emergency Medical Services in Essential Access Community Hospital (E.A.C.H.) pilot project
6. Facilitate development of Rural Health Clinics

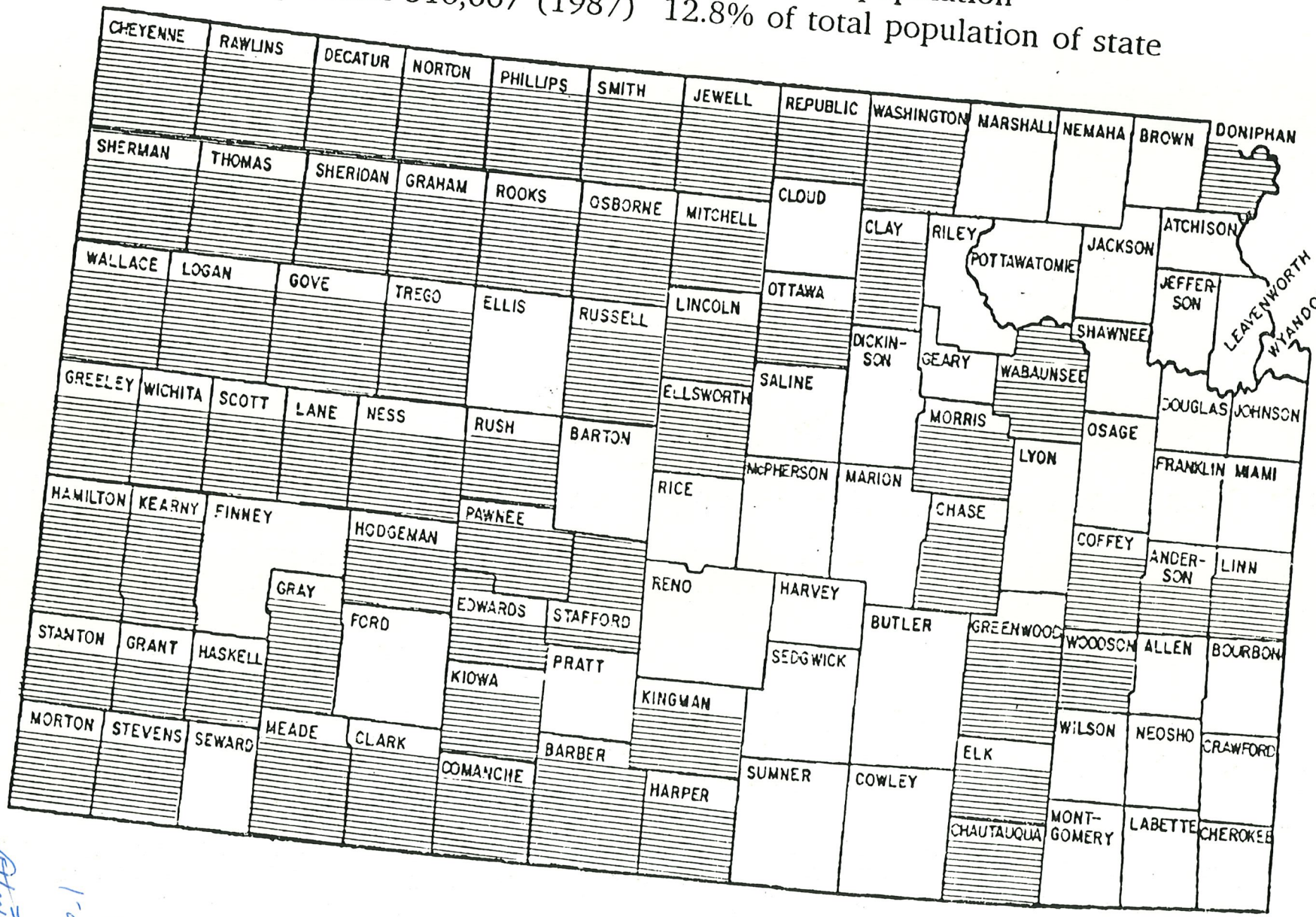
PRIMARY CARE

1. Assess the primary care needs in Kansas
2. Facilitate the development and maintenance of systems to assure primary care services for the medically underserved
3. Direct the Charitable Health Care Provide program
4. Facilitate an adequate supply of qualified primary care providers to meet the needs of the medically underserved
5. Establish relationships between the expanding medically underserved clinic network and local health departments to minimize duplication and maximize resources
6. Assess need for services to special populations and develop strategies to assure adequate primary care and care management services
7. Direct Migrant Health Program
8. Direct Refugee Resettlement Program

Attachment 7

Attnc # 3-23-91 PARCC 1-23-91

Rural Counties (61)
Counties with less than 10,000 population
Population 316,667 (1987) 12.8% of total population of state



Steve McAtee

PHED 1-23-91 Attmt # 3-24

Attachment 9

Steve McDowell

RURAL HEALTH POLICY FOR THE 90'S

THE CONTINUUM OF CARE

EMS---PRIMARY CARE---PUBLIC HEALTH---HOSPITAL---HOME HEALTH---LTC

EMS-- A system of personnel, vehicles, equipment and facilities which provides effective and coordinated delivery in an appropriate geographic area, of emergency health care services.

PRIMARY CARE-- Available, personalized and continuous delivery of
1. Physician directed care
2. Coordination by physician of the health care team
3. Initial assessment and attempts to solve as many of the patients problems as possible.
4. Referral for more complicated problems
5. Follow-up care after discharge from hospital
6. Preventive, diagnostic and restorative dental services

PUBLIC HEALTH-- Disease prevention and health promotion through organized community efforts for the delivery of
1. Sanitation Services
2. Communicable disease Services
3. Health Promotion Services
4. Maternal and Child Care Services
    a. infant and well child care
    b. family planning and pre and postnatal care
    c. school health
    d. WIC
5. Environmental Services
6. Community Diagnosis

HOSPITAL- A facility open 24 hours a day, continuously ready to receive patients, which provides medical care for patients by and under the orders of a physician and which offers a required set of basic services.

HOME HEALTH-- Physician directed provision of medical treatment and rehabilitation services in the home setting by licenced medical personnel.

LONG TERM CARE-- An organized continuum of care for the elderly, and disabled citizens of a community that assures adequate health, social and spiritual care is available both in and out of institutionalized settings and that assures good linkages between institutions and the community.

Pxtd
1-23-91

Attn# 3-25

Steve McDowell

Attachment 10

SUMMARY OF PRIORITY CHANGES AND RECOMMENDATION MADE BY PARTICIPANTS OF "RURAL HEALTH POLICY FOR THE 90'S" OFFICE OF RURAL HEALTH October 26 - November 14, 1989

1

EQUAL AND ADEQUATE REIMBURSEMENT RATES

2

INCREASE FLEXIBILITY OF GOVERNMENTAL REGULATION IN HEALTH CARE MAKE IT MORE SENSITIVE TO RURAL NEEDS

3

HEALTH PROFESSIONS TRAINING NEED RURAL CURRICULA

4

INCREASE COMMUNITY AWARENESS OF HEALTH CARE PROBLEMS

5

INCREASE THE SUPPLY OF HEALTH CARE PROFESSIONALS IN RURAL AREAS

6

IMPROVE ACCESS TO CARE

P&HCW
1-23-91
Attn # 3-26

Attachment 11

Steve McDonnell

BASIC ASSUMPTIONS FOR KANSAS RURAL HEALTH SYSTEMS

PROVIDE INTEGRATED SERVICES

BE LOCALLY GOVERNED

MANAGE THE PLANNED ENTRY AND RETURN FROM HEALTH CARE PROVIDED OUTSIDE THE COMMUNITY

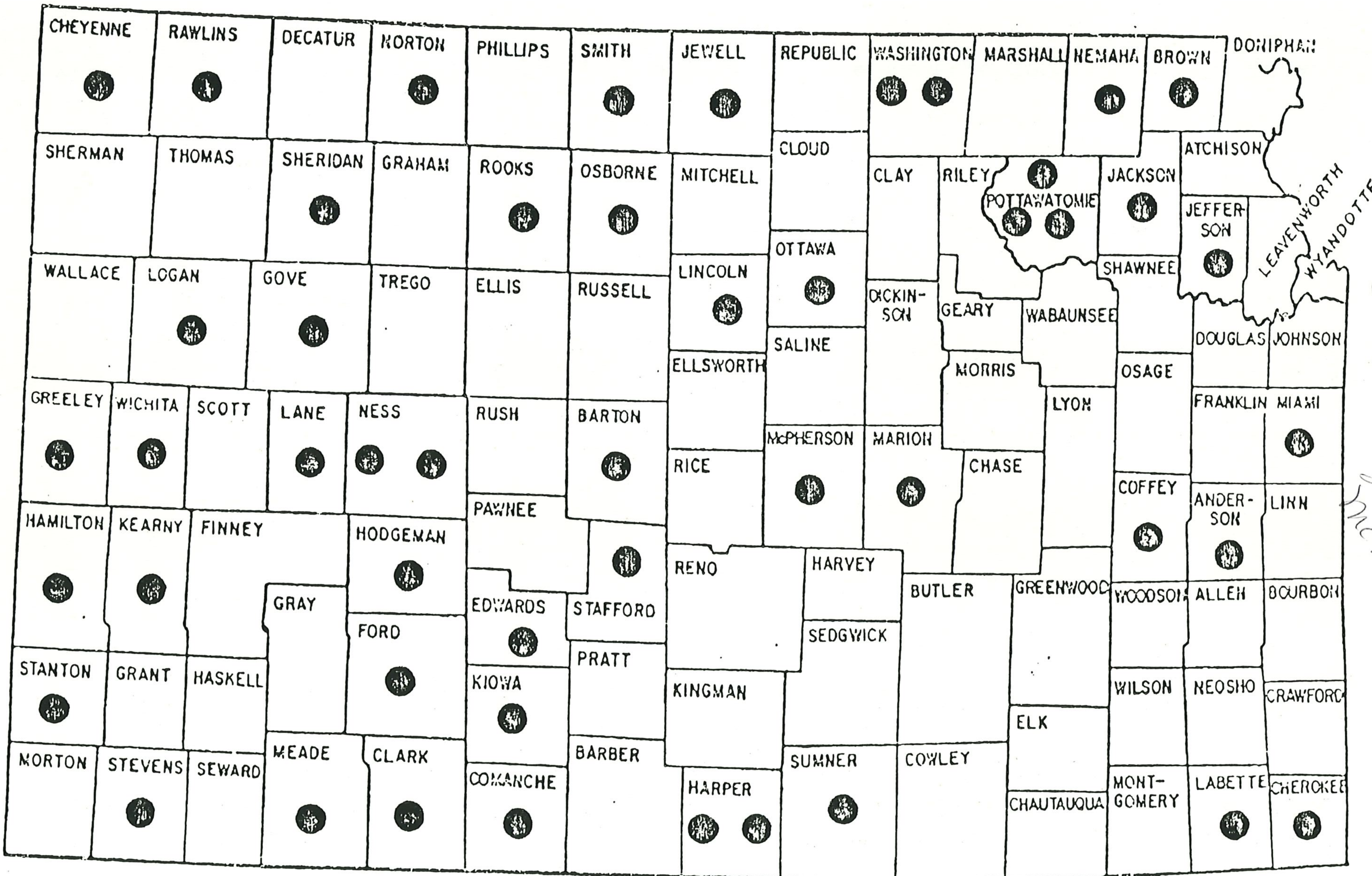
BE INCORPORATED INTO THE HEALTH PROFESSIONS TRAINING CURRICULUM IN MEANINGFUL WAYS

PROVIDE EQUAL ACCESS FOR ALL CITIZENS OF THE COMMUNITY

PH+C
1-23-91

Attn 3-27.

KANSAS HOSPITALS
JANUARY-JUNE 1989 AVERAGE DAILY CENSUS
HOSPITALS WITH ADC $\leq$ 6 TOTAL 49



Attachment 12

Steve McDonnell

PH&W 1-23-91

Attm. # 3-28

Attachment 13

Steve McDaniel

ESSENTIAL ACCESS COMMUNITY HOSPITAL PROGRAM

PH&W
1-23-91

Attn. 3-29

I. ABSTRACT

April 5, 1990

Wesley Foundation Grant ID # 9003071

The E.A.C.H. Concept: A Study of Applicability in Kansas

Submitted by: Emergency Medical Services Board
Kansas Department of Health and Environment
Kansas Hospital Association

Contact Persons: Melissa Levy Hungerford
Vice President, KHA
P.O. Box 2308
Topeka, Kansas 66601
913-233-7436

Steve McDowell
Director, Office of Rural Health
Kansas Department of Health and Environment
900 Jackson Street
Landon State Office Building
Topeka, Kansas 66612
913-296-6752

Joe Moreland
Planning and Regulation Coordinator
Emergency Medical Services Board
111 West 6th Street
Topeka, Kansas 66603
913-296-7296

A major federal project, the Essential Access Community Hospital Demonstration Project, was passed in the last congressional session. The goal of the project is to create a more effective rural health delivery system by networking services and coordinating of delivery systems. The ramifications of the Project are major and potentially of great benefit to Kansas. This grant application seeks funds to study the applicability of the Federal EACH Project in Kansas. The applicants propose to 1. gather citizen input, 2. define rural health networking options, 3. test the viability of proposed health service delivery options for rural health networks, 4. analyze regulatory barriers inhibiting change in rural health service delivery, 5. develop a consensus in the state concerning the EACH concept or alternative models for rural health service delivery, and 6. educate both health care delivery personnel and community leaders to the new network possibilities. Until this demonstration project the only incentive to induce communities to contemplate change in their health care delivery model has been crisis. Local communities have a tremendous investment both financially and emotionally in the traditional

P H & W
1-23-91
Attn: 3-30

system of care. If consensus can be achieved on this Federal model, local communities would have both an empirically tested model and an attractive financing option for developing more effective rural delivery systems based on local rural community needs.

Funds requested: $263,711

Duration of the proposed project: July 1, 1990-June 30, 1992

Bob McDaneld
Administrator
Kansas Board of
Emergency Medical
Services

Stanley C. Grant, Ph.D.
Secretary
Kansas Department of
Health & Environment

Donald A. Wilson
President
Kansas Hospital Assoc.

RHCW
1-23-91
Attm 3-31

EACH

PCH

Essential Access Community Hospital Program

UPDATE

January 22, 1991

The Essential Access Community Hospital (EACH) Program is designed to assist states in maintaining access to health care services in rural areas. The EACH Program was authorized by section 5000(g) of OBRA 1989 and amended in section 4008(d) and 4008(m)(2)(B) of OBRA 1990. Congress has appropriated $9.759 million in FY 1991 to fund seven state demonstration projects and an additional 15 hospital projects (outside the seven states).

The statute defines a Primary Care Hospital (PCH) as a facility that provides limited inpatient services to patients requiring primary care, stabilization before discharge or transfer to a hospital. A PCH may contain up to 6 acute beds and may provide inpatient care for a period not to exceed 72 hours. In addition, the PCH must provide for 24 hour emergency services, however, emergency room hours may be less than 24 hours or less than 7 days per week. Staffing requirements are modified to allow off-site and part-time practitioner with the oversight of a physician. PCHs will be reimbursed by HCFA on a reasonable cost basis for services provided to Medicare beneficiaries.

An Essential Access Community Hospital (EACH) is defined by the statute as a larger, full-service hospital that provides emergency and medical backup services to PCHs participating in the rural health network of which it is a member. An EACH must agree to accept patient transfers, receive and transmit patient data from these PCHs and provide staff privileges to physicians practicing at the PCHs. An EACH must have 75 beds or be located more than 35 miles from another hospital. EACHs will be reimbursed by HCFA as sole community hospitals for services provided to Medicare beneficiaries.

On or before February 1, 1991, the Health Care Financing Administration (HCFA) will mail a grant solicitation package to the Governor's designee in each of the fifty states. The states will have until May 1, 1991 to return their applications to HCFA. HCFA expects to make grant awards in September 1991.

The Kansas Hospital Association, Department of Health and Environment and the Kansas Board of Emergency Medical Services, received a planning grant from the Wesley Foundation to develop rural health delivery options with the specific intent to analyze the applicability of the EACH concept to the Kansas Environment. A Technical Advisory Group (TAG) was appointed to work with staff and consultants in developing the models which would be best suited for Kansas. This activity has been progressing rapidly since July 1990. We believe these planning efforts have placed Kansas in the forefront of states that are likely to be designated.

To date, the TAG has developed draft "Conditions of Participation" for PCHs and has begun the task of developing guidelines for EACHs. Four hospitals have been selected to "paper test" the PCH requirements. These hospitals (Coldwater, Comanche County Hospital; Garnett, Anderson County Hospital; Leoti, Wichita County Hospital; Plainville, Plainville Rural Hospital) will provide both patient

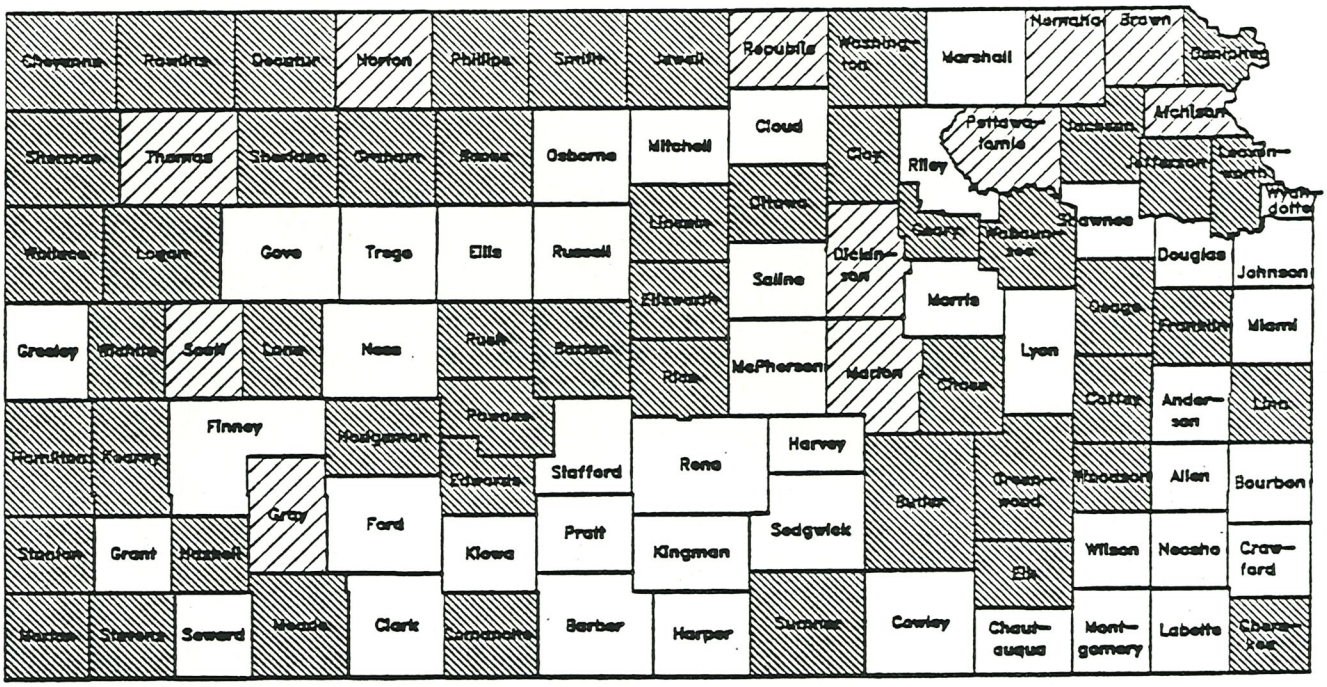
PH ow
1-23-91
Attn. # 3-32

and financial records for staff and consultants to conduct an analysis of the impact and potential benefits derived from conversion. The test will be conducted in January and should be completed early in February. KHA is hopeful that the PCH test will be positive and that Kansas will apply for one of the demonstration grants. The issue of access to health care is a priority and the potential of the EACH Concept in Kansas is significant.

PX&CW
1-23-91
Attm. 3-33

PRIMARY CARE

1989 UNDERSERVED AREAS



Specialties include: Family Practice; General Practice; Internal Medicine; Pediatrics

Atchison	U	Franklin	CU	Logan	CU	Scott	U
Barton*	CU	Geary	CU	Marion	U	Sheridan	CU
Brown	U	Graham	CU	Meade	CU	Sherman	CU
Butler	CU	Gray	U	Morton	CU	Smith	CU
Chase	CU	Greenwood	CU	Nemaha	U	Stanton	CU
Cherokee	CU	Hamilton	CU	Norton	U	Stevens	CU
Cheyenne	CU	Haskell	CU	Osage	CU	Sumner	CU
Clay	CU	Hodgeman	CU	Ottawa	CU	Thomas	U
Coffey	CU	Jackson	CU	Pawnee	CU	Wabaunsee	CU
Comanche	CU	Jefferson	CU	Phillips	CU	Wallace	CU
Decatur	CU	Jewell	CU	Pottawatomie	U	Washington	CU
Dickinson	U	Kearny	CU	Rawlins	CU	Wichita	CU
Doniphan	CU	Lane	CU	Republic	U	Woodson	CU
Edwards	CU	Leavenworth	CU	Rice	CU		
Elk	CU	Lincoln	CU	Rooks	CU		
Ellsworth	CU	Linn	CU	Rush	CU		

U - Underserved (11 counties) CU - Critically Underserved (50 counties)

*Special designation review determined Barton County as critically underserved.

P&HW
1-23-91
Attm. 3-34

Refer to page 7 for information on qualifying medical facilities.

Designation effective December 31, 1989 - December 31, 1992

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
Bureau of Adult and Child Care

LICENSING AND REGISTRATION OF CHILD CARE IN KANSAS

(Authorized by K.S.A. 65-501 through K.S.A. 65-526)

1. INTRODUCTION

The original licensing law which was passed in 1919 placed the licensing authority with the Kansas Department of Health and Environment. The Department administers the licensing law as a preventive program to assure that out-of-home care for children and maternity patients will not be exploitative, unsafe or unhealthy. The main purpose of the law is to protect the health, safety and welfare of children receiving care away from their parents and home. It is also a consumer protection law assuring parents that the care they are paying for meets minimum standards of good care.

Registration or licensure (depending on the number of children in care) is required regardless of the motivation for providing care, and whether or not there is advertisement of or payment for services. The essential fact is that a child or children receive care away from their own homes.

Registration or licensure is required when care is provided to an unrelated child or children more than 20 hours a week.

Registration or licensing <u>is not required</u> as follows:

1) When care is provided for not more than two children unrelated to the provider for 20 hours a week or less.

2) When irregular child care is arranged between friends and neighbors on an exchange basis.

3) When child care is provided in the child's own home.

4) When child care is provided in the home of the child's relative.

II CATEGORIES OF CHILD CARE

A. <u>DAY CARE</u> (less than 24 hours per day)

1. <u>Licensed Day Care Home</u> (K.A.R. 28-4-113 et seq.)

"Licensed Day Care Home" means a home in which care is provided for a maximum of **TEN** (10) children under 16 years of age with a limited number of children under kindergarten age. This total includes children under **ELEVEN** (11) years of age related to the provider.

2. <u>Group Day Care Home</u> (K.A.R. 28-4-113 et seq.)

"Group Day Care Home" means a home in which care is provided for a maximum of **TWELVE** 12 children under 16 years of age with a limited number of children under kindergarten age. This total includes children under **ELEVEN** (11) years of age related to the provider.

3. <u>Registered Family Day Care Home</u> (K.S.A 65-517 et seq. and K.A.R. 28-4-120, 122 through 131.)

"Registered Family Day Care Home" means the family's own residence in which care is provided by the applicant for not more than six children from birth to 16 years of age with not more than three children under 18 months of age. All children under 16 years of age related to the provider are included in the total (Legislation effective 7-1-80).

4. <u>Child Care Centers/Preschools</u> (K.A.R. 28-4-420 et seq.)

a. "Child Care Center" means a facility in which care and educational activities are provided for 13 or more children two weeks to 16 years of age for more than three hours and less then 24 hours per day including day time, evening, and nighttime care, or which provides before and after school care for school-age children. A facility may have fewer than 13 children and be licensed as a center if the program and building meet child care center regulations.

b. "Preschool" means a facility which provides learning experiences for children who have not attained the age of eligibility to enter kindergarten prescribed in K.S.A. 72-1107(c) and any amendments thereto, and who are 30 months of age or older; which conducts sessions not exceeding three hours per session; which does not enroll any child more than one session per day; and which does not serve a meal. The term "preschool" shall include educational preschools, Montessori schools, nursery schools, church-sponsored preschools, and cooperatives. A preschool may have fewer than 13 children and be licensed as a preschool if the program and facility meet preschool regulations.

PH&W 1-23-91 attmt # 3-35

In lieu of being licensed, preschools operated in the same building as private schools providing kindergarten through grade six shall be governed by Kansas statutes applicable to private schools.

B. RESIDENTIAL CARE

1. Family Foster Home (K.A.R. 28-4-311 et seq.) -- Twenty-four hour family care for one to four children.

2. Group Boarding Home (K.A.R. 28-4-268 et seq.) -- Twenty-four hour nonsecure care for five to ten children.

3. Residential Center (K.A.R. 28-4-268 et seq.) -- Twenty-four hour nonsecure care for over ten children.

4. Attendant Care Facility (K.A.R. 28-4-285 et seq.) -- Non-secure care not to exceed 24 hours excluding weekends and holidays for juveniles taken into custody.

5. Detention Center (K.A.R. 28-4-350 et seq.) -- A secure public or private facility which is used for the lawful custody of accused or adjudicated juvenile offenders pending court disposition or placement in an appropriate program and which, if in a city or county jail, must be in quarters separate from adult prisoners.

6. Secure Care Center (K.A.R. 28-4-350 et seq.) -- A secure youth residential facility, other than a juvenile detention facility, used to provide care and treatment for alleged or adjudicated children in need of care pursuant to the Kansas code for the care of children.

The State Department of Health and Environment does not place children in residential care. Children are placed by parents, by a public agency such as Social and Rehabilitation Services, or by a private child placing agency licensed to perform a placement service.

C. SPECIAL CATEGORIES OF SERVICE REQUIRING A LICENSE

1. Child Placing Agency (K.A.R. 28-4-170 et seq.) -- A social service agency which receives children for services including placement in institutions or in foster family homes, or for adoption.

2. Maternity Care (K.A.R. 28-4-268 et seq.) -- Residential care which includes services to females during pregnancy.

3. Maternity Center or Hospital (K.A.R. 28-4-370 et seq.) -- A facility not licensed as a medical hospital, which provides delivery services for normal, uncomplicated pregnancies.

4. Day Care Referral Agency (K.A.R. 28-4-185 et seq.) -- An association, organization, individual or corporation receiving, caring for, and finding homes for children under 16 years of age who need day care.

D. FURTHER INFORMATION:

1. Health certificates are required for all persons SIXTEEN (16) years of age and older in contact with children.

2. Medical records on all children and youth in care must be on file at the child care facility.

*3. The Secretary of the Kansas Department of Health and Environment (KDHE) may levy a fine, suspend, deny or revoke a license or a certificate of registration for violation of regulations of the child care licensing statutes.

Information about licensing procedures and copies of regulations may be obtained from the county health departments (address under county government) or by writing Child Care Licensing & Registration Section, Bureau of Adult and Child Care, Kansas Department of Health and Environment, Suite 1001, Landon State Office Building, 900 SW Jackson, Topeka, Kansas 66612-1290, Telephone number (913) 296-1270.

KDHE/ACC CCLR-008 - 11/90

PKRell
1-23-91
attn 3-36

PROGRAMS AND SERVICES

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

Mike Hayden - Governor
Stanley C. Grant, PhD - Secretary

Compiled by
Office of Public Information Services
Division of Information Systems

July, 1989

TABLE OF CONTENTS

South Central District Office
1919 Amidon, Suite 130
Wichita, Kansas 67203
Ralph O'Connor (316) 838-1071

Southeast District Office
1500 West 7th, P.O. Box 888
Chanute, Kansas 66720
William Towery (316) 431-2390

Southwest District Office
302 West McArtor Road
Dodge City, Kansas 67801
Richard Buchanan (316) 225-0596

SECTION OFFICE

Surface Mining Section
P.O. Box 1418
Pittsburg, Kansas 66762
Murray Balk, BS (316) 231-8540

OTHER CONTACTS

Advisory Commission on Health & Environment
David Traster, KDHE Contact 296-1291

Coordinating Council on Early Childhood Development Services
Judy Moler, Executive Coordinator 296-13

Nursing Home Complaint Coordinator 296-1240

24-Hour Emergency/Spill Response 296-1500

Vital Statistics (birth, death, divorce & marriage records) 296-1400

DIVISION OF INFORMATION SYSTEMS

DIRECTOR OF INFORMATION SYSTEMS	Lorne A. Phillips, PhD	296-1415
Office of Communication Services	James Green, BA	296-5620
Office of Health & Environmental Education	Virginia Lockhart, MPH	296-1226
Office of Public Information Services	Greg Crawford, BA	296-1529
Office of Vital Statistics	Charlene Satzler	296-1400

KANSAS HEALTH AND ENVIRONMENTAL LABORATORY

DIRECTOR OF LABORATORIES	Roger Carlson, PhD	296-1619
Radiation Chemistry	Dominic To, PhD	296-1629
Organic Chemistry	Russell Broxterman, BS	296-1647
Inorganic Chemistry	Robert Bostrom, MS	296-1654
Neonatal Screening/Toxicology	Richard Strecker, DrPH	296-1650
Virology/Serology	Patrick Hays, PhD	296-1644
Diagnostic Microbiology	William Walden, MS	296-1636
Laboratory Improvement Program Office	Theresa Hodges, MS	296-1640
Laboratory Information & Reporting	Roberta Walker	296-1624

DISTRICT OFFICES

North Central Office
2501 Market Place, Suite D
Salina, Kansas 67401
Delbert Zerr (913) 827-9639

Northeast District Office
808 West 24th Street
Lawrence, Kansas 66046
Judith Humphrey (913) 842-4600

Northwest District Office
2301 East 13th Street
Hays, Kansas 67601
Dale Wing (913) 625-5663

PAHwd 1-23-96 4-3

INTRODUCTION

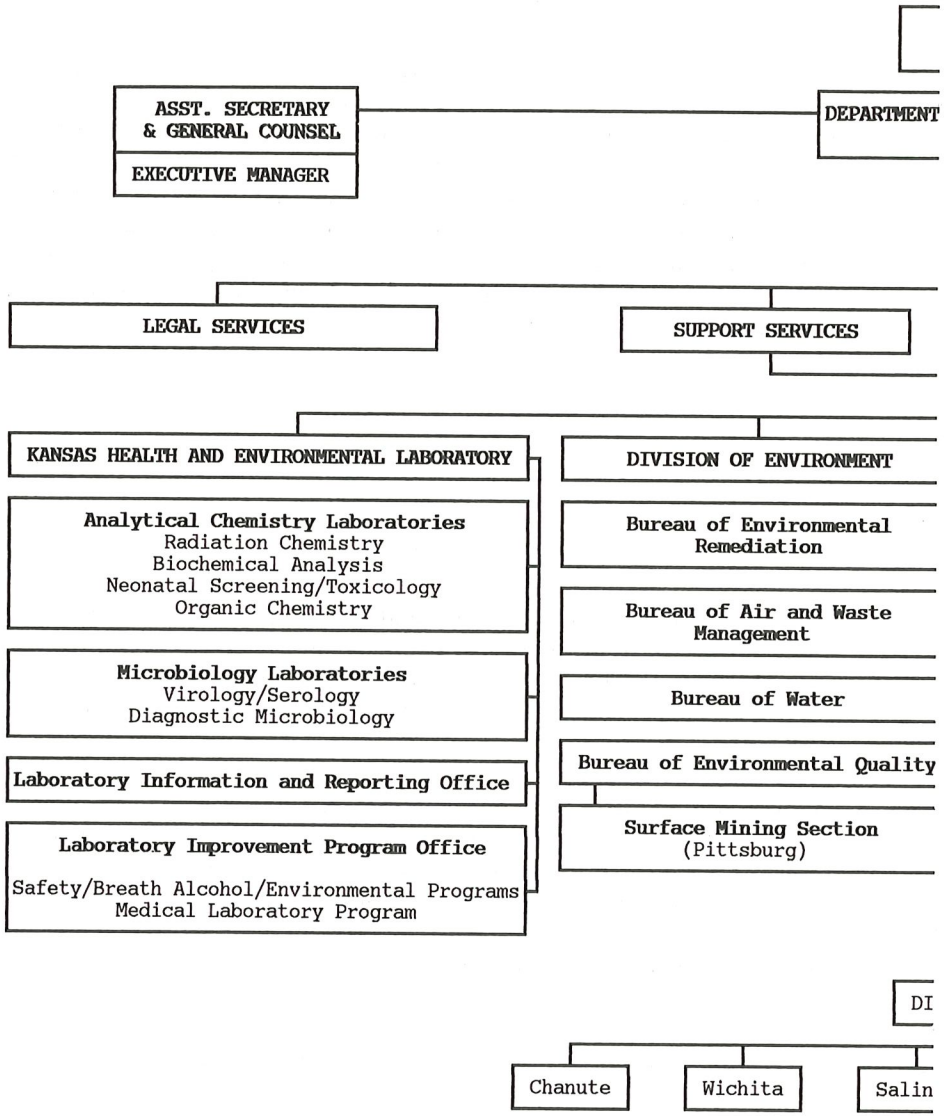
This booklet briefly describes the programs and services provided by the Kansas Department of Health and Environment (KDHE). Legislative authority for Department activities appears in sections of various Kansas statutes. The mission of the Department is to protect and maintain the health of Kansans and the quality of the environment. The Department achieves this through regulation, prevention, information, and education. While many programs take a regulatory tone, the Department has been and remains a service provider -- answering questions, providing technical assistance, and offering guidance.

HISTORY

The Kansas Department of Health and Environment (KDHE) has a proud history of over 100 years of service, information, and protection. The Kansas Legislature established the guiding tenets of the Department when it created the state Board of Health and local boards of health in 1885.

The board hired as its first full-time executive secretary, Dr. Samuel Crumbine, Dodge City, in 1904. Dr. Crumbine's first budget totaled $3,080. Despite those limitations, Dr. Crumbine proved to be an innovative, imaginative, and tireless public health worker. The federal government and many other states later adopted the sanitation and pure food and drug laws pioneered by Dr. Crumbine to control the spread of contagious diseases.

Dr. Crumbine invented the fly swatter as part of his 1906 campaign against the housefly and its spread of disease. He immediately followed that extensive public education effort with his "Bat the Rat" campaign.



Kansas Department of Health & Environment
Landon State Office Building
900 SW Jackson Street
Topeka, Kansas 66612-1290
913-296-1500

ADMINISTRATION

SECRETARY	Stanley C. Grant, PhD	296-1522
Asst. Secretary/General Counsel	David Traster, JD	296-1291
Executive Manager	Laura Epler, MPA	296-691
Director of Personnel	Sally O'Grady	296-129
Management Analysis	Al Gutierrez, MPA	296-1536
Comptroller	Art Schumann	296-1520
Legal Services	Marv Stottlemire, JD	296-1330

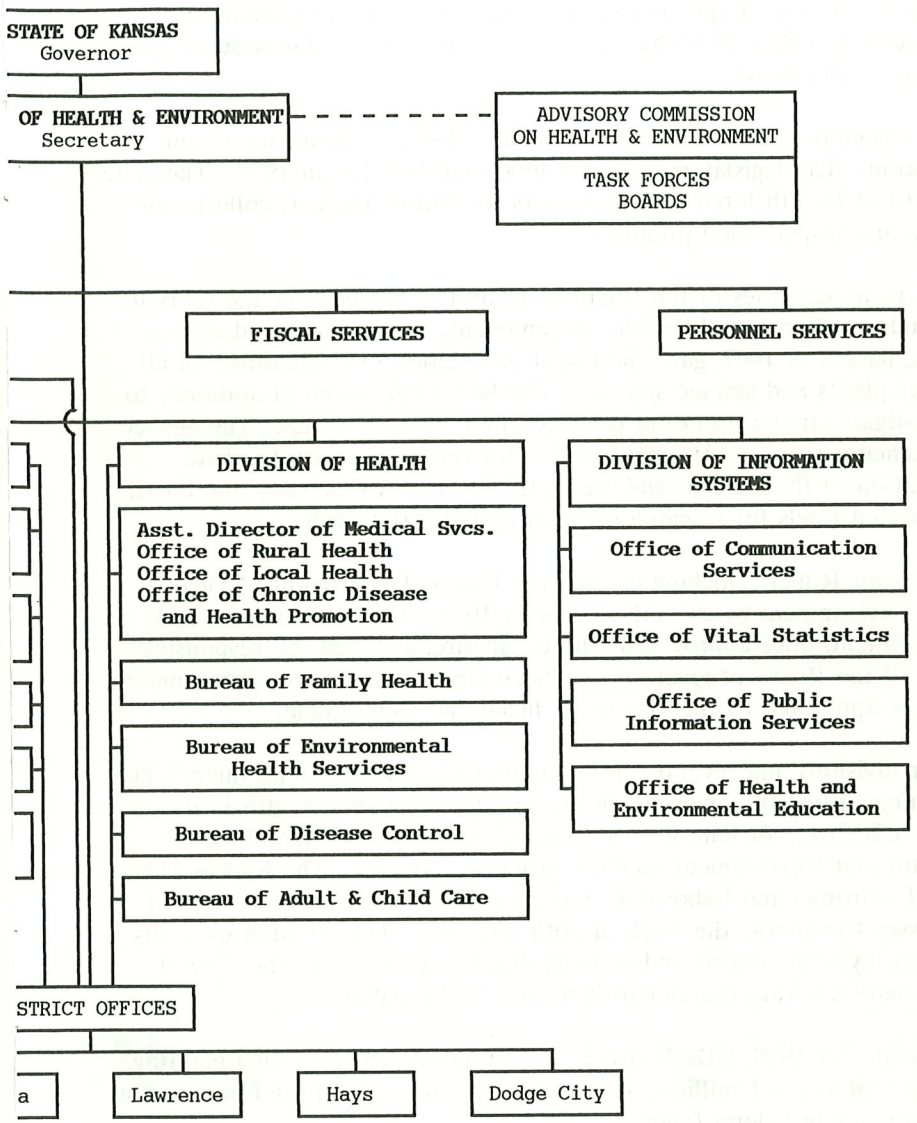
DIVISION OF ENVIRONMENT

DIRECTOR OF ENVIRONMENT	James A. Power, PE	296-1535
Deputy Director		296-1535
Bureau of Air & Waste Management	John Irwin, MS, PE	296-1540
Bureau of Environmental Quality	Ron Fox, MS	296-0077
Bureau of Environmental Remediation	Ron Hammerschmidt, PhD	296-1660
Bureau of Water	Karl Mueldener, MS, PE	296-5500

DIVISION OF HEALTH

DIRECTOR OF HEALTH	Charles Konigsberg, MD, MPH	296-1343
Deputy Director	Richard Morrissey, BA	296-1343
Asst. Director of Medical Services	Virginia Tucker, MD	296-1300
Bureau of Adult & Child Care	Joe Kroll, BGS	296-1240
Bureau of Disease Control	Richard Parker, DVM	296-5586
Bureau of Environmental Health Services	Steve Paige, MPA	296-5600
Bureau of Family Health	Azzie Young, PhD	296-1300
Office of Chronic Disease & Health Promotion	Paula Marmet, MS, RD	296-1343
Office of Local Health	Garth Hulse, BA	296-1200
Office of Rural Health	Steve McDowell, LMSW	296-1200

The Law Enforcement unit provides training and a performance evaluation program for 1,200 certified operators of evidential breath alcohol measurement instruments located in 100 law enforcement agencies throughout the state. Test instruments must produce court defensible data for use in DUI proceedings. On-site evaluations of the instruments and laboratory methods used by the operators are reviewed annually. Alcohol standards and quarterly proficiency test samples are provided to each agency. These components are necessary to maintain the accuracy and legal credibility of breath alcohol data used in prosecution of 13,000 DUI cases throughout Kansas each year. The importance of this activity has increased in recent years due to legislative action to strengthen highway safety statutes pertaining to driving under the influence of alcohol in Kansas.



Tuberculosis became a reportable disease in Kansas in 1907 and Dr. Crumbine lead the way in educating the public about the spread of TB. He persuaded a brick manufacturer to produce paving blocks with the admonition "Don't spit on the sidewalk." In 1908, the legislature appropriated $20,000 to hire six nurses to carry on a statewide campaign against tuberculosis.

Dr. Crumbine directed his public health advocacy toward food adulteration. The legislature passed a food and drug law in 1907. The state Board of Health hired four inspectors to enforce the law, collect samples, and inspect food premises.

The responsibilities of the Board of Health expanded over the years to include environmental health. Amendments to the water and sewage laws, passed in 1907, gave the board jurisdiction over operation of all water plants and sewage systems. The board also received authority to investigate stream pollution produced by industrial wastes. The agency launched a plan in 1911 which called for remedial action to abate pollution of the Neosho and Verdigris Rivers. A year later, the board requested funds for research on treating industrial wastes.

Governor Robert Docking created the Kansas Department of Health and Environment by executive order in 1974. The new cabinet level department, once approved by the legislature, assumed the responsibilities of the Board of Health. The Secretary of Health and Environment, who is appointed by the Governor, heads the Department.

Four divisions and several support units carry out the Department's task of safeguarding the environment and protecting public health in the most effective, efficient, and economical way possible. Divisions of Health and Environment conduct program activities. The Kansas Health and Environmental Laboratory provides chemical and microbiological analyses to support the work of both divisions. The Division of Information Systems, the second support division, coordinates the flow of information within the Department and to the public.

In fiscal year 1989, KDHE had a staff of 675 employees. Its operating budget totaled $61 million, $16 million in state general fund monies and $45 million in federal funds.

are of primary importance for the protection of public health in Kansas and are required by federal safe drinking water statutes.

LABORATORY IMPROVEMENT PROGRAM OFFICE

The Laboratory Certification and Improvement unit monitors the performance of private analytical laboratories in the state to assure uniform quality of data produced. This is accomplished through on-site evaluation, proficiency tests, and the provision of technical assistance as a part of the review and certification process.

Medical laboratories in Kansas are required to participate in authorized performance evaluation programs that are designed to monitor technical capability and to assure the quality of clinical laboratory tests. Unknown performance evaluation specimens that are similar to routine laboratory specimens are forwarded to each laboratory. Test results are returned from each laboratory and are compared with reference laboratory results for each test. Laboratories with unacceptable performance receive consultation, technical assistance, or training. In addition, annual on-site evaluations of each laboratory are completed to ensure laboratory compliance with minimum licensure requirements.

The 200 Kansas laboratories which are surveyed and approved include: all clinical laboratories certified for Kansas hospital licensure, Medicare laboratories, interstate laboratories which operate under the federal Clinical Laboratory Improvement Act of 1988, laboratories approved under Kansas statute to perform prenatal serological tests for syphilis, serological tests for human immunodeficiency virus, and tests for controlled substances. This unit also provides assistance and consultation t physician office and local public health laboratories upon request.

One hundred twenty Kansas environmental laboratories which produce compliance data used for public drinking water supply monitoring permits, wastewater discharge permits, and hazardous waste evaluations are required by statute to participate in a similar review and certification process to ensure data quality. This process includes proficiency tests and the evaluation of staff credentials, laboratory analytical procedures, instrumentation, and quality assurance practices. Evaluation of each laboratory is completed prior to the initiation or renewal of certification.

specimens each year. These analyses are performed in three laboratory units: Diagnostic Microbiology, Virology/Serology, and Environmental Microbiology. Specimens are received from physicians, hospitals, local health departments, public utilities, private citizens, and agency personnel throughout the state. Additionally, these laboratories serve as a point of contact between local health services and the Centers for Disease Control in Atlanta, Georgia.

The Diagnostic Microbiology unit provides clinical and reference microbiological services aimed at the prevention and diagnosis of microbial diseases of public health interest in Kansas. Laboratory analyses are designed to provide support for public health programs in the state and to assist private health care providers in the diagnosis of unusual or diagnostically difficult etiologic agents. Specifically, laboratory determinations are performed to isolate, identify, and establish antibiotic susceptibility patterns for etiologic agents submitted. Examples of diseases caused by these agents are: sexually transmitted disease (gonorrhea), pulmonary diseases (tuberculosis, legionnaires disease, pertussis), enteric diseases (giardiasis, salmonellosis, Campylobacter enteritis, shigellosis), and opportunistic disease associated with HIV infection (cryptosporidiosis, mycobacterioses, mycoses).

The Virology/Serology unit performs a unique function within public health programs in that it is one of the few laboratories in Kansas which is capable of the isolation and identification of viral pathogens. In addition, the serological tests performed in this unit permit the diagnosis of infectious diseases such as viral hepatitis, syphilis, and measles. This unit also performs procedures for the detection of chlamydia, the etiologic agents of one of the most common sexually transmitted diseases. The Virology/Serology unit also performs tests for the presence of the HIV antibody which is indicative of exposure to the virus associated with Acquired Immune Deficiency Syndrome (AIDS). This disease is now recognized as one of the greatest public health emergencies of the Twentieth Century.

Each year, the Environmental Microbiology unit analyzes 45,000 samples from 2,000 public drinking water supplies throughout the state and from several hundred private water wells to ensure the biological safety of these water sources. Ambient waters in lakes and streams are also monitored for coliform indicators of fecal pollution. These examinations

Administration

SECRETARY

The Secretary of Health and Environment, entrusted with broad powers to ensure public health and a safe environment, directs the management of the Department in the provision of services to the citizens of Kansas. The Secretary, who is a member of the Governor's cabinet, sets agency policy and assigns staff to carry out regulatory enforcement and public health tasks.

ASSISTANT SECRETARY/GENERAL COUNSEL

The Assistant Secretary/General Counsel serves as the legal advisor to the Secretary on all matters. The Secretary requires legal advice on administrative actions and lawsuits brought by the Department or filed against the Secretary or the Department. This individual also serves in a important administrative role, helping to formulate the policies and goals of the Department.

FISCAL SERVICES

Fiscal Services is responsible for agency financial management. The office, headed by the comptroller, coordinates the preparation of the annual operating budget, manages funds received through federal and other grant sources, and accounts for receipts and disbursements. Additional duties include managing all facets of agency purchasing and supplying financial information to agency management.

PERSONNEL SERVICES

Personnel Services provides technical support to the agency in the development and maintenance of a wide range of personnel services. Its staff is responsible for: employee recruitment; training and staff development; classification of employees; examination and certification of qualified job applicants; Equal Employment Opportunity and Affirmative Action; employee relations; and technical personnel consultation to agency management.

SUPPORT SERVICES

Support Services is responsible for centralized support services, administrative management of the six KDHE district offices, and the on-going space management and planning activities for all KDHE offices. Central support services include: mail, shipping and receiving services, office supply room, duplicating services, and processing building maintenance requests.

LEGAL SERVICES

KDHE maintains a staff of attorneys to represent the interests of the public in health and the environment matters. Staff attorneys review proposed laws and regulations enforced by the Department. Legal Services researches and prepares administrative actions and lawsuits undertaken by the Department. It provides legal counsel to agency staff and represents the Department in administrative and judicial proceedings.

ADVISORY COMMISSION

The Advisory Commission on Health and Environment advises the Secretary on public health and environmental issues that concern the public. The legislature created the commission by merging separate advisory commissions on health and environment. The Governor appoints the commission's 13 members who represent a cross-section of health and environmental interests. They serve as a sounding board for departmental initiatives.

EARLY CHILDHOOD DEVELOPMENT SERVICES

The Coordinating Council on Early Childhood Development Services, established in 1986, works to ensure that a comprehensive service delivery system is available to all children from birth to five years of age with, or at risk for, developmental delays and their families. The Council's 15 members include: Secretary of Health and Environment, Secretary of Social and Rehabilitation Services, Commissioner of Education, a representative of the Board of Regents, a representative of the Governor, two members of the legislature, and eight members of the public appointed by the Governor.

4-8 PHEW 1-23-91

ANALYTICAL CHEMISTRY LABORATORIES

The Chemistry laboratories consist of four major technical disciplines: Organic Chemistry, Inorganic Chemistry, Radiation Chemistry, and Neonatal Screening and Toxicology. These laboratories analyze 65,000 samples annually, using more than one and one-half million dollars worth of sophisticated instrumentation. These chemical analyses provide essential data for a variety of Kansas health and environmental programs.

Organic Chemistry analyses include the detection and quantification of chemicals such as the volatile organic compounds, pesticides, and other priority pollutants in soil, drinking water, and waste materials. Measurement of inorganic species such as arsenic and lead in air, particulate materials, water, and hazardous wastes is also performed. Data generated in these laboratories are necessary for evaluation of environmental quality, identification of threats to public health and safety, identification of specific toxic chemical species, management of hazardous waste sites, and monitoring environmental problem areas.

Measurement of radioactive materials such as Uranium-238 in water samples and other matrices is performed by the Radiation Chemistry section. This unit also performs laboratory analyses on specimens collected near the Wolf Creek Nuclear Power Station to ensure that a release of radioactivity has not occurred.

Public health analyses performed in the Neonatal Screening and Toxicology section include tests on each of 40,000 newborn children for the presence of metabolic deficiency disorders associated with mental retardation. This laboratory also performs analyses for asbestos materials which may cause cancer if inhaled.

The client group for the Chemistry laboratories includes physicians, clinical laboratories, local governments, public utilities, and other state agencies.

MICROBIOLOGY LABORATORIES

The prevention and control of infectious diseases of public health significance requires a diversity of microbiological analyses on 135,000

Kansas Health and Environmental Laboratory

The Kansas Health and Environmental Laboratory provides chemical and microbiological analyses which support a broad spectrum of Kansas public health programs. Rapid comprehensive analytical information is essential to public health decisions and environmental protection efforts in the state. In addition, laboratory certification and improvement programs ensure the quality of laboratory data reported by over 300 Kansas clinical, environmental, and law enforcement laboratories. The Kansas Health and Environmental Laboratory is the second KDHE support unit. It has four major subprograms: 1) Laboratory Information and Reporting; 2) Chemistry; 3) Microbiology; and 4) Laboratory Certification and Improvement.

LABORATORY INFORMATION AND REPORTING OFFICE

The Laboratory Information and Reporting unit provides the data entry, logistic, and clerical functions necessary for the timely production and delivery of laboratory results to public health clients throughout the state. These operations include the annual procurement and management of one half million dollars worth of specialized materials and supplies necessary to complete laboratory analysis of 200,000 samples and specimens. In addition, this unit serves as an essential communication link between laboratory analytical programs and the client group through the transmission of data reports to physicians, hospitals, law enforcement, governmental agencies, and private citizens in the state. The Laboratory Information and Reporting unit also performs all clerical functions required for the archival storage and retrieval of the 800,000 specific reports generated by laboratory units each year. Rapid access to these records is often necessary in responding to inquiries from clients and for the investigation of public health issues.

Division of Environment

The Division of Environment regulates most environmental contaminants and conditions in the air, soil, and water. Environmental goals are to: maintain a healthful environment free from disease or injury causing agents, reduce and prevent irritants affecting the enjoyment of life and property, preserve natural resources, and develop environmental control programs responsive to the needs of Kansas in a cost-effective manner.

To achieve its environmental goals and legislative mandates the division provides consultation to citizens, municipalities, and industry. The division offers technical review of plans and specifications not only to indicate probable compliance with standards, but to suggest better and more cost-effective alternatives if possible. Staff provide information on safe and effective methods of handling a wide variety of hazardous or toxic chemicals. The division oversees control, containment, or clean up of environmental contamination of soil and water in the state. Staff conduct training programs for operators of municipal and industrial water supplies, waste treatment plants, and solid waste facilities so that compliance, efficiency, and economy result.

To accomplish the responsibilities of the agency, the Division of Environment provides expertise through four bureaus: Air and Waste Management, Environmental Quality, Environmental Remediation, and Water.

BUREAU OF AIR & WASTE MANAGEMENT

This bureau is responsible for air quality, solid waste management, hazardous waste regulation, and control of pollution from those sources. The bureau also implements the state's asbestos licensing and certification program.

The bureau inspects, reviews, and evaluates all air pollution sources. These actions ensure emission controls comply with federal and state air quality standards. Statewide assessments provide an up-to-date inventory of the amount and nature of contaminant emissions. Other functions undertaken to protect air quality are: long-term atmospheric air samp-

ling and enforcement programs and special purpose monitoring to investigate localized air pollution problems and to identify changes in air quality.

The Asbestos Control Program is responsible for licensing those firms engaged in asbestos removal and for certifying the employees who perform removal work. Asbestos staff review all proposed asbestos projects for compliance with state regulations and perform regular inspections at asbestos removal sites.

The bureau oversees the handling of 1.6 million tons of solid waste generated annually by Kansans. Staff issue permits for solid waste landfills and inspect such facilities to ensure compliance with applicable state and federal regulations.

Because solid wastes are a potential source of energy and materials, the bureau encourages the recycling, recovery, and reclamation of solid wastes. Staff conduct periodic seminars on solid and hazardous waste management and waste minimization.

The bureau enforces federal and state regulations governing the treatment, storage, transportation, and disposal of hazardous wastes. It issues permits requested by persons who store, treat, or dispose of such wastes. Staff regularly inspect generators of hazardous wastes and supply technical assistance to the regulated community to better achieve compliance with standards and regulations.

BUREAU OF ENVIRONMENTAL QUALITY

The Bureau of Environmental Quality plans, develops, and implements the Department's nonpoint source pollution program and related activities, including issuance of permits to cattle and hog feeding operations for animal waste lagoons. Three sections carry out the functions of the bureau: mining, nonpoint source pollution, and technical and field services.

The mining section regulates the mining of coal in Kansas. Staff review and approve reclamation plans for current coal operators and contracts for reclamation of land that was mined prior to the implementation of current state and federal mining laws.

1-23-91 H-10

office is responsible for the Department's community health and environmental education activities including the AIDS education program. That program provides education grants to local health departments as well as educating the general public about the disease.

OFFICE OF PUBLIC INFORMATION SERVICES

The mission of the Office of Public Information Services is to provide accurate, timely information regarding the Kansas Department of Health and Environment to the public. The office issues information about agency plans and activities to the news media, other units of governmen and members of the general public. It accomplishes this through news releases, public service announcements, and interviews. The office prepares and distributes informational materials on matters that affect the health and environment of all Kansans. The office is responsible for informing KDHE staff through a clipping service and an internal newsletter. The office provides photography services and coordinates film purchasing and processing.

OFFICE OF VITAL STATISTICS

The Office of Vital Statistics registers vital events occurring in the State of Kansas. Registrations annually total approximately 37,000 births, 21,500 deaths, 270 stillbirths, 22,200 marriages, and 12,500 divorces. The records are received, edited, queried, coded, numbered, and added to the over 8 million permanent records on file. The office keeps a photographic copy of each record on microfilm or optical disk. The original records are kept in off-site security storage. Staff issue certified copies to the public in accordance with statutory authority. Vital records serve as important legal and statistical documents, providing legal proof in the determination of personal and property rights and statistical data to define health problems and measure the impact of programs to deal with those problems.

OFFICE OF COMMUNICATION SERVICES

The Office of Communication Services coordinates all KDHE data systems. Coordination occurs internally and between the Department and other agencies, institutions, local health departments, hospitals, etc. Communication Services is responsible for all aspects of data processing (computer systems analysis, programming, hardware and software acquisition, operations, and data entry), telecommunications, document production (word processing), and data research and analysis. Additional responsibilities include: systems development and integration, user-support services, microcomputer support, computer training, local area network systems, agency automation, and data management systems.

Communication Services maintains computer access to 91 data bases for 15 offices and bureaus within the Department. The office supports numerous communication links enabling KDHE staff (including district offices) to access information using computer terminals, personal computers, a Harris mini-computer (laboratory), an IBM System 38 mini-computer, and the large mainframes at the Kansas Department of Administration (DISC) and the U.S. Environmental Protection Agency. A representative sampling of the data bases maintained includes: AIDS, adult care home facilities, underground storage tanks, the Kansas Water Database, federal Right-to-Know data, sites of concern to the Bureau of Environmental Remediation, radiation, food and lodging certificates, and vital statistics.

Four major sections make up the office: Telecommunications, Research and Analysis, Systems Management, and Data Processing.

OFFICE OF HEALTH AND ENVIRONMENTAL EDUCATION

The Office of Health and Environmental Education coordinates the development of the Department's educational resources and programs offered to the public. The office oversees the printing of major Department publications and pamphlets. It serves as the central repository for all printed and audio-visual materials accumulated by the agency, maintaining a film lending library and literature distribution center for the public. The office maintains the Department's library which includes computer searches and review of periodicals for dissemination. The

The nonpoint source pollution section sets standards for nonpoint source pollution, reviews permits and plans for compliance with standards, and develops strategies for nonpoint source pollution programs and planning.

The technical and field services section, through field activities and technical analysis, collects the data and carries out the research necessary to determine compliance with current water quality standards. The section operates a surveillance program to ensure standards or discharge limits are met. In that program, staff collect and analyze samples of ground and surface water to assess the extent of compliance.

BUREAU OF ENVIRONMENTAL REMEDIATION

The Bureau of Environmental Remediation, established in 1986, is the single point-of-contact for the division's remedial activities; strengthening remedial capability by pooling and expanding technical expertise, legal expertise, and various cleanup fund sources; and maximizing the division's ability to assess and manage restoration of environmental quality by establishing a clearinghouse of information. Bureau programs interact with a wide variety of state and federal programs and activities.

Bureau staff respond to spills of hazardous or nonhazardous materials; analyzing the contaminant and environmental conditions, then directing the cleanup to be carried out in a manner which minimizes risk to public health and the environment.

The Kansas Department of Health and Environment and the Kansas Corporation Commission (KCC) share regulatory authority regarding pollution from oil and gas industry activities. KCC takes the lead in regulating oil production and lease operations and remedial activities at active oil and gas sites. KDHE is responsible for remedial activities at abandoned oil and gas production sites.

Bureau staff investigate sites of suspected contamination by sampling existing wells, installing monitoring wells, and conducting geophysical surveys and groundwater modeling.

The bureau oversees remediation which is the cleanup and containment of pollution. Staff prepare remediation plans to restore the environment in the safest manner possible. The preferred course toward

remediation is to work on a cooperative and voluntary basis with the responsible party. The bureau has legal authority to recover the costs incurred from noncooperative responsible parties.

Underground Storage Tank Program staff monitor approximately 20,000 tanks that contain primarily petroleum products. Staff review and approve plans for new tanks prior to installation. The program directs the removal of leaking underground storage tanks and any contaminated soils resulting from such leaks.

BUREAU OF WATER

This bureau administers programs related to public water supplies and wastewater treatment systems. The programs work to provide safe drinking water, prevent water pollution, and ensure compliance with state and federal laws and regulations.

The bureau, through a comprehensive review process, issues permits governing all phases of the operation of drinking water and wastewater treatment systems. There are 1,111 public water supply systems in Kansas. The bureau regulates wastewater treatment systems for 370 industries, 751 municipalities, 179 commercial, and 7 federal facilities. As part of its regulatory action, the bureau applies applicable laws and regulations to set compliance limits for water supply and wastewater treatment.

The bureau regulates and issues permits for underground injection of wastes (except oilfield brine), solution mining, and LPG storage. It licenses water well drillers to ensure proper water well construction. The bureau administers a grant program and a loan program for construction of municipal wastewater facilities.

In addition to responding to complaints, bureau staff, located throughout the state, provide technical assistance and training to water and wastewater system managers and operators to help protect public health and the environment.

state-level administrative leadership, consultation, and technical and support services to local health units.

The office administers the Aid-to-Counties Program which provides local health departments and other eligible community agencies with state and federal funding assistance. The funding enables the provision of public health services at the local level. The office also maintains a continuing education providership agreement with the Kansas State Board of Nursing.

OFFICE OF RURAL HEALTH

The office serves as a focal point of the effort to maintain rural health care services. It exists to facilitate and coordinate locally generated ideas to improve the availability of a variety of rural health services. The office draws on the resources, program activities, and staffing of the division to ensure that Department activities are responsive to rural health needs.

Division of Information Systems

This division, established in May, 1988, supports the information needs of the entire agency. It coordinates information management and dissemination functions as well as the public education activities of the Department. The Division of Information Systems uses state-of-the-ar technology for the most efficient operation of the Department. The division is responsible for data acquisition; processing, distribution, and publication of the data; collection, certification and dissemination of vital records; and the development of informational and education publications for public distribution. It also operates the AIDS education program, including grants to local health departments, and carries out other health and environmental education functions. Four offices carry out division activities: Communication Services, Health and Environmental Education, Public Information Services, and Vital Statistics.

nutritional risk. In addition to providing food to ensure proper nutrition for at risk clients, WIC offers medical and nutritional screening, counseling, and education for prenatal and postnatal care of women and children under the age of five.

The Maternal, Infant, and Child Health Program provides women's health clinics, maternity and perinatal care programs, well child clinics, expectant parents classes, and a network of other programs targeted to a high-risk population.

The School Health Program addresses the health care and health education needs of the school age population. The program, through consultation, information, and guidelines, seeks to improve the health status of all school age children.

The Healthy Start/Home Visitor Program trains lay visitors to provide support and advice to pregnant women and new mothers. The program attempts to reduce infant mortality and morbidity through identification and education of high risk pregnant women.

OFFICE OF CHRONIC DISEASE AND HEALTH PROMOTION

This office stresses health promotion and the control of chronic disease through a coordinated series of activities and programs. The statewide Health Promotion and Disease Prevention Program gives special emphasis to the major causes of death and disability -- accidents, heart disease, cancer and stroke. The office conducts a statewide diabetes program that focuses on surveillance and public education. The Refugee Health Program funds health assessments for refugees through local health departments. The office also conducts the statewide Injury Prevention and Control Program and staffs the Governor's Council on Fitness.

OFFICE OF LOCAL HEALTH

This office serves as the liaison with local health departments administering a wide variety of services.

Community Health Nurse Consultants serve as the division's field staff and liaison to local health departments. The nurse consultants deliver

Division of Health

The Division of Health protects and promotes the health of Kansans through a variety of public health service delivery and regulatory programs. The division's role is to assure services through: funding assistance to local agencies; establishing policy and procedures; technical assistance; and program consultation, planning, implementation, and continuation. Local health departments, with some exceptions, are the service delivery component of the state's public health system.

BUREAU OF ADULT AND CHILD CARE

This bureau is responsible for the inspection, licensure, or certification of many health care facilities and services. Activities include: developing and enforcing regulations relating to hospitals, nursing homes, home health agencies and ambulatory surgery centers. The bureau operates a certification program for nurse aides, home health aides, and medication aides. It also tests and licenses dieticians and adult care home administrators. The bureau administers a credentialing review program that makes recommendations to the legislature regarding the credentialing of other health care disciplines.

The bureau is responsible for licensing or registering child care centers, family day care homes, foster homes, pre-school facilities, maternity centers, detention centers, and other facilities designed to provide out-of-home care to children. Staff administer a risk management program, requiring hospitals to submit plans for investigating possible occurrences of substandard care.

BUREAU OF DISEASE CONTROL

This bureau is responsible for investigating the causes of disease and injury and for implementing control measures. Activities include: investigation and surveillance of communicable disease outbreaks such as mumps, measles, and whooping cough; control of tuberculosis through administration of a prophylactic treatment program; and disease surveillance.

The bureau works to control sexually transmitted diseases through contact tracing, disease surveillance and funding local health department clinics. Staff administer the statewide AIDS (acquired immune deficiency syndrome) Program that includes health education/risk reduction efforts, funding of testing and counseling sites, and surveillance.

The bureau operates a statewide immunization program that includes supplying vaccine to local health departments, disease surveillance, and consultation.

BUREAU OF ENVIRONMENTAL HEALTH SERVICES

This bureau is responsible for coordinating programs to solve public health problems that involve community sanitation and environmental concerns. The bureau, through inspection, investigation, or licensing, protects the public from unsafe food and consumer products. It licenses and regulates the use of radiation emitting equipment. The bureau also operates the Right-to-Know Program to inform the public of dangerous or hazardous chemicals in their community.

Bureau staff inspect and/or license: 8,000 food service facilities, 1,000 lodging establishments, 4,000 retail food stores, and 200 non-medical residential care facilities. The bureau investigates alleged incidents of food-borne illness and transportation accidents and natural disasters involving food and drugs. Staff inspect wholesale food facilities such as warehouses and grain elevators under a contractual agreement with the U.S. Food and Drug Administration. The bureau, under a contract with the U.S. Consumer Product Safety Commission, investigates faulty or hazardous consumer products.

Bureau personnel inspect all radiation sources. Those include radioactive materials and equipment emitting radiation, used in medicine, research, and industry. The Radiation Control Program also includes annual registration of x-ray machines, revision and development of state regulations governing radiation sources, and inspection and investigation of radiation sources. The bureau monitors the Wolf Creek nuclear generating facility and the surrounding environment. Staff, as part of a state emergency response program, provide technical assistance for the development of emergency plans and assistance during any type of radiological emergency.

The Right-to-Know Program implements community right-to-know activities required under state and federal statutes. The goal of the Right-to-Know Program is to determine the location of extremely hazardous and toxic chemicals in the state and make the information available to the public and local officials. The data can be used for determining the potential health effects and developing emergency response plans and procedures for dealing with discharges. Groups may also use it as a basis for public policy, epidemiological cross reference, and business planning.

KDHE is one of three agencies responsible for the Right-to-Know Program, staffing the State Emergency Response Commission. The commission receives reports, establishes rules and regulations, processes information, responds to public requests for information, and enforces provisions of the program.

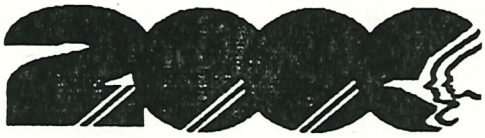
The bureau operates a community sanitation program that provides sanitarians in rural areas where such services are not available. County health departments receive technical assistance through the sanitation program. Issues addressed include vector control, private water supplies, septic tanks, single family lagoons, and sanitation zoning. The bureau also promotes the adoption of sanitary codes by individual counties.

BUREAU OF FAMILY HEALTH

This bureau plans, develops, and administers a network of services to the general maternal and child population and special target populations.

The Services for Children with Special Health Care Needs Program includes planning, development, and promotion of specialty health care for Kansas youth with handicapping conditions. 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.

The Nutrition Program and the Special Supplemental Food for Women, Infants, Children (WIC) Program are designed to improve the nutritional status of the general maternal and child populations that are at



HEALTH FOR THE NATION

NATIONAL HEALTH OBJECTIVES FOR THE YEAR 2000

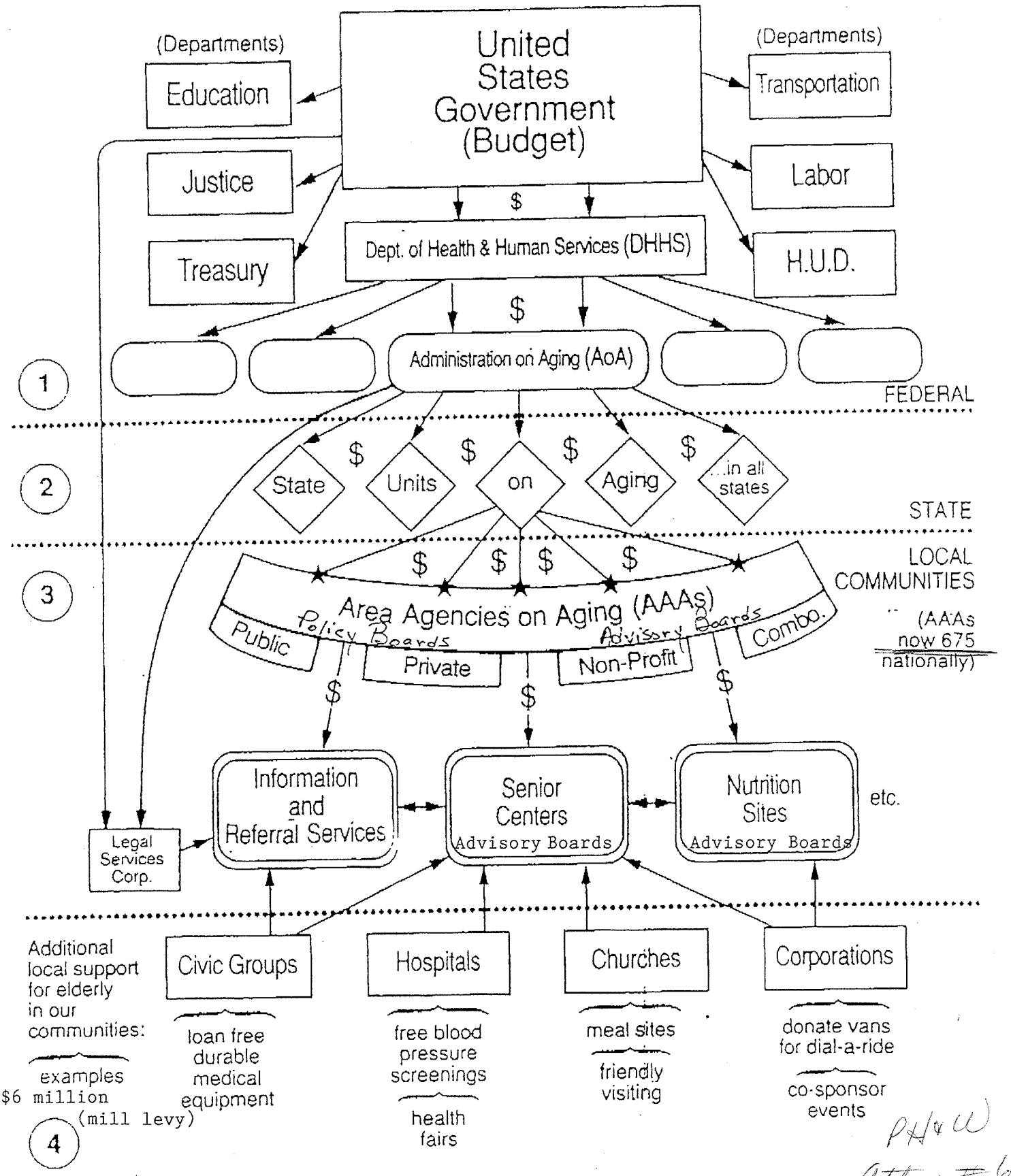
Priority Areas:

1. Reduce **Tobacco Use**
2. Reduce **Alcohol and Other Drug Abuse**
3. Improve **Nutrition**
4. Increase **Physical Activity and Fitness**
5. Improve **Mental Health and Prevent Mental Illness**
6. Improve **Environmental Public Health**
7. Improve **Occupational Safety and Health**
8. Prevent and Control **Unintentional Injuries**
9. Reduce **Violent and Abusive Behavior**
10. Prevent and Control **HIV Infection and AIDS**
11. Prevent and Control **Sexually Transmitted Diseases**
12. Immunize Against and **Control Infectious Diseases**
13. Improve **Maternal and Infant Health**
14. Improve **Oral Health**
15. Reduce **Adolescent Pregnancy and Improve Reproductive Health**
16. Prevent, Detect, and Control **High Blood Cholesterol and High Blood Pressure**
17. Prevent, Detect, and Control **Cancer**
18. Prevent, Detect, and **Control Other Chronic Diseases and Disorders**
19. Maintain the **Health and Quality of Life of Older People**
20. Improve **Health Education and Access to Preventive Health Services**
21. Improve **Surveillance and Data Systems**

P&HW
Attm #5
1-23-91

11/11/88

Who's Who in Aging? (Alphabet Soup)



P H & W
Attm 6
1-23-91

1991 PRIORITIES

KANSAS DEPARTMENT ON AGING

- Long Term Care: Increase the availability of long term care services.
- Marketing Aging Programs: Enhance aging programs' identification through promotion.
- Nutrition Services: Improve and maintain services by maximizing cost effectiveness, establishing minimum standards, increasing senior participation, studying site environment, and securing adequate funding.

KANSAS ASSOCIATION OF AREA AGENCIES ON AGING (K4-A)

- Expansion of the Senior Care Act Statewide
- Increased Funding of the State's Nutrition Program
- Expansion of the Older Kansans Employment Program

KANSAS ASSOCIATION OF NUTRITION AND AGING SERVICE PROGRAMS (KANASP)

- Capital must continue as an allowable expense and funding must be designated for this expenditure.
- Members of KANASP will provide quality service while putting forth every effort to maintain a high level of cost efficiency and addressing the problems of recycling and energy conservation.
- Due to the uniqueness of our varying geographic areas, members of KANASP believe that local decisions concerning the establishment of suggested contributions should be maintained.

KANSAS SILVER HAIRED LEGISLATURE

- Increased funding for nutrition programs, the Kansas elderly and handicapped public transportation assistance act, and senior centers across the State.
- Support for the Senior Care Act statewide, with $900,000 of state funding and flexible local match to be set by the Secretary of KDOA.
- Transferring the Social and Rehabilitation Services homemaker program to the Kansas Department on Aging.
- Urging the Kansas Legislature to implement, monitor and fully fund programs dealing with solid waste, hazardous materials and recycling.
- Allowing credits for in-home care of disabled persons.

P&H attach 7
1-23-91

RETIRED SENIOR VOLUNTEER PROGRAMS OF KANSAS (RSVP)

- State funding for RSVP programs.

KANSAS COALITION ON AGING (KCOA)

- Community Based Long Term Care Services
  - Additional Funding
  - Consolidation of Programs
  - Improved Access

- Nutrition Programs
  Additional Funding

- Medigap Insurance Reform
  - Standardization of Benefits
  - Review Impact of Loss Ratios on Value of Coverage
  - Determine Need for Medigap Insurance Counseling Program
  - Review Effect of Commission Structure on Sales Practices

- Maintain Value of Medicaid Coverage
  - Oppose Changes in Copayments
  - Oppose restrictions on Services Covered

AMERICAN ASSOCIATION OF RETIRED PERSONS (AARP)

- A uniform system for collection and dissemination of health data from health care providers regarding prices, quality of care, and patterns of use.

- A coordinated system of in-home, community and institutionally based long-term care services.

- A comprehensive program to improve access to health care for uninsured persons.

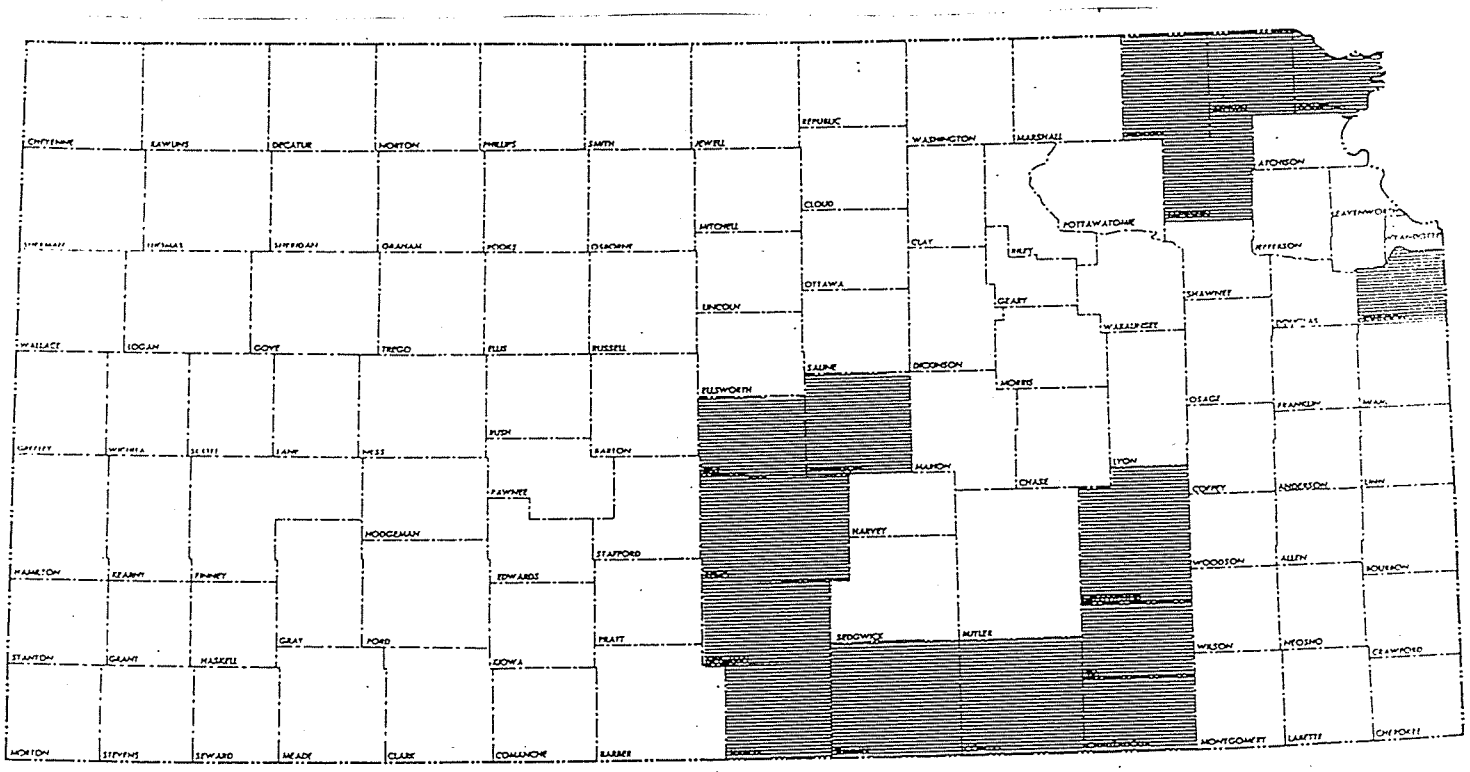
- Legislation authorizing the state to take advantage of selected federally funded programs to deliver needed health care services.

- A fair and equitable tax system adequate to support essential services.

/bms/105
Rev. 1-22-91

P&W
1-23-91
7-2

Senior Care Act (SCA)
FY 1990 Evaluation
1989-1990
Executive Summary



Esther Valladolid Wolf
Secretary on Aging

Prepared by Kansas Department on Aging.
Based on evaluation by Dr. David Balk and Kirsten Tyson-Rawson,
Kansas State University, July, 1990

P&W
1-23-91
Attm. #8

Senior Care Act (SCA)
FY 1990 Evaluation
1989-1990
Executive Summary

Prepared by Kansas Department on Aging.
Based on evaluation by David Balk and Kirsten Tyson-Rawson,
Kansas State University, July, 1991.

A constant theme in the words of Senior Care Act consumers and their caregivers was "This program is a God send."

The 1989 Kansas Legislature authorized the Senior Care Act (SB 60) and appropriated $250,000 as recommended by Governor Hayden. The program now begins its second year in three areas of the state - Johnson County, Northeast Kansas, and South-Central Kansas.

The evaluation of the SCA's first year of operation found:

> For the elderly reached by the SCA program, help was provided in maintaining or increasing a quality of life involving pride, independence, and privacy. The SCA services reduced the risks that elderly persons face when they do house-hold chores -- risks such as falling, breaking bones, and placing stress on hearts and lungs. The SCA allowed some people to leave hospitals and return home. A constant theme in the words of SCA clients and their caregivers was "This program is a God send."

By the end of May, the three programs had served 451 persons with 9,905 hours of homemaker care and 1,343 hours of attendant care.

The first year's evaluation measures both successes to be continued and problems to be corrected or needs to be studied in the second year of the program.

What We Have Learned - *Year 1*

1. Advantage of Local Control

The SCA program struck us as a fine example of local empowerment through public funds. For instance, the elderly clients' development of trust and caring for the housekeepers speaks eloquently of the sensitivity of local programs to local needs -- and of the political wisdom of the shapers of this SCA program at the State level.

2. Acceptance of Cost Sharing

An unserved and needy population was identified and -- in terms of SCA eligible clients -- provided in-home care. It

Revised
1-23-91

8-2

became clear that elderly citizens will participate in an in-home care program structured along cost-sharing lines. The elderly were willing and glad to share costs. Johnson County suggested at one point, however, that up to half of the persons it screened were eligible but unwilling to pay the cost of SCA services.

The evidence we obtained is that participants found the SCA program costs were reasonable, particularly in light of the services received. We believe that one must not overlook intangibles gained through the SCA (for instance, providing a trust-worthy homemaker, easing concerns over getting a home "clean and livable", reducing the prospect of injury to elderly who struggle to do household chores; and giving respite for caregivers such as adult children of elderly parents).

3. Help for Caregivers

The caregivers of the elderly -- many of whom are also elderly -- are vulnerable to multiple demands and pressures. We believe the SCA program reduced their vulnerability, and in this way the program added to the quality of these persons' lives too.

4. Efficiency

The three AAAs implementing these pilot programs demonstrated competency to manage public funds allocated for needs-based programs. Whenever called, each AAA had a clear record of SCA funds expended to that point in time.

The three programs demonstrated marked ability to deliver cost effective services. The average cost per client -- and the average hourly cost per service -- presented clear evidence of making do with tight budgets.

The three AAAs delivered SCA services for an average of $290.25 per person and $10.77 per hour of service.

5. Area Agency (AAA) Administration

The three AAAs did provide some contrasts in program delivery and implementation. The Northeast Kansas area is more sparsely populated than the other two PSAs and is characterized by geographic distance which can create greater isolation for its clientele. Case finding occurs one at a time. While all programs find cases one at a time, this truism seems even more pronounced for the NEK AAA due to population characteristics. The NEK approach to recruitment and program development is more direct, personal, and informal than a larger organization could permit; direct, personal, informal approaches fit the context in which NFK operates. AAA professionals and service providers demonstrated great

P&Rec'd
1-23-91
Attm. # 8-3

skill at providing grassroots services using local resources that create what is needed for clients.

In comparison to NEK, the Johnson County AAA was required to abide by and meet the standards of a greater number of governing bodies with a greater number of rules and procedures than NEK. This AAA serves a predominantly densely populated area and relies on a more centralized administration and implementation of programs. There was less of a direct, personal involvement between AAA staff, providers and clients than found in the NEK and SCK areas. However, the AAA professionals responsible for the implementation of the program were able to maintain their strong commitment to individual clients while negotiating the bureaucratic hoops necessary to make the program a reality.

South Central Kansas (SCK) struck us as a model of community organization and community empowering. We have concluded that the success of the SCK AAA with the Senior Care Act is attributable to many interacting factors: the well organized and coordinated aging network, earlier experiences of the AAA in providing similar services on a smaller scale, and a wealth of open communication between organizations.

Problems To Be Solved - Year 2

6. Start-Up Costs

Start up costs were greater than anticipated -- as were efforts to get the SCA project rolling. Some of these start up costs were incurred in familiarizing some service providers with monthly reporting requirements. This type of cost will emerge as each new local project is begun, and the experiences of the first three AAAs could produce expert advice on reducing problems and eliminating mistakes.

7. Management Information

Data collection problems hindered better management of program activity data and presented obstacles to understanding monthly and year-to-date operations. As one AAA director said, "I don't know what the SCA software is doing, and I don't understand it. Maybe it is helping you, but it's not helping us."

It is paramount in the opinion of the evaluators that a unified, reliable computerized management information system be ready for the next year of SCA programming.

PN&W
1-23-91
Attm # 8-4

8. Targeting

Nearly everyone screened was White (96.7%), with 1.2% Black and 2.1% "Other." According to 1980 census data the racial characteristics of persons 65 and older in the three Planning and Service Areas were 96.5% White, 0.9% Black, and 2.6% "Other."

Although the data suggest that the racial composition of the persons screened matches the 1980 census data in terms of proportions -- the evaluators will not make any bold statements about targeting services.

9. Prevention of Institutionalization

No direct evidence confirms that the SCA kept clients out of nursing homes. A carefully designed longitudinal study would be needed to test that hypothesis. A mine of indirect evidence supports the belief in the efficacy of these services in preventing institutionalization -- evidence derived primarily from the comments of persons interviewed (clients and their relatives).

10. Gaps in Services

Gaps in service bear investigation. These gaps come in several forms, such as:

(a) services needed but unavailable (e.g., respite care);
(b) elderly in need but not served due to policy restrictions (the SRS/SCA demarcators of eligibility);
(c) elderly in need but not served due to location restrictions ("the very rural";
(d) elderly in need but not served due to organizational limitations.

For more information contact:

Bill Cutler
Kansas Department on Aging
Docking State Office Building
915 S.W. Harrison
Topeka, Kansas 66612-1500
(913-296-4986)

NOTE: KDOA summary is written in italics. KSU evaluation is written in regular type

PH&W
1-23-91
Attm. # 8-5

Case Studies

Here are examples of consumers who have been served by the Senior Care Act. Interviews were conducted by the evaluators from Kansas State University.

An Interview with Mr. K

Mr. K is an 81 year old retired farmer and railroad engineer. He worked forty years on the railroad and suffered an accident that damaged his right arm; he can barely raise the arm to chest level. His hands tremble noticeably.

Mr. K has lived in his home for the past ten years. He has been getting SCA homemaker services "for the past six months...more or less."

He says the housekeeper "comes in about once a week. She cleans everything in the house she can get to. She washes the sheets, cleans my kitchen and the bathroom, vacuums the carpet, and dusts all the furniture. She washes clothes once a week. She's got a good personality and is a good worker. She's a real good help. I used to clean the house, but things finally got to where I couldn't. Yeah, she's a big help. Don't know what I'd do without her.

"Financially I ain't too good. Got enough to get by. My daughter can't help around the house. She has two kids and has all she can do to take care of herself."

An Interview with Mr. and Mrs. F

Although Mr. F., 81, was a skilled carpenter, the outside of their home shows a somewhat rundown appearance. Mrs. F. remains in her chair most of the time because even with her walker, "I feel uneasy," she says. "I guess I have a phobia about falling, especially down steps. It gives me the chills to think about it."

Mr. F reports says that he worries about his wife. "I just can't do for her the way those little girls (SCA bath aide and homemaker) can. They have the best time. They just laugh and talk--girl talk I imagine."

Mrs. F adds, "I tell you, they just can't stop this (service). I have to get after that nice girl that does the cleaning or she'll just work too hard. At least we can pay our little bit that feels good too."

An Interview with Mrs. M

Mrs. M is 86 years old. Her home is part of a residential neighborhood but is concealed on all sides by large bushes and

P Hall
1-23-91

Attn # 8-6

trees. She has lived in her home since 1949, and has been on her own for the past 26 years since her husband's death. She has no children.

Mrs. M is confined to a wheelchair. "I have arthritis in my back, hip, and knees. I can't walk at all. When I lose my balance and fall, I'm not able to get back up. That's happened a lot. The good Lord has been with me. No broken bones.

"My husband died 26 years ago, and I've lived on my own since 1964. I'm used to being independent. Doesn't mean I don't get lonesome 'cause I do. But there's nothing you can do about it. Four years ago I had surgery for cancer. That's when I started to need help.

"I was with SRS for a long time until I go a $3.00 raise on Social Security. I have to have somebody clean my place. I can't do things that require me to stand. There's no use taking chances. I didn't know anything about these aging services deal. My nurse told the aging people that I needed help.

"I don't want to just pick up somebody out of the paper. I'm pretty skeptical. Rather than take chances, I decided to go to the Aging Services -- where the person they send will have been checked. I don't want someone in here I don't know if I can trust. People these days just take advantage of you.

"I've been getting these housekeeper services since this Spring. I can't remember for sure. She does general housework. Puts in two hours a month. Sweeps, cleans the bathroom, dusts. I do my own washing.

"We've been getting along well so far. She does what I tell her. Of course, no one will clean like you do yourself. She gets the place pretty well cleaned. She doesn't get in back of things or move things. The cost is very, very reasonable for two hours. You can't look a gift horse in the mouth.

"I don't know what I'd do if these services weren't available. I don't want just any Tom, Dick, or Harry in my house.

"The doctor told me, 'You ought not to be by yourself.' And I said, 'Don't talk to me about nursing homes.' I've been in a nursing home once. No thanks. I couldn't afford to go into a nursing home. They cost too much, and you can't get any service.

"The only way they'll get me into a nursing home is with a court order. I want to be in my own home, do what I want, eat what I want. Of course, if I no longer could think for myself, it wouldn't make any difference."

PAHCW
1-23-91

Attn. 8-7

Balance Needed in State's Health Care System

by Esther Valladolid Wolf

Kansas is aging. The fastest growing segment of the population is people 85 and older. Between 1990 and 2000 that age group will increase by 24 percent. Already we have seen an increase of 14 percent during the past decade among people 74 to 84 and 22 percent among people 85 and older.

These demographic changes are now challenging our health care system. The Kansas Department on Aging believes that health services for older Kansans can be improved by creating a better balance between institutional and home care services.

Home care options:

When its older citizens have required some kind of long-term care, Kansas has chosen institutionalization as its number one option. Of all states, Kansas ranks seventh in the number of nursing home beds per 1,000 population over 65. Kansas has devoted 92 percent of its long-term care dollars to institutional care. A person in need of long-term care has usually only one choice in this state -- a nursing home.

Nursing home costs are escalating. The Legislative Division of Post Audit found a 65 percent increase in nursing home costs between 1982 and 1988. The 1990 Kansas Legislature confronted the issue and has asked SRS to revise its reimbursement rates.

PH&W
1-23-91
Attm. #9

Despite our investment in nursing homes, problems persist. The Health Care Financing Administration has identified serious problems in the use of restraints, in the provision of personal hygiene, and in the preparation and service of food. Our dollars have not always bought quality care.

The Department on Aging believes that we must provide older Kansans alternatives to nursing home care. We have a foundation for such alternatives through the following programs supported by federal, state and local funds.

* The department is funding in-home services through the Older Americans Act throughout the state.

* The 1989 Kansas Legislature authorized the Senior Care Act, which dedicated state funds to in-home services in three areas of the state.

* SRS is operating the Home Care Program which provides homemaker and attendant care services to people with incomes below 150 percent of poverty.

* SRS is operating the Home and Community Based Services Program that provides in-home services to people eligible for Medicaid.

* Local governments are supporting in-home services by matching Senior Care Act funds and by using aging mill levies in other areas to fund services.

Despite this foundation for service delivery, older Kansans have to be poor and/or lucky to get in-home care. With only 8 percent of the state's long-term care dollars, neither SRS nor the Department on Aging can meet the need for in-home care. Kansas has chosen to invest in nursing home care, but our people would prefer home care.

PHCC
1-23-91

9-2

Caregivers:

The most important source of long-term care is not a government program. Families provide most of the caregiving. One-fourth of the caregivers are aged 65 to 75, and 10 percent are aged 75 or over. In this way, older Kansans are an important provider of health care.

Younger family members also have an important role in long-term care. Adult daughters are 29 percent of the caregivers for disabled older family members. For children and spouses, the caregiving burden can be significant.

The Department on Aging has paid special attention to Alzheimer's disease through the work of the 1985 Task Force on Alzheimer's and Related Diseases and the Department's helpline. Like other catastrophic illnesses, Alzheimer's Disease victimizes the family caregivers as well as persons with the disease.

Kansas lags behind other states in providing help to caregivers who are sacrificing their own health to care for victims of catastrophic illnesses. Respite care and other in-home services are a part of the solution. Most of the burden of the "36-hour days" will fall on the families, but the state needs to lend a hand.

Health Promotion:

Older Kansans are taking responsibility for their own health through participation in health promotion activities. In the long

PHHC
1-23-91
93

run, investments in health promotion will pay dividends as we all age.

One study estimated that 60 percent of all health problems are a result of such personal discretionary behavior as cigarette smoking, abuse of alcohol, lack of exercise, poor nutrition and poor stress management. Targeting these behaviors can be a productive endeavor for our health and aging programs.

The initiative for health promotion has come jointly from the federal Administration on Aging and the Public Health Service. In Kansas, the Department of Health and Environment has funded LIVELY health promotion programs for older Kansans through local health departments.

Health and Environment and the Department on Aging have joined together this year with the National Resource Center on Health Promotion and Aging to promote cardiovascular health.

Acute Care:

Acute care is a problem for older Kansans because of the repeal of the Medicare Catastrophic Coverage Act. The repeal left a significant gap in coverage: payment for prescription drugs. Only people who are eligible for Medicaid can get help with the costs of medications.

Another gap that neither Medicare nor Medicaid will cover is dental care. The Kansas Dental Association offers a discount program, but 10 percent to 20 percent discounts will not make much difference on a monthly SSI income of $386 per month. Kansas has

PHCW
1-23-91
attn 9-4

chosen to delete adult dental care from its Medicaid plan as a way to balance the budget.

Acute care is also limited by geography and age. Rural health care is important to older Kansans because 20 percent to 40 percent of the population of rural counties is older Kansans. The Department on Aging supports the activities of the Office of Rural Health in promoting better services in Kansas.

Age is also a barrier because people can only qualify for Medicare at age 65. Many people between ages 55 and 65 have no insurance because they have no job or a job with no fringe benefits. This is a problem addressed by The Commission on Access to Services for the Medically Indigent. The 1989 Silver Haired Legislature endorsed the Commission's proposal for a Kansas Health Benefits Program.

One other program deserves your attention because of its underutilization: the QMB (Qualifying Medicare Beneficiary) Program. It was one part of the Medicare Catastrophic Coverage Act that survived. The program pays the deductibles, copayments and premiums under Medicare, if a person has less than $4,000 in assets and an income less than 90 percent of the poverty level. Many people have never heard of this program although it has been in operation since January, 1989.

Older Kansans have an important role in health care delivery as caregivers for family members in need of long-term care and as participants in health promotion activities. Without this resource the health system would be even more reliant on institutionalization and hospitalization.

PHCW
1-23-91
9-5

Testimony

KANSAS DEPARTMENT ON AGING: Informational Presentation

By
Acting Secretary of Aging Esther V. Wolf

Before the
House Public Health and Welfare Committee
January 23, 1991

Federal and State Priorities

The future will be shaped by changing state and federal priorities.

I. Federal changes will be made this year when the Older Americans Act is reauthorized.

- There will probably be a new authority for cost sharing.

The Senior Care Act with its sliding fee scale is a model of what federal legislation may authorize.

- There will probably be a new emphasis on targeting people in greatest economic and social need.

KDOA has funded two pilot projects in FY 1991 for targeting people in Southeast and Northeast Kansas.

II. State priorities are also changing. KDOA has established three external priorities for FY 1991.

- Information and referral has also been a program priority of the aging network. In the future, KDOA plans to expand on its success in developing a popular Legal Guide, an innovative senior press service, and a media campaign to promote nutrition and transportation services.

- Long term care has been a continuing priority of the aging network for over a decade. In the future, Kansas should expand the successful Senior Care Act projects as authorized by the 1989 Kansas legislature into a statewide program.

PHell
1-23-91
Attm. # 10

Senior Care Act

- The first year evaluation of the Senior Care Act shows that in-home services are a critical factor in keeping Kansans independent in their own homes.

Area agencies on aging competently administered programs in three areas of the state.

- A statewide program is needed. Only 15 counties are now served.

The Senior Care Act has even successfully served people on the SRS waiting list.

Nutrition

- Nutrition services have always been the largest program at KDOA. In the future, we should redesign the delivery of these services to ensure quality and efficiency.

The Kansas Department on Aging plans to implement the following priority in 1991 for nutrition services: Improve and maintain services by maximizing cost effectiveness, establishing minimum standards, increasing senior participation, studying site environment, and securing adequate funding.

- Establish task force.
- Write standards.
- Market services.
- Increase targeting.
- Increase number of minority participants.
- Advocate for increased funding.

PH&W
1-23-91
10-2

Adult Abuse

The Attorney General's Task Force on Victims' Rights has endorsed three changes to deal with adult abuse.

- Adult abuse should be made a crime in Kansas as it is in 28 other states. Currently it is a crime not to report abuse, but it is not a crime to commit abuse.

- An elder abuse prevention fund should be created. The Children's Trust Fund for the prevention of child abuse is a model.

- A toll-free telephone line to report abuse should be established as authorized by K.S.A. 39-1441.

PH&W
1-23-91
10-3