Approved: February 4, 2004
Date

MINUTES OF THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE

The meeting was called to order by Chairman Jim Morrison at 1:30 p.m. on February 2, 2004, in Room 526-S of the Capitol.

All members were present except:
Representative Doug Patterson- excused
Representative Mario Goico- excused
Representative Roger Reitz- excused
Representative Scott Schwab- excused
Representative Joe McLeland - excused

Committee staff present:
Dr. William Wolff, Legislative Research Department
Renae Jefferies, Office of Revisor of Statutes
Gary Deeter, Secretary

Conferees appearing before the committee:
Dick Morrissey, Interim Health Director, Kansas Department of Health and Environment
Terri Roberts, Executive Director, Kansas State Nursing Association

Others attending:
See Attached List.

The Committee minutes for 1-29-04 were approved as printed.

The Chairman raised the question of whether the Health and Human Services Committee violates the open meetings act with Instant Messaging. He said he will check with the Kansas Attorney General and provide an answer for the Committee.

Dick Morrissey, Interim Health Director, Kansas Department of Health and Environment (KDHE), gave an overview of the state of health in Kansas. (Attachments 1 and 2) He listed several chronic diseases, saying that cardiovascular disease (heart disease and stroke) is the leading cause of death in Kansas, accounting for 27% of all deaths. Speaking of tobacco use, responsible for 3800 deaths annually, he said it is the one preventable cause of death in Kansas. Commenting on obesity, he said one in five adult Kansans is obese, and three in five is overweight, increasing medical costs for a variety of concomitant diseases. He said the medical response to these three factors is: Don't smoke, move more, and eat less. He also commented on various violent injuries: from motor vehicles, falls, fires, and suicide.

Speaking about infectious diseases, Mr. Morrissey said that Kansas has had at least one case of each of the latest infectious diseases, such as West Nile, SARS, and viral hepatitis. He noted that immunization rates for Kansas' children are some of the lowest in the country, prompting a KDHE task force to determine why so many Kansas children are not being immunized. He noted that AIDS and HIV rates are lower than the national average.

Mr. Morrissey stated that maternal and child health is a critical area because it is a reflection of the current health status of the Kansas population; it is also a predictor of the health of the next generation. He said the live birth rate of 87% compares favorably with the baseline of Healthy People 2010 data, noting that the Kansas death rate for babies has decreased 58% over the past 30 years in Kansas. He said breast-feeding is an important contributor to infant health, and that Kansas mothers were above the national initiation rate for breast-feeding (74%), but that they were below the national rate at six months (29%).

Regarding access to health care, Mr. Morrissey said that over 2/3 of Kansas children are covered by private insurance, 15% by public insurance, and 8% have no health insurance. For women of reproductive age, the figures are 83%, 4%, and 13% respectively.

Representative Sharp suggested to the Committee that perhaps there are immunization statutes that need updating in the light of the low immunization rates.

Answering questions, Mr. Morrissey said that marriage certificates issued made up 7.3% of the population in 2002, and divorces/annulments were 3.6%. Dr. Pezzino, State Epidemiologist, KDHE, said the more rapid conversion rate from HIV to AIDS compared with the national population could be a variance in reporting standards, or KDHE's message may not be effective. Mr. Morrissey stated that KDHE had discussed an immunization registry for years, but federal funding last year will allow it to become a reality.

For purposes of hearing **SB 106**, Representatives Kirk and Long chaired the meeting. Representative Long opened the hearing on **SB 106.** Mr. Morrissey spoke in support of the bill, saying that the contents of the bill fit the goals and mission of KDHE, noting that although no funds were allocated to Healthy Kansans 2010 in the Governor's budget, he believes there may be private funding from foundations that will get the program started and achieve the basic objectives of the bill. He said the bill serves as a roadmap for collaborative health planning across the state. (Attachment 3)

Terri Roberts, Executive Director, Kansas State Nurses Association, spoke in support of **SB 106**. (Attachment 4) She said the bill supports KDHE in providing leadership and direction on health-prevention activities, work that the nurse's association has partnered for the past 14 years.

Representative Long closed the hearing on **SB 106**.

Representative Bethell, who chaired a hearing on January 29, made some observations about chairing an electronic committee. He said it ran smoothly for several reasons: a hard copy of the agenda was provided for the chair; use of Instant Messaging (IM) assisted in handling committee questions; and the testimony projected on the wall was a good reference point. He noted two glitches: IM keeps the chair from seeing committee members who raise their hands to comment; and the possibility of an IM message inadvertently being projected on the wall is slightly disconcerting. He summarized by saying that in general the process worked very well.

MINUTES OF THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE at 1:30 p.m. on February 2, 2004 in Room 526-S of the Capitol.

Staff Bill Wolff briefed the Committee on **HB 2562**, a bill creating a care-giver's authorization affidavit for children and minors. He said the bill creates a new category of care-giver, who by signing the affidavit is given certain legal rights for decision-making of a minor child. He said the care-giver's decision can be superseded only through a contravening decision by a parent or guardian. He noted that the term "qualified relative" gives the same rights to authorize medical and dental care for a minor as are given to guardians, noting that the affidavit is valid for one year. Dr. Wolff said that any person acting in good faith on the decision of a care-giver's authorization affidavit would be protected from professional disciplinary action. He noted that the bill states that no one is relieved of liability for violations of other provisions of law, but said that what these other provisions might be is unclear. He stated that the affidavit must contain a warning statement that if any statements are incorrect, the person signing it will be committing a crime. He observed that the concept of a care-giver's affidavit is apparently popular in other states and that several forms are available on web sites.

Answering questions, Dr. Wolff said the wording of the bill indicates that the content and design of the affidavit form should be uniform. Members discussed various kinds of residence situations where minors are living with relatives or friends, but came to no conclusions about how the bill might address such issues. Dr. Wolff said that the person who receives the form has no obligation to make any further inquiry or investigation as to the validity of the affidavit.

Representative Storm observed that, in larger school districts, the bill would create problems by individuals who abuse the system. She said the House Education Committee is dealing with a similar bill.

The meeting was adjourned at 2:47 p.m. The next meeting is scheduled for Tuesday, February 3, 2004, at 1:30 p.m.

HOUSE HEALTH AND HUMAN SERVICES COMMITTEE
GUEST LIST

DATE: FEBRUARY 2 2004

NAME	REPRESENTING
Linda Kenney	KDHE
Ron Seeber	Hein Law Firm
Chip Wheelen	Assn of Osteopathic Med.
Amber Polansky	—
Paula Marmet	KDHE
Sharon Patnode	KDHE
Dick Morrissey	KDHE
Susan Kang	Kdhe
GIANFRANCO PEZZINO	KDHE
[illegible]	Tobacco Free Kansas Coalition
Marie Ann Rover	KAHP
John Peterson	Ks Governmental Consulting
Terri Roberts	Kansas State Nurses Assn.

Review of the State of Health in Kansas
before the
House Committee on Health and Human Services
by
Roderick L. Bremby
Secretary of Health and Environment

February 2, 2004

Mr. Chairman, members of the committee, I appreciate this opportunity to talk with you about the health of Kansans. No other aspect of our lives affects our overall well being as much as health. The folk wisdom of our grandmothers is still true today: if you have your health, that's the most important thing. Kansans are relatively healthy, but there are significant opportunities to improve health outcomes related to chronic diseases - particularly relevant for Kansas elders, and related to injuries and infectious diseases. I will also outline for you key issues affecting the health of mothers and children in our state.

Chronic Disease

The significance of chronic disease can be described in terms of health care expenditures. Our nation spends more on health care than any other country in the world: spending $1.4 trillion in 2002. This figure is projected to reach $2.8 trillion by 2011. Health care costs have been increasing rapidly in the past decade. In 1980, the nation's health care costs totaled $245 billion - an average of $1,066 for each American. By 2001, this figure grew to $5,035.00 per American, approximately $12 billion in Kansas. Chronic diseases account for roughly 75% of health care costs each year, approximately $9 billion per year in Kansas. As states struggle to meet the staggering costs of providing health care to those in need, the most cost-effective interventions to lessen the growing burden of chronic disease are frequently overlooked.

The premise of the chronic disease and health promotion programs are based on the fact that tremendous achievements in health are possible if we focus on the risk factors that underlie chronic disease. In fact, 33% of all deaths are attributable to three modifiable health-damaging behaviors: tobacco use, lack of physical activity and poor eating habits.

Chronic Disease Burden

Cardiovascular Disease (heart disease and stroke) remains the leading cause of death in Kansas, accounting for 27% of all deaths, in spite of declining rates of heart disease mortality. The health disparity between black and white Kansans appears to be growing, especially among younger ages. Geographically, the highest rates are found in the eastern and central areas of the state.

Attachment 1
HHS 2-2-04

Cancer is the second leading cause of death in Kansas, accounting for 22% of deaths in 2001, despite the preventable and often treatable nature of many types of cancer. More than 12,000 cases were reported to the Kansas Cancer Registry in 2000. Female breast, prostate, lung and bronchus, colorectal, skin and cervical cancers account for over 63% of the cancer incidence and over 54% of cancer deaths each year, despite the preventable nature of many of these cancers.

Diabetes prevalence and death rates have doubled in the past two decades, positioning it as the 6th leading cause of death in 2001, with total direct (medical) and indirect (lost productivity and premature cost) costs totaling about $1.3 billion in 2001. Much of the rise is likely due to an increasingly older, more sedentary and progressively overweight population.

Tobacco Use

Tobacco use alone is responsible for approximately 3,800 deaths each year in Kansas and remains the number one *preventable* cause of death in Kansas. Tobacco use prevention is the area for which the science is most precise. A growing number of states are reaping huge benefits from investing in statewide tobacco use prevention programs. From California to Maine, these states have accomplished huge reductions in smoking and are already experiencing decreases in lung cancer and heart disease as a result.

"Best Practices for Comprehensive Tobacco Control Programs", recommended by the Centers for Disease Control and Prevention outlines the 9 component areas of a state approach to cut existing rates in half:

1) Community Programs (partnerships)
2) Chronic Disease Programs (focus on tobacco related disease)
3) School programs (policy, curriculum, training of staff, community/family involvement, cessation support, evaluation)
4) Enforcement
5) Statewide programs (technical assistance to regional programs and support of organizations representing disparate populations)
6) Counter marketing
7) Cessation
8) Surveillance and Evaluation
9) Administration & Management

Tobacco currently costs Kansas $724 million in direct medical costs, plus another $741 million in indirect (lost productivity) costs per year. This includes $153 million in total state Medicaid program expenditures. An investment of $18.1 million per year in a comprehensive tobacco use prevention program for a period of 5 years is projected to save 33,100 adult lives and the lives of 35,600 youth who are alive at the time of the investment. From a medical expenditure perspective, this same 5 year investment is projected to accrue into a lifetime savings of $814.3 million in health care savings among adults and an additional $427.2 million additional healthcare savings over the adult lifetimes of the youth who would be prevented from starting to smoke.

Overweight and Obesity
More than 1 in 5 Kansas adults are now obese, representing a 70% increase since 1992. Almost 3 in 5 Kansas adults are at least overweight. While increased consumption of fruits and vegetables helps reduce risk for heart disease, diabetes and certain cancers, fewer than 1/4 of adults in Kansas report eating the recommended minimum of 5 servings of fruits and vegetables per day.

The costs of obesity are staggering: the increase in Medicaid per capita costs for adults is estimated at $864/person. In 2000, the total cost of obesity in the US was estimate to be $117 billion, including estimates of $14.1 billion in Medicaid expenditures, and $23.5 billion in Medicare expenditures, prompting the federal government to convene a national work group to produce the guidelines, based upon best available science at that time.

The lifetime medical costs of five diseases and conditions (hypertension, diabetes, heart disease, stroke, and high cholesterol) among moderately obese people are $10,0000 higher than among people at a healthy weight. While the body of research of studies to support promotion of healthy eating and physical activity is not as extensive as those for tobacco, they are nevertheless showing the same degree of promise for preventing chronic disease. Lifestyle changes in diet and exercise to promote losses of 5% to 7% in body weight can prevent or delay the onset of type 2 diabetes for Americans at high risk for the disease - those defined as prediabetic and have been shown to decrease pharmacy costs for diabetes and hypertension.

Physical Activity
More than one-fourth of Kansas adults engage in no leisure-time physical activity of any kind and less than ½ of adults in Kansas obtain the recommended level of physical activity. In 2000, health care costs associated with physical inactivity were more than $76 billion. If 10% of adults began a regular walking program, $5.6 billion in heart disease costs could be saved. Every dollar spent on physical activity programs for older adults with hip fractures results in a $4.50 return.

Injury and Violence
In Kansas, injuries are the leading killer of children, youth, and adults ages 1-44. Injury costs are a major drain on state resources, costing an estimated more than $224 billion each year. These costs include direct medical care, rehabilitation, lost wages and lost productivity. Because injuries are predictable, a small investment in injury prevention will save both lives and money: $1 spent on smoke alarms save $69, $1 spent on bicycle helmets saves $29 and $1 spent on child safety seats saves $32.

Motor Vehicle Injuries: In 1999, motor vehicle traffic crashes resulted in 40, 965 deaths (540 deaths in Kansas) and were a leading cause of death in the United States among people ages 1 to 34. Each year, an additional 3.5 million people (30,528 injuries in Kansas) suffer nonfatal motor vehicle motor vehicle-related injuries, causing about 4 million emergency department visits and 500,000 hospitalizations. In 1994, motor vehicle crashes cost more than $150 billion in property damage, lost productivity, and medical expenses.

Failure to use protective helmets: 1n 1996, 2,160 motorcyclists died (20 Kansans deaths in "2-wheeled vehicle accidents") and approximately 56,000 were injured (593 injured Kansans) in highway crashes in the US. Per mile traveled, a motorcyclist is approximately 16 times more likely to die in a crash than is an automobile occupant. That same year, 761 bicyclists were killed, and approximately 59,000 were injured in traffic-related crashes. Children ages 14 and under accounted for 223 (29%) of these fatalities, making this one of the most frequent causes of injury-related death for young children. Head injury is a leading cause of death in unhelmeted cyclists.

Falls: Every hour an older adult dies as the result of a fall. In 1998, more than 9,600 persons 65 and older died from fall-related injuries (159 Kansans died), making falls the leading cause of injury death among this age group. Approximately 300,000 older adults suffer fall-related hip fractures each year. In 1994, the estimated cost of fall-related injuries was $20.2 billion. By 2020, it may reach $32.4 billion.

Fires: Every 27 minutes someone is killed or injured in a home fire. About 79% of all fire deaths occur in the home. In 1999, approximately 383,000 residential fires killed about 2,900 people (22 Kansans) and injured another 16,050 in the US.

Suicide: In 1998, 30,575 Americans (328 Kansans) took their own lives, an average of 84 each day. In 1998, suicide was the eighth leading cause of death in this country. For 10 - 24 year olds, it was the third leading cause. The number of completed suicides reflects only a small portion of the impact of suicidal behavior. In 1998, and estimated 671,000 visits to US hospital emergency departments were due to self-directed violence.

If we are serious about improving the health and quality of life of Kansans AND keeping our heath care budget under control, we cannot afford to ignore the power of prevention.

Infectious Disease

Infectious diseases are becoming increasingly burdensome in our present day world. Kansas has not escaped this trend. Increases in infectious diseases result from many factors, including: increased vulnerability to infection, increased contact among people from around the world, decreased emphasis on public health disease prevention interventions, and increased antibiotic use leading to the emergence of drug-resistant diseases. Illnesses once unknown in the U.S. have emerged to kill many Americans. One example of a disease undetected in this country until 1999 is West Nile Virus. One human case was reported in Kansas in 2002, while the number of severe cases reached 90 in 2003. In the fight against the spread of infectious disease in Kansas, particular challenges face KDHE in several areas. Strengthened required disease reporting implemented in late 2002 provides increased ability of KDHE to monitor the advent and spread of disease. Diseases added to required reporting by medical facilities and clinicians include SARS and West Nile Virus-related diseases. Federal bioterrorism funding is allowing KDHE to develop improved disease intervention training for both State and local public health officials. Because State-provided funding has not kept

pace with emerging disease, this federal funding has been crucial to the State's keeping pace with world disease trends.

Immunization
Immunization rates for Kansas's children in vaccine-preventable diseases are some of the lowest in the country. All factors leading to this aren't clear; however, I will be convening a task force reviewing this issue and recommendations for increasing immunization rates should be made by late summer. Nationally recognized success in this area is the development of a statewide immunization registry and increased mandates of vaccination for school entry, both which are being undertaken by the Kansas Immunization Program currently. (Kansas will have new Hepatitis B and Varicella - chickenpox - mandates in place in the coming year.)

The Kansas Immunization Program is partnering with the Department of Social and Rehabilitation Services to conduct an outreach project to increase immunization rates of Medicaid children in ten counties with lower rates.

Tuberculosis
While successful monitoring of the disease and targeted intervention strategies have led to an 18% decrease in total Tuberculosis cases from 2002 to 2003 (73 cases of TB in Kansas in 2003), the complexity of the remaining cases makes successful treatment difficult. While the good news is the lowered rate of disease (Kansas had experienced increasing disease rates for five years until 2003, when the rate decreased), Kansas is mirroring national trends by experiencing increased numbers of multidrug resistant TB. (Kansas had experienced no such cases until 2001, when the first case appeared. Thereafter, Kansas has had two multidrug resistant cases in each of 2002 and 2003.) This form of the disease causes increased costs for medications and increased treatment duration. In addition, the social issues surrounding many of the remaining cases makes treatment difficult. An outbreak in 2003 in an urban area's homeless population warranted assistance by staff from the federal Centers for Disease Control and Prevention. Remaining problematic is the number of people with tuberculosis fighting alcoholism. One final note on Tuberculosis disease rates is the fact that ten cases of TB in 2003, primarily treated in Kansas, are not included in case counts because they were diagnosed in other states. This counting problem is a federal disease counting rule, which masks the impact of the disease on the State's tuberculosis control program resources.

Sexually-transmitted Disease
While in general, sexually-transmitted disease rates have decreased, racial and ethnic minorities are disproportionately represented among cases of the three major reportable bacterial STDs. (Rates of gonorrhea decreased 2% in 2002; early syphilis rates dropped 13% in the same year.) STD remains a disease few people want to hear about. Lack of public attention to these diseases remains true in Kansas because of stable disease intervention strategies that could be comprised if budget cuts continue. Two points to consider in this area are the fact

that Kansas is following the country in experiencing periodic outbreaks of syphilis. Kansas STD staff, have been recognized nationally for successful early disease intervention, which has curtailed the expansion of syphilis outbreaks in urban areas of the State. More focused testing of high-risk populations for chlamydia (women under the age of 25) have resulted in increased positivity rates (because those at highest risk for the disease are the targeted test populations.

HIV and AIDS

The rates for HIV and AIDS in Kansas remain below the U.S. rate (HIV: Kansas 3/100,000 vs. U.S. 11.8/100,000; AIDS: 2/100,000; U.S. 14.8/100,000) which allows the State to "get its arms around" the disease more successfully than states with overwhelming populations infected with the disease. However, Kansas exceeds the national average (Kansas 2001 68%; 2002 57%; U.S. 41%) of individuals converting to AIDS within one year of HIV diagnosis, which indicates a need for improvement of prevention activities that aim to encourage earlier testing. Confidential (named) reporting has allowed for this qualitative understanding of how the disease is impacting Kansans. Since implementation of HIV confidential reporting in 1999, Kansas is also beginning to see minorities, women and heterosexual disease transmission as emerging HIV/AIDS disease trends, mirroring national trends. Important to recognize is the new national strategy, also implemented in Kansas, for combating HIV/AIDS stressing testing, partner counseling and referral services and testing for HIV to all pregnant women. Kansas is also incorporating new rapid and other targeted testing technology to enhance ongoing prevention efforts, which is improving efforts to test at-risk populations. CDC is recognizing Kansas nationally for its prevention to positives and partner counseling and referral services programs. Kansas continues to serve its HIV/AIDS infected persons with an effective continuum of prevention and care services designed to prevent, find and treat disease.

Viral Hepatitis

First reportable in Kansas in 2000 was viral hepatitis. KDHE is gaining valuable information about this disease in the State and its complications when found in persons with other diseases. KDHE's Bureau of Epidemiology and Disease Prevention staff have been piloting public health assistance measures to this population by providing Hepatitis A and B vaccinations to those people with Hepatitis C.

Maternal and Child Health

Demographics

The health of Kansas mothers, infants and children is of critical importance, both as a reflection of the current health status of the Kansas population but also as a predictor of the health of the next generation of Kansans. KDHE provides leadership to enhance the health of Kansas women and children through partnerships with families and communities. The target populations for Kansas' maternal and child health efforts are: women of reproductive age (15-44, 21%); preschool children (0-4, 7%); and school age

children (5-19, 22%).

Natality
In 2002, of all 39,338 Kansas live births, 87% received prenatal care starting in the first trimester. This compares favorably with Healthy People 2010 baseline data for the U.S. of 83%. The pregnancy rate for all Kansas women has declined significantly over the past decade with the pregnancy rates for teens mirroring that decline.

In 2002, the incidence of low birth weight in Kansas was 7% of all live births. This exceeds the national objective of 5% but is more favorable than the U.S. baseline of 8%. Low birth weight infants are at increased risk for physical and developmental complications, and are almost 40 times more likely to die in the first month of life and 5 times more likely to die before the first birthday. Premature births are more likely to be low birth weight.

Mortality
Infant mortality is considered an important indicator of general health status and social well-being. In 2002, 282 Kansas infants died (7.2/1,000 live births). This rate is a 58% decrease over the past three decades. The Kansas rate is equal to the U.S. baseline for Healthy People 2010 but it is below the national target of 4.5. The white infant death rate (6.5) is significantly lower than the black infant death rate(15.3). Although both white and black infant death rates have declined over the past 30 years, the disparity in infant mortality rates between whites and blacks and other racial and ethnic groups persists. Since 1991, there have been five or fewer maternal deaths each year despite medical and technological advances.

The deaths of children, adolescents, and young adults present a public health concern and an opportunity for prevention. In 2002, 130 children ages 1-14 (24.3/100,000) and 356 adolescents, and young adults ages 15-24 (86.0) died. The leading cause of death for both age groups was unintentional injuries (9.3 and 47.3, respectively), namely motor vehicle crashes. Among adolescents, and young adults (15-24), suicide was the second leading cause of death (15.0). Youth suicide was one area where Kansas data appear considerably higher than that of the U.S. (8.9 for ages15-19 and 13.6 for ages 20-24).

Morbidity/Risk
Breastfeeding is an important contributor to overall infant health because human milk presents the most complete form of nutrition for infants. The American Academy of Pediatrics recommends exclusive breastfeeding for infants in the first 6 months of life. Only about 74% of Kansas mothers initiated breastfeeding and only 29% were still breastfeeding at six months. Kansas' initiation rates are above the national average; however, the six month breastfeeding rates are below the national average and breast feeding rates at 6 months have declined from 34% in 2000.
Data from the 1997-98 retrospective survey of kindergarten students indicated that Kansas had achieved the Healthy People 2010 objective for MMR (91% coverage) and Polio (95% coverage) for 2 year old children. The coverage for DTP was 82% which represents an increase from the 1994-95 level of 73%.

Data for children (age 36-59 months) enrolled in the WIC program between 1992 and 1999 show an increasing prevalence of obesity (>=95th percentile of weight for height). During these years the prevalence increased from 5% to 8%. The most recent data shows overweight prevalence highest among Hispanic children followed by blacks and whites (12%, 9%, 8%, respectively).

Also, important to child health are the prevention and treatment of disabilities. Health People 2010 points out that, in 1994, 11% of all U.S. children (5-17) had limitations in learning ability, 6% had limitations in communication, 1% had limitations in mobility, and 0.9% had limitations in personal care. The burden of childhood disability is compounded because affected children live with their disabling conditions many more years than do persons acquiring disability later in life.

Access

The 2001 Kansas Health Insurance Study reported that over two thirds of Kansas children (age <18) are covered by private insurance, 15% by public insurance, and 8% have no health insurance. For women of reproductive age (15-44), 83% are covered by private insurance, 4% by public insurance, and 13% are uninsured. The number of births financed by Medicaid in Kansas has risen from 23% of live births in 1999 to over 33% in 2002. Kansas maintains the eligibility level for the Medicaid program at the federally required minimum for both women and children.

In closing, Mr. Chairman, I know that there are other important diseases and health issues I've not touched on today. I wanted to focus on the most critical challenges from a public health perspective, but at the same time, be assured that we are aware that there are other diseases and conditions that are critically important for many of our citizens. In the interest of time, I did not focus on important issues related to access to health and public health services across the state. If you wish, I would be happy to visit with you at another time about these issues.

I have also provided you with a PDF file on Vital Statistics and Health Data from the Center for Health and Environmental Statistics in KDHE. This document describes the Vital Statistics system, provides an overview of the data available, and provides electronic links to the Annual Summary of Vital Statistics and other recent reports and publications.

Thank you for this opportunity Mr. Chairman. I would be happy to stand for any questions.

Vital Statistics and Health Data
Kansas Department of Health and Environment
Center for Health and Environmental Statistics

Kansas laws define milestones of humanity, i.e., birth, death, stillbirth (fetal death) marriage, divorce, etc. Each individual milestone is commonly known as a vital event. The laws authorize establishment of methods and procedures to capture data and information describing each vital event. The combination of data and forms (including certificates) which document or describe each vital event is known as a vital record.

Each vital event occurring in Kansas requires establishment of a vital record which must be registered with the State of Kansas. As part of the registration process, documents associated with each vital record, particularly certificates are stored on optical disks. The registration process also includes entry of vital record information and data into the Vital Statistics Database. Applied information technology makes it possible to produce standard reports and special studies when issuable and confidential portions of vital record files of groups of individuals are complies and analyzed on a yearly basis.

Once a reporting year is considered complete, a history file is created. From this file annual tables of vital statistics are generated.

Recent Reports and Publications

Mental Health Parity Costs: Special report to the Kansas Legislature 2001

Annual Summary of Vital Statistics – published annually

Annual Report of the Health Care Data Governing Board – published annually

Abortions in Kansas: Preliminary Report - published annually

Fatal Occupational Injuries in Kansas – Published annually

Kansas Health Statistics – a health care data research brief published quarterly

Suicides in Kansas, 1989-1998 – a ten year analysis of suicide deaths in the state

Survey of Occupational Injuries and Illnesses in Kansas – published annually

Infant Mortality Statistics, Period Linked Births and Infant Deaths, Kansas, 1995-1998

Age-Standardization of Kansas Death Rates: Implications of the Year 2000 Standard

While Vital Statistics has long been considered the "gold standard" of public health data, supplementing that information with other health data adds value to the information. Greater insight is gained into the health and wellness of all Kansans. The evaluation of health data is a core public health function: assessing the health of the population.

Other health statistics data is also provided to the Center for Health and Environmental Statistics: health professional licensure, hospital discharge data through an agreement with the Kansas Hospital Association, and health insurance claims data through agreements with Workman's Compensation and the Kansas Insurance Commissioner. Much of this data is collected in collaboration with the Health Care Data Governing Board, to which the Center provides staff support.

Reports on these data are shared with policy makers, program officials, and the public. Many reports and documents are available publicly through Internet portals: http://www.kdhe.state.ks.us/ches/ or http://www.accesskansas.org/hcdgb/ or http://kic.kdhe.state.ks.us/kic/. In some instances data are posted to the Internet for individuals to self-query through a service known as Kansas Information for Communities (KIC). Special analyses may also be performed on request.

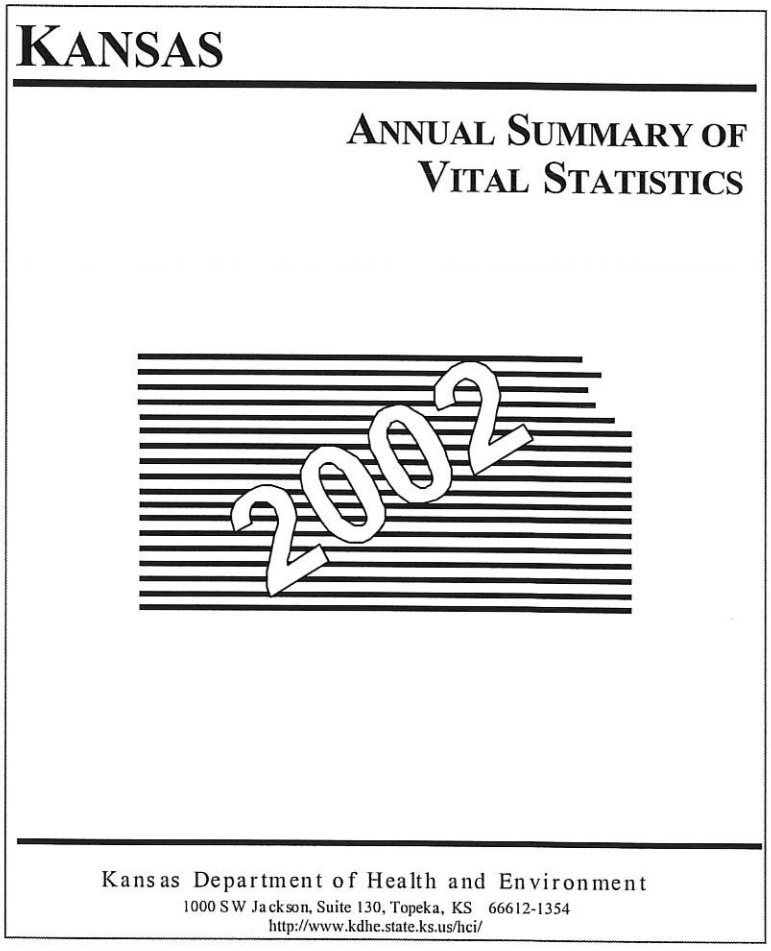
Attachment 2

HHS 2-2-04

Vital Statistics in Kansas

The 2002 edition of the *Annual Summary of Vital Statistics* is a summary of data compiled from vital event records for the 2002 calendar year. The content of this report includes summaries of vital events such as live births, fetal deaths, abortions, deaths, marriages, and marriage dissolutions documented by certificates and reports filed with the Office of Vital Statistics, Center for Health and Environmental Statistics.

Kansas vital events (resident-live births, deaths, fetal deaths, abortions, and occurrence-marriages and marriage dissolutions) decreased 0.4 percent from 100,557 in 1992 to 100,187 in 2002.



Between 1992 and 2002, the most significant changes in vital events were a 35.1 percent decrease in the fetal death rate and a 26.7 percent increase in the out-of-wedlock birth ratio.

The number of out-of-wedlock births to Kansas residents reached a record high in 2002 at 12,129. This represented 30.8 percent of all Kansas resident births, which is the highest proportion ever reported.

The live birth rate in 2002 (14.5) decreased 3.3 percent from the 1992 rate of 15.0. The rate of 14.2 in 1996 was the lowest on record, dating from 1935. The death rate increased 5.7 percent, from 8.7 in 1992 to 9.2 in 2002.

Hebdomadal, perinatal, neonatal and infant death rates decreased from 1992 to 2002, with percentage decreases of 11.4, 24.0, 7.5, and 18.2, respectively.

In 2002, the number of couples married in Kansas declined slightly, continuing the generally downward trend that began in 1993. The marriage rate (7.3) decreased 16.1 percent from the 1992 rate of 8.7. The number of marriage dissolutions (divorces and annulments) granted in the state continued its generally downward trend.

Over half (10,368) of the marriages in 2002 were first marriages for both the bride and groom.

Every Day During 2002*

Each day Kansas residents experienced approximately...

108 Live births
33 Out of wedlock live births
1 Infant death
0.5 Fetal death

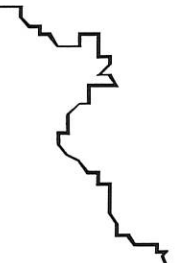
18 Heart disease deaths
15 Cancer deaths
5 Cerebrovascular disease deaths
4 Chronic lower respiratory disease deaths
3 Accidental deaths
2 Pneumonia and influenza deaths

Each day in Kansas there occurred approximately...

54 Marriages
26 Marriages dissolutions

and

32 Abortions



- Based on 365 Days in 2002

Source Kansas Department of Health and Environment
Center for Health and Environmental Statistics

Selected Vital Event Rates And Ratios
Kansas, 1992-2002

Vital Event	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Live Births											
Number	37,848	37,283	37,269	37,087	36,524	37,191	38,372	38,748	39,654	38,832	39,338
Rate	15.0	14.7	14.6	14.5	14.2	14.3	14.6	14.6	14.7	14.4	14.5
Out-of-Wedlock Births											
Number	9,183	9,599	9,653	9,594	9,798	10,260	10,657	11,068	11,491	11,592	12,129
Ratio	24.3	25.7	25.9	25.9	26.8	27.6	27.8	28.6	29.0	29.9	30.8
Fetal Deaths											
Number	216	222	231	183	179	202	199	175	177	209	146
Rate	5.7	5.9	6.2	4.9	4.9	5.4	5.2	4.5	4.4	5.4	3.7
Hebdomadal Deaths											
Number	165	171	140	134	157	147	132	159	146	148	155
Rate	4.4	4.6	3.8	3.6	4.3	4.0	3.4	4.1	3.7	3.8	3.9
Perinatal Period III Deaths											
Number	381	393	371	317	336	349	331	334	323	357	301
Rate	10.0	10.5	9.9	8.5	9.2	9.3	8.6	8.6	8.1	9.1	7.6
Neonatal Deaths											
Number	199	201	177	166	199	173	172	189	174	178	192
Rate	5.3	5.4	4.7	4.5	5.4	4.7	4.5	4.9	4.4	4.6	4.9
Infant Deaths											
Number	332	325	285	256	299	274	263	281	266	285	282
Rate	8.8	8.7	7.6	6.9	8.2	7.4	6.9	7.3	6.7	7.3	7.2
Maternal Deaths											
Number	2	3	2	2	2	5	3	4	4	1	2
Rate	0.5	0.8	0.5	0.5	0.5	1.3	0.8	1.0	1.0	0.3	0.5
Deaths											
Number	22,052	23,508	23,219	23,807	23,788	23,609	23,928	24,380	24,676	24,590	24,968
Rate	8.7	9.3	9.1	9.3	9.2	9.1	9.1	9.2	9.2	9.1	9.2
Marriages											
Number	21,845	21,527	21,524	21,057	20,657	20,537	20,403	20,905	20,426	20,457	19,783
Rate	8.7	8.5	8.4	8.2	8.0	7.9	7.8	7.9	7.6	7.6	7.3
Divorces and Annulments											
Number	12,365	12,068	11,659	11,029	10,779	10,618	10,363	9,926	10,105	9,885	9,654
Rate	4.9	4.8	4.6	4.3	4.2	4.1	3.9	3.7	3.8	3.7	3.6

Residence data are presented for births and deaths
Occurrence data are presented for marriages, divorces and annulments

Source Kansas Department of Health and Environment
Center for Health and Environmental Statistics

Kansas CHES

Kansas Department of Health and Environment
Center for Health and Environmental Statistics
Vital Statistics ♦ Health Care Information

Kansas Vital Events

Event	Description	Collection Began	Uses
Abortion	(Induced termination of pregnancy): The purposeful interruption of pregnancy with the intention other than to produce a live born infant or to remove a dead fetus and which does not result in a live birth.	1971	Public health and social research
Birth	The complete expulsion or extraction of a product of human conception from its mother, irrespective of the duration of pregnancy, that, after such expulsion or extraction, shows any evidence of life such as breathing, heartbeat, pulsation of the umbilical cord, or voluntary muscle movement, whether or not the umbilical cord has been cut or the placenta attached. Frequently called "live birth" although use of the word "live" is redundant.	1911	School attendance Passports Social Security participation Public health and social research Sports participation Employment Driver's License
Death	The irreversible cessation of vital functions in a living individual esp. as indicated by permanent stoppage of the heart, respiration, or brain activity, beyond the possibility of resuscitation.	1911	Survivor's benefits Preservation of property rights Cause and circumstances of death Place of interment Evidence of age, sex, or race Genealogical information File clearance (governmental only) Public health and social research
Divorce & Annulment	The dissolution of a legally binding marriage contract.	1951	Public health and social research
Fetal Death	Any complete expulsion or extraction from its mother of a product of human conception the weight of which is in excess of 350 grams, irrespective of the duration of pregnancy, resulting in other than a live birth, and which is not an induced termination of pregnancy. Formerly called "stillbirth." Changed to avoid confusion with the term "live birth."	1911	Public health and social research
Marriage	The legal union of a male and female	1913	Public health and social research

The Kansas Vital Statistics Registration System

Responsible Person or Agency	Marriage Record	Divorce or Annulment Record
Clerk of County Government	1. Receives application for marriage license, and reviews application for completeness, accuracy, and compliance with law. 2. Issues marriage license and records date. 3. Checks completeness of entries about the marriage ceremony. 4. Sends specified information regarding marriage to State Registrar.	
Marriage Officiant	1. Checks the validity of the marriage license. 2. Performs the marriage ceremony. 3. Certifies to the facts of the marriage ceremony. 4. Returns the record to the license clerk within the legally prescribed time.	
Clerk of Court		1. Provides form for report to plaintiff or attorney, or makes entries on such form from petition for decree. 2. Verifies entries on return form. 3. Enters information on final decree. 4. Sends completed report to State Registrar.
Attorney for Plaintiff		1. Enters appropriate personal data 2. Returns form to Clerk of Court.
State Registrar, CHES, Office of Vital Statistics	1. Verifies completeness and accuracy of report. 2. Queries incomplete or inconsistent information. 3. Enters data into electronic database. 4. Maintains files for permanent reference and as a source of certified copies.	
State Registrar, CHES, Office of Health Care Information	1. Develops vital statistics for use in planning, evaluating, and administering state and local health activities and for research studies. 2. Compiles health related statistics for state and civil divisions of state for use by health department and other agencies and groups interested in the fields of medical science, public health, demography, and social welfare.	

Source: KDHE Center for Health and Environmental Statistics

The Kansas Vital Statistics Registration System

Responsible Person or Agency	Birth Certificate	Death Certificate	Fetal Death Certificate	Induced Termination of Pregnancy Report
Hospital Authority, Physician, or Other Professional Attendant	1. Completes the personal data part of certificate in consultation with parent(s). 2. Secures signatures of certifier and of parent(s) 3. Completes medical and health section per records of attending physician. 4. Files certificate with State Registrar.	1. Completes medical certification and signs certificate. 2. Returns certificate to funeral director.	1. Completes or reviews medical items on certificate. 2. Certifies the cause of fetal death and signs certificate. 3. Returns certificate to funeral director or hospital administrator. 4. In absence of funeral director, files certificate with local registrar.	1. Completes personal data and medical data in consultation with the patient. 2. Submits the report to the State Registrar.
Funeral Director or Hospital Administrator	⇓	1. Completes personal data part in consultation with next of kin. 2. Takes certificate to physician for medical certification. 3. Signs section on disposition of the body. 4. Delivers completed certificate to State Registrar (and obtains burial permit).	1. Completes personal data part in consultation with parent(s). 2. Takes certificate to physician for medical certification. 3. Signs section on disposition of the fetus. 4. Delivers completed certificate to State Registrar (and obtains burial permit).	⇓
State Registrar, CHES, Office of Vital Statistics	1. Verifies completeness and accuracy of certificate. 2. Queries incomplete or inconsistent information. 3. Scans certificate into Optical Disk System, enters data into electronic index database. 4. Maintains files for permanent reference and as a source of certified copies. 5. Prepares a subset of the data contained in birth, death, and fetal death certificates and transmits to the National Center for Health Statistics.			1. Enters report data into electronic database
State Registrar CHES, Office of Health Care Information	1. Develops vital statistics for use in planning, evaluating, and administering state and local health activities and for research studies. 2. Compiles health related statistics for state and civil divisions of state for use by health departments and other agencies and groups interested in the fields of medical science, public health, demography, and social welfare.			1. Verifies completeness and accuracy of report. 2. Queries incomplete or inconsistent information. 3. Compiles health related statistics for public distribution.
National Center for Health Statistics	1. Prepares and publishes national statistics of births, deaths, and fetal death; and constructs the official U.S. life tables and related actuarial tables. 2. Conducts health and social-research studies based on vital records and sampling surveys linked to records. 3. Conducts research and methodological studies in vital statistics methods including the technical, administrative, and legal aspects of vital records registration and administration. 4. Maintains a continuing technical assistance program to improve the quality and usefulness of vital statistics.			⇓
US Centers for Disease Control and Prevention	⇓			1. Prepares and publishes national statistics of induced terminations of pregnancy. 2. Combines data with birth and fetal death data to prepare and publish statistics on reproductive health.
City and County Health Departments	1. Use data to allocate medical and nursing services and planning programs. 2. Measure effectiveness of services. 3. Conduct research studies.			

Source: KDHE Center for Health and Environmental Statistics

Testimony on SB106

To

House Health and Human Services Committee

By Roderick Bremby
Secretary

Kansas Department of Health and Environment

February 2, 2004

Chairman Morrison and members of the House Health and Human Services Committee, I am pleased to appear before you today to discuss SB106. The Kansas Department of Health and Environment enthusiastically supports the intent of SB106 to identify major health care issues in Kansas and to establish objectives and priorities. Responsibility for a statewide health planning process is appropriate for and well within the mission and goals of the state health agency. Successful implementation of the project will be contingent, however, upon identifying new resources necessary to complement existing resources to carry it out effectively.

Major gains have been made in public health during the past 40 years, to the point where acute and infectious diseases have been replaced by chronic diseases and injury as the leading causes of death. Kansas must remain diligent in addressing acute and infectious diseases, so as not to lose ground on the progress made. The progress made in infectious disease, combined with changes in lifestyle have given way to a new era in which chronic diseases, such as coronary heart disease, hypertension, asthma and diabetes have become the leading causes of death, affecting over 100 million Americans and accounting for three-quarters of the nation's annual health care costs. (Institute for Health and Aging 1996) With the continued aging of the American population, both the prevalence and costs of chronic illness care are expected to rise by at least 15% by the year 2010 and by 60% by 2050. Yet, much of this growing chronic disease burden is preventable through more effective prevention and management. McGinnis and Forge (1993) estimate that 50% of mortality form the ten leading causes of death is attributable to lifestyle behaviors that cause or complicate chronic illness. Finding effective strategies for prevention and managing chronic disease will be a major challenge for health care in the 21ST Century.

Healthy People 2010 outlines a comprehensive, nationwide health promotion and disease prevention agenda. It is designed to serve as a roadmap for improving the health of all people in the US during the first decade of the 21st Century. Like the preceding Healthy People 2000 initiative which was driven by an ambitious, yet achievable, 10 year strategy for improving the Nation's health by the end of the 20th Century, Healthy People 2010 is committed to a single, overarching purpose: promoting health and preventing illness, disability and premature death.

Attachment 3
HHS 2-2-04

Previous experience in facilitating a number of other statewide planning processes, such as Healthy Kansans 2000 and the RWJ Turning Points initiative, indicates that a planning project of this magnitude will require significant dedicated staff time. Existing staff in the Division of Health have first hand experience in designing and implementing statewide health planning processes and would be well positioned to oversee such a project. However, the extensive involvement of external partners, while crucial to the success of a statewide health planning initiative, is a labor intensive project which needs the full time attention of specified staff in order to be effective and timely. Other cost considerations include travel costs or per diem reimbursement for participants of the process. While experience has shown that most organizations will contribute this type of support, it is expected that some participants representing disparate groups would need reimbursement assistance in order to participate. The Healthy Kansans 2000 process involved more than 200 people from across the state; approximately 15 requested assistance for travel and per diem in order to participate in meetings. Because such a process is dependent upon active involvement of a broad base of people representing a wide spectrum of interests, it is essential to be inclusive in the planning process.

We commend the legislature for recognizing the importance of initiating a collaborative health planning process that embraces the Healthy People 2010 Objectives, as this will undoubtedly result in identification of health issues of common interest to participants and subsequently lead to opportunities for collective response to the greatest health threats we currently face. I thank you for the opportunity to appear before the committee and will gladly stand for questions.

For More Information Contact:
Terri Roberts J.D., R.N.
785.233.8638 troberts@ksna.net
February 2, 2004

S.B. 106 Identifying Major Health Care Issues and Establishing Objectives and Priorities

Chairperson Morrison and members of the House Health and Human Services Committee, my name is Terri Roberts R.N. and I am representing the KANSAS STATE NURSES ASSOCIATION (KSNA) in support of SB 106.

KSNA supports that the state health agency provide leadership and direction on health prevention activities. For the past 14 years we have partnered with KDHE in establishing and promoting priorities, most significantly the Healthy Kansans 2000 health objectives, and now the 2010 Healthy People objectives for Kansas. Registered nurses work in the many settings (acute care, home health, community health to name just a few) where the prevention campaigns can be supported and benchmarking can be facilitated. We that progress has been made, that Kansans are aware of risk factors in maintaining health, and assuming greater responsibility for changing behaviors (activity, tobacco reduction, diet, etc.).

The Bureau of Chronic Disease and Health Promotion has been very successful in soliciting federal grants to support Healthy Kansans. Currently the Bureau receives over 7 Million in federal grants and does and excellent job of re-distributing the dollars for targeted health promotions in Kansas communities. There efforts to date should not go unrecognized. The past Directors of Health, namely Dr. Potsic and Dr. Mosier were very receptive to focusing the Division of Health on these very important concepts of prevention and reducing risk factors to promote greater health for all ages of Kansans.

This proposed statute embraces the concept of continuing the agency focus on Healthy Kansans 2010. We anticipate that this leadership will continue if this bill is passed.

Thank you for this opportunity to present testimony.

Attachment 4
HHS 2-2-04