Approved: January 30, 2006
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 January 26, 2006, in Room 526-S of the Capitol.

All members were present except Representatives Kelley, Watkins, Otto, Colloton, Landwehr and Storm, all of whom were excused.

Committee staff present:
Melissa Calderwood, Kansas Legislative Research Department
Mary Galligan, Kansas Legislative Research Department
Renae Jefferies, Revisor of Statutes' Office
Gary Deeter, Committee Secretary

Conferees appearing before the committee:

Rod Bremby, Secretary, Kansas Department of Health and Environment (KDHE)
Dr. Howard Rodenberg, Director of Health, Division of Health, KDHE

Others attending:
See attached sheet

The Minutes for 1-25-2006 were approved.

Rod Bremby, Secretary, Kansas Department of Health and Environment (KDHE), provided an overview of the agency (Attachment 1). He stated that the mission of the agency is to promote and protect health and to prevent disease and injury among the people of Kansas. He outlined three areas by which the mission is accomplished: assessment, the systematic gathering, analyzing, and publishing of information; policy development, which uses the gathered data to develop policies to address the needs of Kansans; and assurance, implementing services that touch the life of nearly every Kansan.

Mr. Bremby reviewed the divisions, offices, and bureaus of the agency relating to health and their areas of service to Kansans, providing details for various programs to illustrate the comprehensive nature of the agency's outreach to the state. To cite an example, the Bureau for Children, Youth, and Families partnered with 41 local agencies to provide nutrition, education and counseling through the WIC (Women, Infants, and Children) Supplemental Nutritional Program. As another example, Mr. Bremby described a newly developed service--the statewide immunization registry.

Mr. Bremby commented on four agency initiatives making their way through the legislative process: **HB 2396**, assuring vaccination for college students living on-campus; **HB 2497**, establishing further

regulations for those residing, working, or volunteering at child-care or family day-care facilities; a bill regarding phenylketonuria (PKU); and a bill regarding a statewide trauma registry.

Mr. Bremby responded to questions from members. He said KDHE advises school districts regarding school lunches and encourages districts to use local produce in school lunch programs. He stated that vending machines should not be in elementary schools, should have limited use in middle schools, and should offer healthy choices in high schools. To a member's question about disposal of medical waste, he said he would investigate and provide the requested information. A member encouraged Mr. Bremby to expedite the implementation of the statewide immunization registry. Regarding onerous regulations imposed on foster parents, he replied that instead of enforcing blanket regulations about home conditions, the agency is dealing with problems on a case-by-case basis. He said SRS (Social and Rehabilitation Services) and KDHE regularly collaborate to obviate the unintended consequences that regulations of one agency might have on another. He replied regarding the prescription drug assistance program that the Governor's original budget did not have funds allocated, but an enhancement of $750,000 is being requested, noting that the agency attempts to fund all requests, but rarely at the level requested.

Mr. Bremby introduced Dr. Howard Rodenberg, Director of Health, Division of Health, Kansas Department of Health and Environment, who testified about the state of health in Kansas (Attachment 2), including a PowerPoint presentation (Attachment 3). Dr. Rodenberg stated that he represented 146,000 health-care professionals within the state who are committed to promoting health for Kansans. He commented on various Kansas health statistics, noting that the 2,735,502 Kansans reflect extremes in age, with highs in the 18-24-year age group and those over 85, presenting the opposite of a bell curve. Dealing with the cause of death under the category Years of Productive Life Lost, he said three causes top the list: cancer, heart disease, and unintentional injury. He further observed that 11% of Kansans have no public or private health insurance coverage, compared with 15% nationally.

Dr. Rodenberg commented on three areas of preventable death: tobacco use, obesity, and accidental death, stating that KDHE is developing comprehensive new programs to mitigate these statistics. He listed the most effective health measures as immunization and clean and fluoridated water, and he commented on two pressing issues facing the state: the disparities in health care caused by race, ethnicity, geography, and socio-economic status; and the lack of preparedness for a public health emergency. He offered three avenues for action: education, evaluation of present policies, and setting high goals, the last illustrated by the Healthy Kansans 2010 project. He concluded by comparing Kansas health statistics with national averages and identifying strategic initiatives of the department.

Answering a question, Dr. Rodenberg said obesity in Kansas has increased 70% since 1992.

Dr. Rodenberg continued his testimony by outlining the agency's emergency plans for addressing the occurrence of a pandemic flu epidemic (Attachment 4). He explained that the various strains of flu virus affect the respiratory system, that most individuals have developed immunity to existing strains, but that pandemic flu is a virus to which no one is immune, creating a cascading effect worldwide, an effect which could overwhelm society's infrastructure functions; thus, preparedness must involve all levels of society—local, state, and national. He stated that the planning process is important even if plans may

later be discovered to be incomplete.

The meeting was adjourned at 3:21 p.m. The next meeting is scheduled for Monday, January 30, 2006, at 1:30 p.m. in Room 526-S.

HOUSE HEALTH AND HUMAN SERVICES COMMITTEE
GUEST LIST

DATE: January 26 2006

NAME	REPRESENTING
Doug Cruce	Office of Judicial Administration
Lindsey Douglas	Hein Law Firm
ROGER MARTIN	KHI
Susan Zalenski	J+J
Roderick Bremby	KDHE
Susan Kang	KDHE
Beth Jones	Hutfles Gov't Relations
Nathan Wernert	Rep. Trimmer
Sharon Sowers	KDHE
Carli Woods	KHK
Melissa Miller	Rep. Hill
Michelle Peterson	Capitol Strategies
Tracy Pitman	KFMC

K A N S A S

RODERICK L. BREMBY, SECRETARY

KATHLEEN SEBELIUS, GOVERNOR

DEPARTMENT OF HEALTH AND ENVIRONMENT

Presentation on the Kansas Department of Health and Environment Division of Health To House Health and Human Services Committee

Presented by Roderick L. Bremby, Secretary
Kansas Department of Health and Environment

January 26, 2006

Chairman Morrison and members of the Committee, I am pleased to appear before you today to provide an overview of the Division of Health at the Kansas Department of Health and Environment.

The mission of the Division of Health is to promote and protect health and prevent disease and injury among the people of Kansas. This is accomplished through three basic functions:

Assessment - The Division systematically collects, analyzes and publishes information on many aspects of the health status of Kansas residents. Assessment includes examining trends in health, disease and injury.

Policy Development - The Division uses information from its assessments and other sources to develop policies needed to promote and protect health and prevent disease and injury among the people of Kansas. Public health policies incorporate current scientific knowledge about health and disease. Examples of such policies are new or improved service programs, regulatory changes, and recommendations to the Kansas Legislature and the Governor.

Assurance - The Division provides services that are needed to achieve state health goals. In some programs, services are provided by state employees. In other programs, public health services are provided by employees of local health departments or other community-based organizations, with financial and/or technical support from the Division. Services may also be provided indirectly through activities encouraging individuals and organizations to become involved in serving the health needs of the people of Kansas.

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Attachment 1
HHS 1-26-06

Summary of Division of Health Responsibilities:

KDHE's Division of Health is responsible for investigating disease outbreaks and taking steps to prevent the spread of communicable diseases, as well as preparing for bioterrorism acts against the state. The Division of Health promotes healthy lives by developing and supporting programs to reduce the preventable chronic diseases and promote health activities such as good nutrition and physical activity. The division also provides assistance to Kansas communities in establishing or modifying health care delivery. It is also responsible for ensuring children's special needs are addressed through screenings and treatments, and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). The Division of Health also licenses and regulates numerous facilities in the state including childcare, hospitals, home health agencies, mental health facilities, restaurants, and food service facilities. In addition, health care workers receive credentials and certifications through the KDHE Division of Health. Another important function of the Division of Health is the management of all vital statistics records for Kansas and the gathering and analysis of health and environmental data.

Division of Health Highlights for 2005

1. HK 2010 - One of our major accomplishments this year has been the Healthy Kansans 2010 Project. This effort, which involved a series of 23 meetings involving 200 representatives from over 100 different organizations, reviewed the Kansas profile of the 10 Leading Health Indicators as identified by the CDC Healthy People 2010 Objectives for the Nation. Cross-cutting themes which impacted the majority of these targets were considered targets of opportunity, areas in which a dedicated effort could show real benefit to the health of our state. These areas were noted as risk identification and disease prevention in women and children, interventions to address the social determinants of health, and the elimination of health disparities between racial and ethnic groups. Workgroups have taken these themes and developed sets of action steps to enhance our efforts in these areas. Tobacco control, enhancing healthcare provider cultural competency, and further characterization of health disparities were identified as the realms of activity which could have the most impact on the areas of need. The counsel is wide in scope, and takes full advantage of the range of public health interventions available for use. The HK 2010 process supports the Healthy Kansas Initiative to improve the state's health by focusing on proper nutrition, physical inactivity, and tobacco use in children in schools, adults in the workplace, and aging seniors

2. Office of Oral Health - In 2005, KDHE added an Office of Oral Health to provide factual information and encourage participation in providing preventative oral hygiene services in community settings, and to ensure quality oral health guidelines in schools and childcare settings.

3. Office of Minority Affairs - The spring of 2005 featured the release of a joint KDHE/KHI report detailing Minority Health Disparities in Kansas. This release was announced at the first annual Kansas Minority Health Conference held in Lawrence. At this meeting, KDHE made a commitment to establish an Office of Minority Affairs by the time of the next statewide meeting. A community-based Steering Committee is finishing their work on the mission and goals of this office, and we are looking to establish it in fact within the next few weeks.

4. Center for Public Health Preparedness - The Center for Public Health Preparedness was created to unify the wide range of preparedness activities within DOH under a central consolidated structure. The center provides leadership on preventing, detecting, reporting, investigating, controlling, and recovering from human illness related to chemical, biological, and radiological agents, as well as naturally occurring human health threats. The Center serves as the agency's lead in the health and medical response to all public health emergency situations, whether caused by natural events or acts of terrorism.

5. New Health Director: The hiring of Dr. Howard Rodenberg, the new Director of the Division of Health, culminated a lengthy recruiting process for the post of State Health Officer. With his presence, the Division of Health now has the necessary leadership in place to move forward in promoting our goal of health for all.

Division of Health Budget and Finance Information:

The Division of Health utilizes a mixture of state general funds, federal funds, and fees to support programs and activities. Expenditures for state fiscal year 2006 and 2007 reflect this mixture of funding sources. The total budget for fiscal year 2007 is approximately $133.9 million of which approximately $19.4 million comes from the State General Fund.

Division of Health Organizational Structure:

The Division of Health is organized into four distinct bureaus, three offices, and one center. Collectively, the staff of the Division is authorized at 415 FTEs. A description of the focus and activities of each section follows this global overview.

Office of Health Promotion: The mission of the Office of Health Promotion is to improve the quality of life and reduce the incidence of preventable death and disability from chronic disease and injury. Program activities are supported by federal and private grant funds.

Healthy Kansans 2010 – Planning process involving external partners to identify the priority health issues for the state and develop plans for addressing the selected issues (please refer to prior discussion).

Coordinated School Health Program (CHSP) – The CHSP is a collaborative project between KDHE and KSDE to integrate chronic disease prevention strategies into the school setting. Specific risk factors addressed include physical inactivity, nutrition, tobacco use and obesity.

Cancer - The Cancer Program facilitates development of the Kansas Cancer Plan. The plan outlines strategies to improve prevention, screening and early detection; assure quality treatment and pain management; and assess survivorship and end of life care. It also provides breast and cervical cancer screening to women who meet certain income and age (40-54) guidelines.

Diabetes - A Diabetes Quality of Care Initiative provides funding and training to health care

providers for implementation of a Chronic Care Model. The program also facilitates a statewide planning effort to identify opportunities to improve diabetes outcomes.

Cardiovascular Disease - Heart Disease and Stroke Prevention efforts involve statewide planning for identifying priorities for intervention. Provider and public educational efforts focus on stroke recognition and treatment and heart disease prevention and management.

Worksite Wellness- In conjunction with community partners, KDHE plans to pilot the CDC Heart Healthy and Stroke-Free WorkSite Toolkit.

Arthritis - The arthritis program provides funding to the Arthritis Foundation to expand the People with Arthritis Can Exercise (PACE) program and other services statewide.

Tobacco Use Prevention – The Tobacco Quit Line is a 24/7 hot line service to Kansans to access help to quit smoking and/or to assist patients with quitting. A smoking cessation during pregnancy initiative has also been successful in engaging providers across the state to refer pregnant women to the Quit Line. The Tobacco Use Prevention Program provides technical assistance and funding to communities across Kansas who are working to implement comprehensive tobacco use prevention programs.

Injury - The Injury Program facilitates a statewide planning process to identify the leading injury issues for Kansas and devise action plans to address these concerns. The program facilitates the activities of the Kansas SAFE KIDS coalition, and provides local grants and technical assistance to communities to address fire and burn related injuries. The program also facilitates a state Suicide Prevention Coalition, and provides funding and technical assistance to communities to support Rape Prevention Education.

Health Risk Behavior Surveillance - The program conducts a continuous, confidential, population-based survey of Kansas adults (the Behavioral Risk factor Survey System, BRFSS) to estimate the prevalence of health risk behaviors, utilization of preventive health practices, and knowledge of health risks in the population. Youth surveys are also conducted to estimate the prevalence of tobacco use among middle and high school students and the prevalence of risk for overweight among Kansas children grades 6-12.

Nutrition and Physical Activity - The Kansas LEAN Campaign facilitates a planning process in conjunction with key partners across the state to develop consistent nutrition and physical activity messages for professionals and the public. The Kansas Kids Fitness and Safety Day coordinates a statewide event to promote physical activity among Kansas third grade students. Incentives and program enhancements connect this event to activities throughout the year.

Chronic Disease Risk Reduction Grants - Local grants and technical assistance are provided to communities to address tobacco use, physical inactivity and nutrition, the three leading risk factors for the prevention of chronic disease.

Office of Local & Rural Health (OLRH):

This office provides assistance to Kansas communities in establishing or modifying health care delivery systems. The mission of the office is to assist communities to provide public health, primary care, and prevention services for all Kansans. A comprehensive approach using policy development, assessment and resource coordination is used to fulfill this mission. Cooperation with local health departments, community based primary care clinics, other state agencies, non-profit voluntary organizations and professional associations is essential.

Community Based Primary Care (CBPC) - Established by the Legislature in 1990, this program supports clinics in twenty-eight locations across the state. Kansas last year invested state aid totaling $1,520,840 to support operation of local primary care clinics for low-income, uninsured and underserved Kansans.

Federally-Funded Community Health Centers (CHCs)- The OLRH is the state agency contact point for the federal agencies that provide grants to support local community health centers (CHC) in 11 Kansas communites. Planning and discussion about the feasibility of additional CHCs (also known as Federally Qualified Health Centers, or FQHCs) are underway in Hutchinson, Newton, Hays, and Pratt.

Prescription Drug Assistance Program- In 2005, the Legislature appropriated $750,000 in the KDHE budget to improve access to prescription medication through patient assistance programs and implementation of 340B federal drug purchasing programs. Twenty-two clinics have received grant funding through this program.

Charitable Health Care Provider Program - Many individual health care providers participate as a "charitable health care provider" as defined by K.S.A. 40-3401 and 65-4921 by entering into a participation agreement with the Secretary of KDHE. Current agreements include 27 primary care "safety-net" clinics, 1,841 physicians, physician assistants and nurse practitioners, 505 dentists and dental hygienists, and 722 in nursing.

Kansas Rural Health Information Service (KRHIS) -a free subscription service of OLRH since 2002, issues notices by email or fax to over 900 registered users. Each user may opt to receive notifications, news, and information in one or more specific categories of interest.

National Health Service Corps (NHSC) - The NHSC assists communities through site development and through scholarship and loan repayment programs that help underserved communities in HPSAs recruit and retain primary care clinicians. During 2005, 21 primary medical care, 4 dental care and 22 mental health professionals practiced in underserved Kansas communities through the NHSC program.

State 30 Program/J-1 Visa Waivers - Graduates of international medical schools are allowed to remain in the United States to practice medicine after completion of residency training if they commit to practice in a federally designated shortage area. Today, 85 international medical graduates have been recruited to medically underserved areas of the state.

Rural Health Clinics (RHC) - In the late 1990s, KDHE began using a provision in the RHC law which allowed state governors to designate areas as underserved for RHC purposes. This greatly expanded the number of counties eligible for the program and there are now 178 federally certified Rural Health Clinics operating in Kansas.

Critical Access Hospitals (CAH)- CAH are smaller facilties that must be part of a rural health network. As a CAH, hospitals qualify for certain financial supports that allow them to keep their doors open. Kansas has the largest number of CAH's in the nation, comprising 84 facilities within 21 rural health networks.

State Trauma Program- The program encompasses a statewide trauma plan, statewide trauma database and registry, and six regional trauma councils with regional plans. The program provides trauma education to EMS providers, other first responders, emergency room personnel and physicians.

Local Public Health Departments- The OLRH provides support to build organizational competence and assure professional performance by providing technical assistance, education and new employee orientation for 99 local public health departments. Liaison activities involve direct and electronic contact with local public health administrators, elected officials, community and public health nurses and other local agency staff members using a combination of on-site assistance, district meetings, resource and instruction manuals, a newsletter, workshops, and conferences. The agency also maintains a Public Health Directory.

Office of Oral Health:

The Office of Oral Health (OOH) collaborates with and provides technical assistance to communities, schools, health professionals, local health departments, and others to increase awareness of the importance of oral health and improve the oral health status of Kansas.

Dental Sealants - The OOH received a $195,000 HRSA grant to pilot a first-ever school-based sealant program of Kansas's second grade and sixth children year in order to provide preventive oral health services and obtain baseline information on the oral health status of children in the Flint Hills Community Center catchment area of Lyon, Chase, Coffey, Osage, and Greenwood counties.

Public Awareness - KDHE partnered with the Kansas Action for Children (KAC) in a joint media campaign to develop and implement a statewide communications campaign to increase awareness of children's oral health issues. The OOH also prepared an oral health "growth chart" in conjunction with KAC detailing the developmental milestones for oral health care to be provided to physicians, school nurses, child care providers, and families with children.

Flouride Varnish - As of January 2006, OOH will receive a $100,000 private grant to support the promotion of Fluoride varnish in medical settings. Nearly 100 non-dental Public Health personnel, including local health department Public Health nurses, graduate nurses, Healthy Start Home Visitors, and Head Start Health Specialists have already received training in the application of Fluoride varnish.

Oral Health Assessment – An innovative project involving the training of 90 Kansas scholl and public health nurses with a non-invasive laser fluorescent dental device (DIAGNOdent) to screen children for dental caries is underway. Children are referred as needed to local dentists and the nurses act as case managers to assure follow-up treatment. Private funding of $200,000 supports this program.

Bureau of Child Care and Health Facilities (BCCHF):

The child care program of the bureau involves licensure and regulation of many types of child care facilities in Kansas including day care homes, group day care, school age programs, pre-schools and child care centers, and family foster homes.

The health facilities program of the bureau involves licensure and certification of all types of health facilities in Kansas, including hospitals, home health agencies, and facilities for the mentally retarded. The programs exist to assure quality care through two primary means -- establishing licensing standards and inspecting facilities to assure these standards are being met. The bureau also participates in the credentialing and licensing of specific allied health professionals.

Child Care Registration and Licensure- The department regulates more than 11,000 childcare facilities and family care homes. In FY 05 additional funding was allocated to the department to strengthen the program's ability to timely inspect family foster homes and to strengthen the overall regulatory program. The additional resources are being used to make a number of program improvements. For example, 8 existing staff positions within the department were reassigned to the Child Care Licensing and Registration Program to address the need for timely foster home inspections.

Reorganization of the program is underway to better address enforcement capabilities, keep regulations up-to-date, and enhance and expand the CLARIS (Child Care Licensing and Registration Information System) data base to partner agencies. In FY 05, user access and training was completed for local health departments and child care resource and referral agencies. SRS was given access the year before. Over 10,000 hits a month are being logged into CLARIS by these agencies. Future rollouts to other agencies are being planned for later this year.

Enforcement protocols were rewritten to address consistency and effectiveness of actions. The number of administrative orders issued by the department continue to increase. In FY 05, 486 orders were issued. The quality of the inspection process and determining compliance is being addressed through written protocols and staff training.

Hospital and Medical Program – This program regulates over 900 health care facilities, conducting 300 inspections and issuing nearly 50 letters of enforcement each year. Although this section successfully restructured after the transfer of adult care home responsibility to KDOA, completing required workload with existing resources is difficult. Since FY 04 over 70 new providers have become licensed or certified, with over 40 applications pending. CMS has also significantly increased the number of Emergency Medical Treatment and Labor investigations (10 this year).

Health Occupation Credentialing – A "Paid Nutrition Assistant" curriculum and certification exam was developed by a cross section of industry and other interested parties. Regulations were adopted by the Department on Aging to allow the use of these assistants, and the program became available to providers in November. The Nurse Aide Registry system has converted to a web-based format, and the credentialing program has also upgraded other systems to provide more and quicker access to credentialing records, including on-line license verification for adult care home administrators, speech-language pathologists, and dieticians.

Bureau for Children, Youth and Families:

The mission of the Bureau for Children, Youth and Families is to provide leadership to enhance the health of Kansas' women and children through partnerships with families and communities.

Women's, Infant's, and Children's Supplmental Nutritional Program (WIC) - In SFY 06 WIC assured statewide services for pregnant, breastfeeding, and postpartum women and children up to age five <185% poverty through its $7.2 M in contracts with 41 local agencies that provide nutrition education/counseling and checks for supplemental food from vendors. Over 50,000 women and 100,000 children are served each year.

Aid-to-Local Efforts - In SFY 06, the Children and Families Section provided $7.7 million in contracts to local agencies for the purpose of providing public health services at the local level: Maternal and Child Health, Family Planning, Teen Pregnancy, Disparities/Black Infant Mortality, School Health Services, and Abstinence Education. Over 49,000 women's health and 50,000 children well-child checkups and screenings were provided through these programs.

Newborn Screening and Children with Special Health Needs – The state newborn screening program assures that every infant born in Kansas (≅ 39,000/yr) obtains screenings for phenylketonuira (PKU), galactosemia, hypothyroidism, sickle cell and hearing. Follow-up on abnormal results is assured with providers and families. In SFY 06, Children's Developmental Services Section contracted almost $6 million to 36 local agencies and organizations to provide Part C of IDEA (tiny-K) early intervention services for over 5,000 children up to age 3 with disabilities. BCYF coordinated CFIT Training (Caring for Infants and Toddlers) for doctors and nurses to help them identify and refer very young children for developmental screening services. In SFY 06 through 12 contracts with hospitals and clinics, assured a state system of medical specialty services for children with complex medical needs. Over 11,000 children were served by this program.

Pregnancy Maintenance Initiative – BCYF developed regulations and contract procedures for this initiative. Four organizations were funded for service in 2005.

Bureau of Epidemiology and Disease Prevention (BEDP):

The Bureau of Epidemiology and Disease Prevention encompases the following programs: HIV-STD, Immunization, Tuberculosis and Epidemiologic Services.

Immunization - Improving childhood immunization rates has been a priority for the Division of Health. Rates for two year olds rose 14% from 2003 to 2004 (63% to 77% for the minimum advised complement of vaccines). Nearly 10,000 more Kansas children were immunized during the year. KDHE is continuing to follow-up on recommendations made by the 2004 Governor's Blue Ribbon Task Force on Immunization. One specific note is the implementation of a statewide immunization registry in Kansas. As of 12/31/05, 229 users, including local health departments and private providers and clinics, were using the new immunization registry, called WEBIZ. About 1.7 million vaccinations had been entered into the system at the end of 2005.

While there is much we can do within KDHE, we also recognize that the primary factor driving whether a child receives a vaccination is the presence of a "medical home," a primary point of medical care for the child and his or her family. In this regard, we believe that the Governor's proposal to extend insurance coverage to all children less than five years of age will increase access to "medical homes," and result in further rises in immunization rates.

In response to this data, the Governor convened a Blue Ribbon Task Force to evaluate why Kansas children were immunized at lower rates than the national mean. The Task Force completed a study featuring several recommendations. A summary of those recommendations, and the progress made by KDHE and our community partners in meeting these objectives, include:

Develop an immunization registry	The Immunization Registry is installed and working well for 27 providers (including 18 local health departments), 37 clinics, and containing nearly 1.7 million vaccinations.
Change the Age for Administration of Fourth Dose of DtaP (Changed the recommendation for the vaccination to an earlier period in a child's life to ensure the vaccination given in a timely manner)	Following consultation with the KS Academy of Family Physicians and the KS Chapter of the American Academy of Pediatrics notice was sent to physicians across the State in early June. We have initial feedback from several doctors that they are implementing this change. Wide media attention has been given to this change.

Expand Immunization Reminder Systems	Kansas Immunization Program site visits are now targeted equally to private and public clinic sites. Immunization Nurse Consultants provide education to private providers regarding reminder/recall systems, and assist with clinic appropriate methods for their implementation.
Expand the Current, Successful Medicaid Immunization Outreach Project	The *Immunize, Win a Prize* project has been expanded statewide. Under the Government Performance Review Act (GPRA) evaluation, immunization rates among Medicaid children increased 19% statewide as of last summer. Kansas was one of only a handful of states honored at a national GPRA conference last week because of the innovation of this project.
Expand Current WIC/KDHE Partnership	Four counties now have WIC Linkage Projects: Sedgwick, Finney, Ford, and Wyandotte. With next year's federal grant funds (depending upon the amount of the award) and local foundation funds, we plan to expand to several more counties in the coming year.
Expand Access to Childhood Immunizations through the Child's Medical Home	Through a contract and close working relationship with the Kansas Academy of Family Physicians, the Kansas Immunization Program is regularly involved in educating this organization's 1200 members statewide about the importance of a child's medical home. In addition, changes are underway to improve the accessibility of the Vaccines for Children (VFC) program so that more physicians will become a part of this. The federal grant application for the coming calendar year sets a goal of a 30% increase in VFC providers for 2006.
Vaccine Costs: Making Vaccine More Readily Available	This recommendation included conducting a study reviewing the current system for financing childhood immunizations and analyzing costs and benefits associated with shifting to a statewide universal vaccine coverage program (vaccines at no cost to all children.) Preliminary cost estimates to become a "universal coverage state" were too costly to pursue, there were federal barriers to becoming a "universal state," and there wasn't conclusive evidence that doing so would increase immunization rates

Kansas Health Foundation Immunization Initiative	The Kansas Health Foundation in partnership with the Kansas Health Institute and the Kansas Department of Health and Environment has developed a comprehensive intervention project which starts where the Governor's Task Force ended. It will involve all the relevant partners in immunization in Kansas, follow through on recommendations from the Governor's Task Force, and identify areas and interventions to increase immunization rates across the State.

These measures have already shown their efficacy in raising immunization rates. The percentage of children in Kansas receiving the minimum set of vaccinations in 2004 rose to 77%, and those getting the full set increased to 75%. In real terms, this means that nearly 10,000 more Kansas children were immunized during the year. It is our intention to continue to work aggressively to improve immunization rates in Kansas.

While there is much we can do within KDHE, we also recognize that the primary factor driving whether a child receives a vaccination is the presence of a "medical home," a primary point of medical care for the child and his or her family. In this regard, we believe that the Governor's proposal to extend insurance coverage to all children less than five years of age will increase access to "medical homes," and result in further rises in immunization rates.

Epidemiology - This section keeps track of the State's communicable diseases, conducts field investigations of disease outbreaks, and provides assistance to local health departments in disease investigations. This staff investigates about 25 disease outbreaks per year, including food borne outbreaks. A Request for Proposal (RFP) has been issued to replace the current outdated disease investigation system. It will be replaced with a readily accessible, user-friendly, web-based disease investigation system, which will maximize efficiency at the state and local levels when communicable diseases are found.

Experts agree that an influenza pandemic will sweep across the world in the not-so-distant future. A plan for dealing with this certainty has been finalized and includes participation by KDHE, local health departments, hospitals, and other public health partners. Staff in the epidemiology section also work with public health preparedness staff to develop a plan to respond to influenza pandemic. A diverse Task Force of statewide leaders is meeting to develop community flu response plans.

Bureau of Consumer Health:

The Bureau of Consumer Health is composed of two programs: Food Protection and Consumer Safety (FPCS), and the Kansas Childhood Lead Poisoning Prevention Program (KCLPPP). Food Protection and Consumer Safety regulates and inspects food service establishments and lodging facilities. Inspectors provides a core public health function by ensuring safe food and preventing foodborne illness through consistent and progressive enforcement of applicable statutes rules and regulations specific to food service and lodging establishments (restaurants, schools, senior meal sites, special events) and through educational outreach and consultation to industry statewide. 10,320 food service establishments (restaurants, school food service, senior food service,

mobile food facilities) are licensed and regulated by KDHE; 780 lodging facilities are licensed and regulated. Seven contracting counties provide inspection services for 42% of food service establishments. This program is fully funded by licensure fees.

The Kansas Childhood Lead Poisoning and Prevention Program coordinates statewide lead poisoning prevention activities, including blood lead testing, medical and environmental follow-up, case management of children with elevated blood lead levels, and educational outreach through the distribution of prevention materials. The program provides medical surveillance, pre-renovation education, licensure and certification, adult blood lead epidemiology and surveillance. The program screens clients, identifies and recommends medical actions and environmental changes to address lead poisoned adults and children, and educates the public about exposure to lead hazards. In 2005, the Childhood Lead Prevention Program served approximately 28,900 children of all ages (27,200 were ages 0-6 years) in blood lead screening and prevention actives. This activity is funded through the CDC. The Lead Hazard Control project, funded by HUD and designed to ensure identification and remediation of lead hazards in housing within Wyandotte County, is operating well ahead of benchmarks.

Center for Health and Environmental Statistics (CHES):

CHES provides public health information by collecting and processing data regarding various health and environmental issues in the state. Vital records including births, deaths, marriages and divorces in Kansas are recorded by this office and made available to individuals according to Kansas law. Health care information data, such as worker's compensation insurance and health insurance data, are collected and studied to determine trends.

Vital Statistics - After five years of work, the vital statistics electronic system re-engineering is complete. It is a web-based system for internal and external processing, providing access to hospitals, funeral homes, and courts across the state. In addition, KDHE has adopted a new vital records certificate. These new standards will provide improved information regarding race/ethnicity, health care financing and health status indicators

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In 2005, the statutory penalty for fraudulent use of vital records was successfully increased, along with the expansion of defined fraudulent activity.

Health Care Information - The functions of the Health Care Data Governing Board have been transferred to the Kansas Health Policy Authority. Staff completed a final report to the Board's work along with suggestions for future data needs. Work continued in data collection for health care professionals, hospital discharge, vital statistics and insurance claims data. Specific efforts included participation in a study on the impact of specialty hospitals on community hospitals (in partnership with the Kansas Health Institute), supporting the needs of the Kansas Insurance Department, assisting in the development of a medical fee schedule for the Division of Workers Compensation, and preparing district-specific data for legislators on local health status.

Other KDHE Divisions:

In addition to the Division of Health, KDHE includes two other operational divisions the Division of Health and Environmental Labs and the Division of Environment. Two support divisions, the

Division of Fiscal Services and the Division of Human Resources and Service Quality, provide a centralized resource for internal fiscal, personnel and employee needs for the agency.

Division of Environment:

The mission of the Division of Environment is *protecting public health and environment for Kansas.* In order to fulfill this mission and meet these goals the Division of Environment has developed and implemented regulatory, compliance assistance, monitoring, and educational programs within each of the bureaus and the division as a whole. The Division conducts regulatory programs involving the following facilities: public water supplies, industrial discharges, wastewater treatment systems, solid waste landfills, hazardous waste, air emissions, radioactive materials, asbestos removal, refined petroleum storage tanks, and other sources which impact the environment. In addition, the Division administers other programs to remediate contamination, lessen non-point source pollution (such as storm water runoff, grazing livestock, feedlots, development, spills, and leaks), and to evaluate environmental conditions across the state. The Division of Environment works to ensure compliance with federal and state environmental laws through inspection and monitoring. In addition, the Division of Environment also conducts financial or technical assistance programs such as the Wastewater Revolving Loan Fund and the Pollution Prevention Program to assist the regulated community. The Division of Environment works closely with the Environmental Protection Agency and other partners throughout the state to take the necessary steps to preserve the state's natural resources.

Division of Health and Environmental Laboratories (DHEL):

DHEL provides timely and accurate analytical information for public health, and certifies laboratories in the state to assure the quality of services provided. State lab information is used to diagnose and prevent diseases of public health interest that range from AIDS to childhood lead toxicity. DHEL surveillance information also guards the safety of public drinking water as well as ambient air and water quality. Health and environmental analytical operations are performed in accordance with rigid scientific standards.

Kansas: Our State of Health

Howard Rodenberg, MD, MPH

Director, Division of Health

State Health Officer

Kansas Department of Health and Environment

January, 2006

There is an advertisement on television that describes Kansas as a land without limits. As people focused on progress, all of us in the room today see unlimited opportunities to help Kansans reach their full potential. As State Health Officer, it's my honor to represent the over 146,000 health care professionals within our state committed to promoting health as a means towards this goal.

We live in a time where people and communities have more information than ever before about how to achieve and maintain optimal health. Conversely, we also have more opportunities to make choices that do not contribute to good health — the use of tobacco, the excess use of alcohol, inattention to the need for a healthy diet and physical activity, the choice to not use seat belts and motorcycle helmets, and the persistence of lifestyles that foster stress and anxiety. Those of us in leadership positions within the public health and health care community have the responsibility to encourage and empower our citizens to be healthy and achieve the highest quality of life.

Attachment 2
HHS 1-26-06

So how do we evaluate the health status of Kansas? As you know, states are continually compared and contrasted with one another in nearly every conceivable way. This is also true in measurements of health status, and the reports would indicate that in most ways, Kansas is remarkably "average." In the minds of national policymakers, there is really not much worth noticing about the health status of the citizens of the Sunflower State.

I'm not satisfied with the notion that Kansas is "average." While it's true that being average (what the statisticians call being at the median) means that half the states are doing worse than you, it also means that half the states are doing better. Kansas is a great place to live, work, raise a family, and care for our elders. It's my goal to insure that we work towards Kansas being a great place for health.

Allow me to start the discussion by giving you a "snapshot" of the health of Kansas. Basic demographics, those numbers that tell us who and what we are, come first. In 2004, there were 2,735,502 Kansans. Kansas is a diverse state, evenly divided between men and women; 16% of us are Hispanic, African-American, Native American, or Asian. Our population curve encompasses two extremes. Kansas ranks 8th in the nation for percent of residents in the 18-24 year age group, and 9th in the nation for those over 85. Like many states, the Kansas population has its share of baby boomers, and the population as a whole is aging. Our per capita income in 2003 was close to $30,000, ranked 26th in the nation. Nearly 89% of us graduated from high school, and 31% hold a four year college degree. Approximately 70% of Kansans live in urban

areas and 30% in rural communities; Kansans continue to leave these open spaces at a rate of 3% each year. These factors…a graying population, a growing multiethnic culture, and a significant but shrinking rural presence…are all factors which influence the health status of our state. These kinds of factors are described as "social determinants" of health, those demographic and cultural characteristics of our population that affect not only health status, but also use of the health care system.

In terms of health data, our first level of evaluation is with birth and death statistics. In 2004, there were over 39,000 live births in Kansas and nearly 24,000 deaths. The leading causes of death were heart disease, cancer, stroke, respiratory conditions and unintentional injuries. It's often interesting to think about what health events happen each day in Kansas, and we've included a summary in your handout to illustrate this point.

EVERY DAY KANSANS EXPERIENCE:

108 live births
- 11 live births to teenagers
- 8 low birth weight infants
- 1 stillborn and 1 infant death

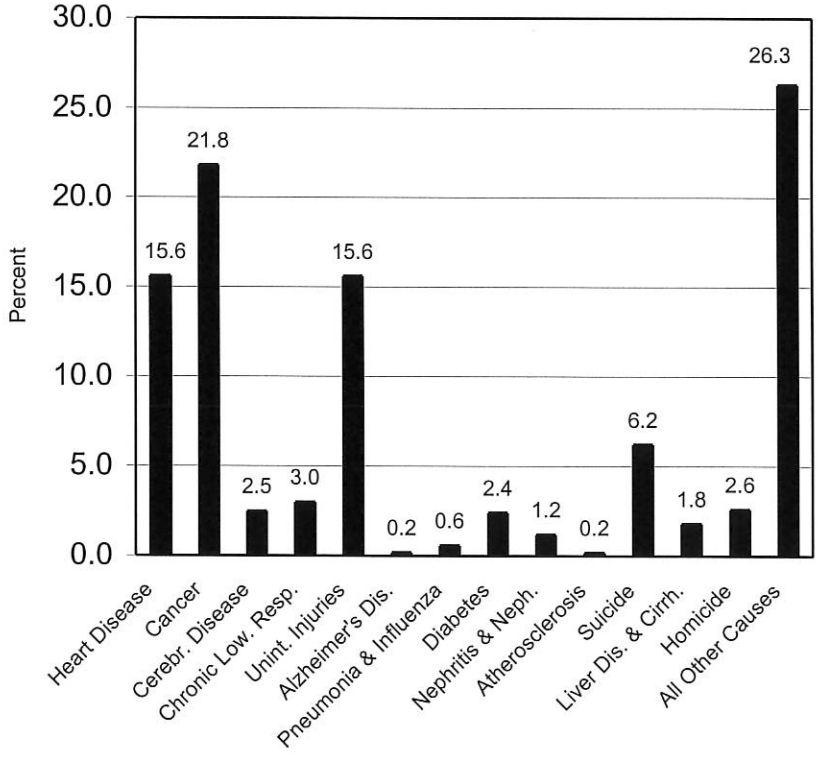
909 hospital discharges:
- 9 hip fractures in the elderly
- 14 victims of heart attack
- 35 pneumonia patients
- 11 diabetics

65 deaths
- 16 due to heart disease
- 14 due to cancer
- 4 due to chronic lower respiratory disease
- 1 due to motor vehicle accidents
- 1 suicide

Source: DOH, Center for Health and Environmental Statistics

In public health and health care policy, looking at raw numbers is never enough. One of our tasks is to identify those opportunities to make the biggest difference in the lives of individuals and in the overall health of society. One of our tools is to review Years of Productive Life Lost , or YPLLs. These numbers represent the impact of disease or injury on young people and those actively contributing to the workforce. In Kansas, the top three causes of YPLLs are cancer, heart disease, and unintentional injury. Even a superficial turn at these numbers demonstrates that simple measures such as decreasing tobacco consumption and enhancing seat belt use can have a major impact on the lives of Kansans.

Percent Years of Potential Life Lost
By Selected Causes of Death
Kansas, 2004



2-4

How do our numbers stack up against national norms? Let's address some of the successes first. Overall, we have much to be proud of. The 2005 Health Care State Rankings places Kansas as 15th in the nation in overall health status. Kansas is a national leader in insuring that women receive early prenatal care, resulting in successful pregnancies and healthier babies. The success can be credited to physicians, nurses, local health departments, and hospitals throughout the state dedicated to serve this vital need. Kansas is also a leader in the number of hospital beds per population, especially in rural areas. This statistic demonstrates our commitment to insuring that medical care is available and convenient, and that we recognize that staying close to home has a healing value all it's own. Kansans also know that health care coverage is important. Only eleven percent of Kansans have no private or public health insurance coverage, as compared with a national average of 15%. Our rate of uninsured children is half that of the nation as a whole. That being said, the prospect of even one person, and especially a child, being unable to get the health care they need because of a lack of resources is clearly one too many. Birth to five are the formative years where health setbacks can cause the greatest long-term problems and destroy what should be an exceptional future for a child in our state.

Major Indicators of Health-How Does Kansas Rank Compared to the Nation?													
Indicator	Teenage birth rate	% Mothers receiving prenatal care in 1st trimester	Percent of Community Hospitals in Rural Areas (2003)	Rate of Beds in Community Hospitals (per 100,000 population)	Cancer EDR (All Sites)	Cerebrovascular Disease (Stroke) AADR	Diabetes AADR	Heart Disease AADR	Injury Death Rate AADR	Motor Vehicle Death Rates AADR	Suicide Deaths AADR	Percent of Population Not Covered by Insurance	Percent of Children Not Covered by Insurance
National Statistic	46.1	84.1	44.2	280	194.2	56.2	25.4	240.8	54.9	15.7	10.9	15.1	11.4
Kansas Statistic	47.6	87.7	79.9	387	196.3	59.5	26.3	220.6	58.2	20.3	12.6	10.9	6.4
Rank in US	20	8	10	8	32	19	24	28	23	17	20	35	44
KS Strength		↗	↗	↗				↗				↗	↗
KS Weakness	↗				↗	↗	↗		↗	↗	↗		

EDR=Estimated Cancer Rate
AADR= Age-Adjusted Death Rate
CDR=Crude Death Rate

Source: Health Care State Rankings, 2005
Morgan Quitno, Lawrence, Kansas

While we should all be proud of our successes and resolve to build upon them, comparison with national means also demonstrates areas that need work. In areas such as death from cancer, injury, and heart disease, our standing at or below the national average links with our known leading causes of years of productive life lost. Linking these two sets of information helps us to focus our efforts even more sharply on three major areas of work.

Tobacco use remains a significant problem in Kansas, and it is the leading cause of preventable death within the state. Despite educational efforts, smoking rates have been consistent in Kansas for several years. Twenty percent of Kansans continue to smoke cigarettes. Most concerning is that smokers who quit or die are being continually replaced by new ones. We need to empower our citizens with more tools to achieve success in preventing tobacco use throughout the state. These efforts may encompass tools such as increased tobacco taxation, enforcement of the prohibition of sales to minors, and promoting clean indoor air. The health benefits of such efforts are real and unquestionable. A comprehensive program of tobacco use prevention will, over time, save 4,000 lives each year and up to $720 million dollars annually in smoking-related direct health care costs.

We've also learned that despite the image of the lean, weathered prairie farmer or cottle producer, Kansas ranks 8th in the nation in percent of persons who are overweight, and 23% all Kansans are obese. Since 1992, our obesity rate has soared by 70%. We know that these numbers will continue to rise as long as over half of Kansans do not engage in moderate physical activity for 30 minutes daily, and 80% of adults fail to eat at least five servings of fruits and vegetables each day. Obesity contributes to heart disease, cancer, diabetes, and disability, and it trails only tobacco use as a cause of preventable death. Estimates indicate that over 3,700 of us will die early deaths each year from the complications of being overweight or obese, and that over $650 million dollars will be incurred annually in Kansas from obesity-related medical expenditures. These costs, both human and financial, simply cannot be ignored. They will continue to

plague us in the decades ahead if we don't act now with programs and policies designed to promote healthy nutritional habits, encourage physical activity, and insure that our schools, our homes, and our communities establish these habits for life in our kids.

An area of personal concern to me, not only as the State Health Officer but also as an emergency physician, is our rate of accidental injury and death. In 2005, the National Highway and Traffic Safety Administration (NHTSA) reported that Kansas ranked 45th in the nation for seatbelt usage. Only 67% percent of our citizens regularly buckle up, compared with 82% of motorists nationwide. Our failure to properly use seat belts means that Kansas ranks in the top 20 for motor vehicle death rates, exceeding the national average by over 30%. Every year 450 Kansans die on our roads. Motor vehicle crashes are the leading cause of death for all Kansans 34 and younger, and death rates are highest for those between 15 and 24. A primary seat belt law in Kansas can raise seat belt usage and save 150 lives and $450 million dollars in health care costs each year. As one who spent the better part of a career treating the victims of motor vehicle crashes and tending to their families, these fully preventable deaths that take the youngest and most promising people from our lives our are totally unacceptable.

When people look at those health measures that have been most effective within the last 200 years, they are often surprised to find that the top items include the advent of immunizations and the provision of clean and fluoridated water. Because we know so

much about the benefits of vaccination, it is concerning that here again, Kansas shows room for improvement. In 2003, only 63% of our children had received the minimum recommended vaccinations by age two. At that time, our Governor convened a Blue Ribbon Task Force to evaluate the immunization process in Kansas. KDHE has been implementing the short-term recommendations identified in the Task Force report, moving forward with innovative programs such as developing a statewide electronic immunization registry, linking immunization to WIC services, and advancing the recommended schedule of vaccination. These efforts have been successful even at an early stage. Our immunization rate for two-year-olds in 2004 was 77%, and over 10,000 more Kansas children had been vaccinated between 2003 and 2004. We are also proud to note that by school entry, over 95% of Kansas kids are "up-to-date" on their required shots. KDHE, the Kansas Health Institute (KHI), and the Kansas Health Foundation (KHF) are now engaged in a joint effort to improve these numbers even more by reviewing those processes and structures within Kansas that may assist or be barriers to us in achieving our goals.

There are two pressing issues I want to bring to your attention which are not well reflected by national comparisons. An emerging issue within Kansas is that of health disparities. Put simply, health disparities are those differences in health status that exist between groups distinguished by race, ethnicity, geography, or socioeconomic status. Despite what many outsiders may think, all of us here today recognize that Kansas is becoming a diverse society. The multiple benefits of diversity also come with some challenges. For example, we know that African-American infants die at rate more than

twice that of white infants. Over 18% of Hispanic mothers do not receive adequate prenatal care, compared to 6% of white mothers. Native Americans have a 75% greater chance of dying from complications of diabetes than the rest of the population. Youth in rural areas use tobacco at twice the rate of their urban peers, and are more likely to use alcohol while driving.

The magnitude of these disparities is such that, taken as a whole, the reduction of health disparities alone would allow Kansas to reach the United States Centers for Disease Control Healthy People 2010 goals. It is our challenge to close this gap, and to identify those cultural and systemic issues we must address so that every Kansan can enjoy good health. Key to this effort is an honest evaluation of cultural competency, the ability of our healthcare system to respond to the unique values and beliefs of every Kansan. At KDHE, we are moving to establish an Office of Minority Affairs to focus our efforts on addressing these issues, and to reinforce the multiple efforts in which we're currently engaged.

The second issue I want to mention is public health emergency preparedness, and specifically the prospect of influenza. Even during this year's "normal" flu season, we've seen challenges in equitable vaccine distribution across the state Many of these challenges are federal, and beyond our control. I am gratified, however, to report to you that local health departments have done a yeoman's job in managing their supplies, and at KDHE we've given all doses of flu vaccine we received to local health departments, state universities, and other state institutions. In the context of pandemic influenza,

KDHE has issued a plan encompassing surveillance, emergency response, and communications aspects in order to help our state prepare. We have a working group at the state level with invitations extended to representatives of the health care, business, education, law enforcement, agricultural, and emergency management communities. We are correlating our efforts with those of our federal partners to ensure coordination and cooperation. During November and December, our State Epidemiologist Dr. Gail Hansen and I toured 13 cities across the state presenting public forums on pandemic influenza. These forums have been focused not only on empowering Kansans to better care for themselves and their communities, but also on promoting multidisciplinary local planning efforts. We'll also be speaking with legislative committees about pandemic flu so we can all plan ahead using the same set of information. While we cannot prevent the possibility of pandemic influenza reaching our state, we can work together to lessen it's impact upon our families and friends.

In the last few minutes, I've tried to provide you with a "snapshot" of the health status of Kansas. Where do we go from here?

I see three avenues in which we as a state must move ahead. The first is in the dissemination of information just as we've done here today. Communities need information on their health status in order to prioritize local efforts and monitor their effectiveness. We have already initiated a project at KDHE to make data such as I've shared today more accessible through our website, and are working to expand our information sharing even more as we acquire new data sets and new technologies for

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sharing. As another part of this effort, each legislator here today will receive a health profile of their own Senate or House district in comparison with state norms. The information has also been posted on our website. We encourage you to use this data to identify local health concerns, to share the information with your constituents, and to use this knowledge to further local efforts to promote good health.

The second action item is to take a hard look at the wide range of policy and program options available to us as we collectively work to improve the health of our state. I have previously testified to legislative interim and oversight committees that I believe one of the critical roles of KDHE and the public health community is to bring best practices in the realm of prevention to the attention of policymakers. These may be primary preventive action designed to halt disease or injury before it happens, such as measures to increase seat belt use and limit tobacco consumption; or they may be secondary preventive measures such as promoting disease management programs and community-based elder care. As we look at our options, we should not be bound by a limited or restrictive definition of what constitutes public health programs and what does not. We must be ready and willing to explore all avenues to improve health, be they educational, fiscal, legislative, regulatory, or environmental. And while there are many issues within health and health care that call for attention, the bottom line for all of them is the health status of our state. It's our task to insure that no matter what subject or nature of the policy change, we develop some measure of the impact upon health status to help judge the ultimate efficacy of these plans.

The last is to set high goals for ourselves, and to hold ourselves accountable to those goals. One of our major accomplishments this year has been the Healthy Kansans 2010 Project. The process was funded by the Kansas Health Foundation, and we're grateful to acknowledge their support.

This Healthy Kansans 2010 effort involved a series of 23 meetings involving 200 representatives from over 100 different organizations. The process began by reviewing the Kansas profile of the 10 Leading Health Indicators as identified by the CDC Healthy People 2010 Objectives for the Nation. These ten indicators include rates of physical activity, percent of persons overweight and obese, and rates of use of tobacco and alcohol. They focus on responsible sexual behavior, the mental health of the population, and rates of death from injury and violence. They reflect environmental quality, immunization rates, and the individual's access to medical care. You will have noticed that these indicators do not reflect specific diseases, but rather more specific behaviors and societal structures. The underlying concept is that by changing behavior and enhancing access to care, we can have a significant impact on the preventable causes of death and disability.

The project began with an evaluation of the ten leading health indicators and the status of Kansas relative to these goals. The following pages describe the relationship between the current status of Kansas and the Healthy People 2010 goals. In virtually all cases, it's clear that there is work to be done. (A more complete table of indicators, Kansas measures, and reference sources follows this text.)

To reach these goals, it was important to focus our efforts. Cross-cutting themes which impacted the majority of these targets were considered targets of opportunity, areas in which a dedicated effort could show real benefit to the health of our state. These areas were noted as risk identification and disease prevention in women and children, interventions to address the social determinants of health, and the elimination of health disparities between racial and ethnic groups.

Workgroups have taken these themes and developed sets of action steps to enhance our efforts in these areas. Tobacco control, enhancing healthcare provider cultural competency, and further characterization of health disparities were identified as the realms of activity which could have the most impact on the areas of need. The counsel is wide in scope, and takes full advantage of the range of public health interventions available for use. In the realm of tobacco cessation, the recommendations encompass agency, organization, local, and state tobacco control polices, funding for tobacco control efforts, and clean indoor air legislation. Comprehensive data collection systems and engaging under-represented communities in the collection process are tools used to further examine and categorize health disparities, while the establishment of an information clearinghouse and development of training courses help us to address issues of cultural competency.

As stewards of public resources and the public trust, we must insure that we can measure the effect of these interventions in an objective fashion. While the natural history of disease means that the final impact of an action on our overall health may not

be known for years…if nothing else, public health tends to be a patient science…we must identify markers. Markers are those intermediate steps that we know from experience correlate with long-term outcomes. The markers we use will also vary by the nature of the larger issue. In the realm of tobacco control, markers of progress may include the passage of clean indoor air policies at the state and local level, compliance with laws on tobacco sales to minors, and additional tobacco taxation to pay for the health care costs of smoking. We may judge our movement towards a better understanding of health disparities by insuring our data tools are able to capture the information we need to make informed decisions about the health of our state. Cultural competency may be furthered through noting the number of people participating in training courses and in promoting the linguistic and cultural diversity of the public health workforce to best reflect those people we serve. We are currently developing concrete action plans to lead us towards these goals, and look forward to presenting them for your consideration.

Healthy Kansas 2010 is a critical piece of the new KDHE Division of Health strategic plan. Our balanced scorecard model is based on identifying high-priority outcomes, finding ways to measure them, and formulating means to exert an impact upon those aims. Some of these goals are external, and many more internal; but all are geared towards improving the health of Kansans.

I started this talk with the notion that Kansas is, in many ways, acutely average. In the last few minutes, I hope I've convinced you that average is simply not good enough. I

mentioned the advertisements running on television that promote Kansas as a place of unlimited spaces. I believe that there is unlimited opportunity for the health of Kansas to improve. I also believe that the only place for Kansas as we measure the health status of our nation is in first. I bring you the assurance that all of us at KDHE, and all the health care professionals that we are privileged to call our partners, are fully engaged in making this dream a reality. We ask you to join us in this work.

Thank you for your time and your interest in this topic. I'd be delighted to entertain any questions you might have. Thank you once again.

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Healthy People/Healthy Kansans 2010: 10 Leading Health Indicators

Objective	Kansas Rate	HP2010 Goal
Physical Activity		
Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardiorespiratory fitness 3 or more days per week for 20 or more minutes per occasion.	70% (2005 KS Youth Risk Behavior Surveillance System, grades 9-12)	85% (grades 9-12)
Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes per day.	33% (2003 KS BRFSS)	50%
Overweight and Obesity		
Reduce the proportion of children and adolescents who are overweight or obese.	11% (ages 12-18, 2002 KS Youth Tobacco Survey)	5% (ages 12-19)
Reduce the proportion of adults who are obese.	23% (2004 KS BRFSS)	15%
Tobacco Use		
Reduce cigarette smoking by adolescents.	21% (2005 KS Youth Risk Behavior Surveillance Survey, grades 9-12)	16% (grades 9-12)
Reduce cigarette smoking by adults.	20% (2004 KS BRFSS)	12%
Substance Abuse		

Objective	Kansas Rate	HP2010 Goal
Healthy People: Increase the proportion of adolescents *not* using alcohol or any illicit drugs during the past 30 days.	69% of 6th, 8th, 10th, and 12th graders reported *not* using alcohol at least once in the past 30 days 91% of 6th, 8th, 10th, and 12th graders reported *not* using marijuana at least once in the past 30 days (2005 Kansas Communities That Care Survey Youth Survey)	89%
Reduce the proportion of adults engaging in binge drinking of alcoholic beverages during the past month.	13% (2004 KS BRFSS)	6%
Responsible Sexual Behavior		
Increase the proportion of adolescents who abstain from sexual intercourse.	55% (Abstinence only - 2005 KS Youth Risk Behavior Surveillance System, grades 9-12)	95% (includes abstinence or condom use if sexually active)
Mental Health		
Increase the proportion of adults with recognized depression who receive treatment.	No Kansas data available that is directly comparable to HP2010 target.	50%
Injury and Violence		
Reduce deaths caused by motor vehicle crashes .	18.5 deaths per 100,000 population (2004 Vital Statistics, KDHE)	9.2 deaths per 100,000 population
Reduce homicides.	4.3 homicides per 100,000 population (2004 KS Vital Statistics)	3.0 homicides per 100,000 population
Environmental Quality		

Objective	Kansas Rate	HP2010 Goal
Reduce the proportion of persons exposed to air that does not meet the U.S. Environmental Protection Agency's health-based standards for ozone.	0% (EPA Aerometric Information Retrieval System)	0%
Immunization		
HP2010 Objective: Increase the proportion of young children who are fully immunized (4:3:1:3:3 series)	75% (4:3:1:3:3 series - 2004 National Immunization Survey)	80% (4:3:1:3:3 series)
Increase the proportion of noninstitutionalized adults aged 65 years and older who are vaccinated annually against influenza. Increase the proportion of adults aged 65 years and older ever vaccinated against pneumococcal disease.	68% (2004 KS BRFSS) 63% (2004 KS BRFSS)	90% 90%
Access to Health Care		
Increase the proportion of persons with health insurance.	85% (2004 KS BRFSS)	100%
Increase the proportion of persons who have a specific source of ongoing primary care.	84% (2004 KS BRFSS)	96%
Increase the proportion of pregnant women who begin prenatal care in the first trimester of pregnancy.	88% (2003 Vital Statistics, KDHE)	90%

Attachment 3
HHS 1-26-06

3-2

Kansas: Our State of Health

Howard Rodenberg MD MPH
Kansas State Health Officer
January, 2006

Kansans: Who Are We?

- 2.7 million Kansans
- Diversity: Gender, age, race, ethnicity
- $30,000 per capita income
- 89% high school graduates; 31% hold a four-year degree
- 70% urban, 30% rural
- "Social Determinants of Health"

EVERY DAY KANSANS EXPERIENCE:

108 live births

- 11 live births to teenagers
- 8 low birth weight births
- 1 stillbirth and 1 infant death

909 hospital discharges:

- 9 hip fractures in the elderly
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- 11 discharges for diabetics

65 deaths

- 16 due to heart disease
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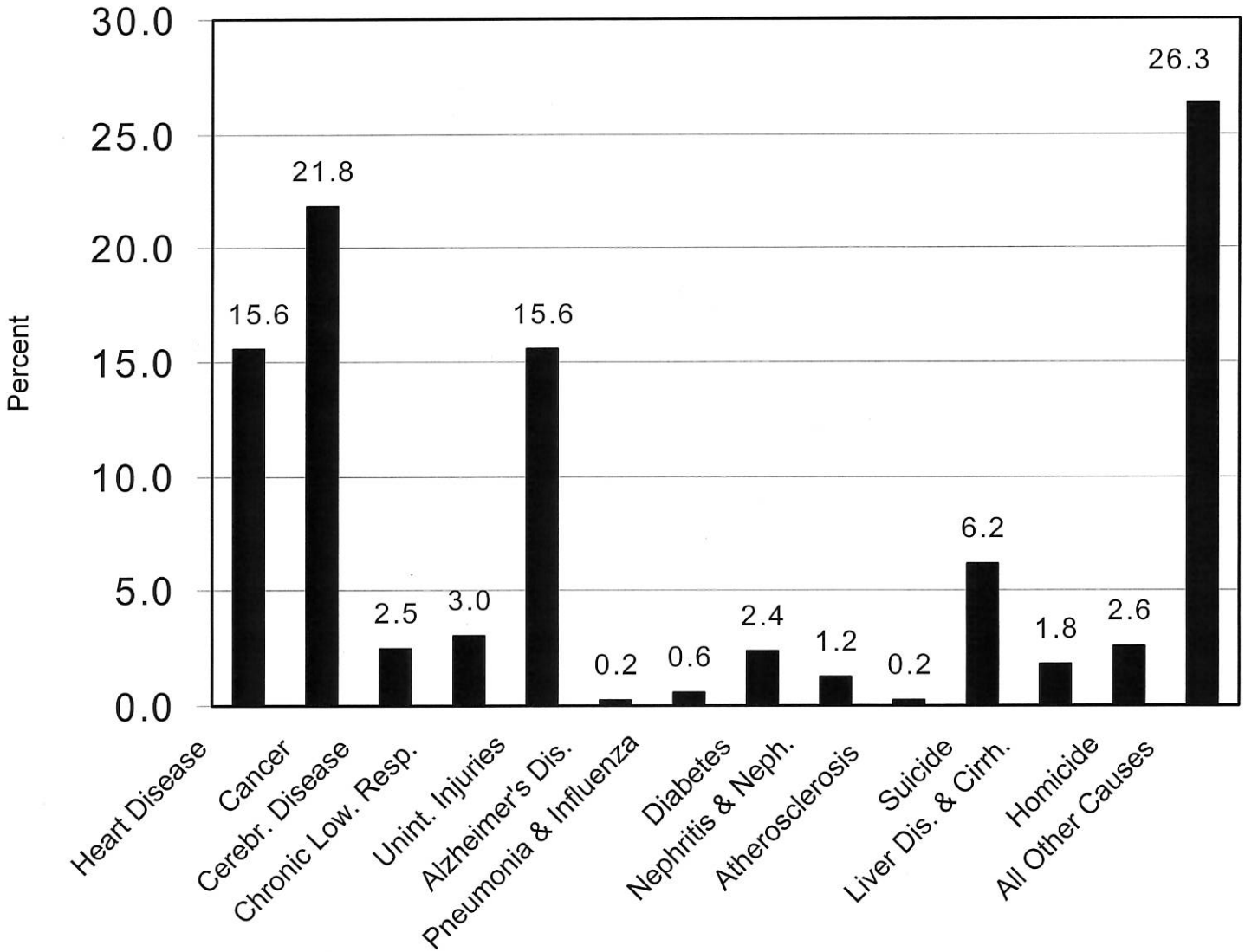
- 4 due to chronic lower respiratory disease
- 1 due to motor vehicle accidents
- 1 suicide

Percent Years of Potential Life Lost By Selected Causes of Death Kansas, 2004



Major Indicators of Health-How Does Kansas Rank Compared to the Nation?

Indicator	Teenage birth rate	% Mothers receiving prenatal care in 1st trimester	Percent of Community Hospitals in Rural Areas (2003)	Rate of Beds in Community Hospitals (per 100,000 population)	Cancer EDR (All Sites)	Cerebrovascular Disease (Stroke) AADR	Diabetes AADR	Heart Disease AADR	Injury Death Rate AADR	Motor Vehicle Death Rates AADR	Suicide Deaths AADR	Percent of Population Not Covered by Insurance	Percent of Children Not Covered by Insurance
National Statistic	46.1	84.1	44.2	280	194.2	56.2	25.4	240.8	54.9	15.7	10.9	15.1	11.4
Kansas Statistic	47.6	87.7	79.9	387	196.3	59.5	26.3	220.6	58.2	20.3	12.6	10.9	6.4
Rank in US	20	8	10	8	32	19	24	28	23	17	20	35	44
KS Strength		↗	↗	↗				↗				↗	↗
KS Weakness	↗				↗	↗	↗		↗	↗	↗		

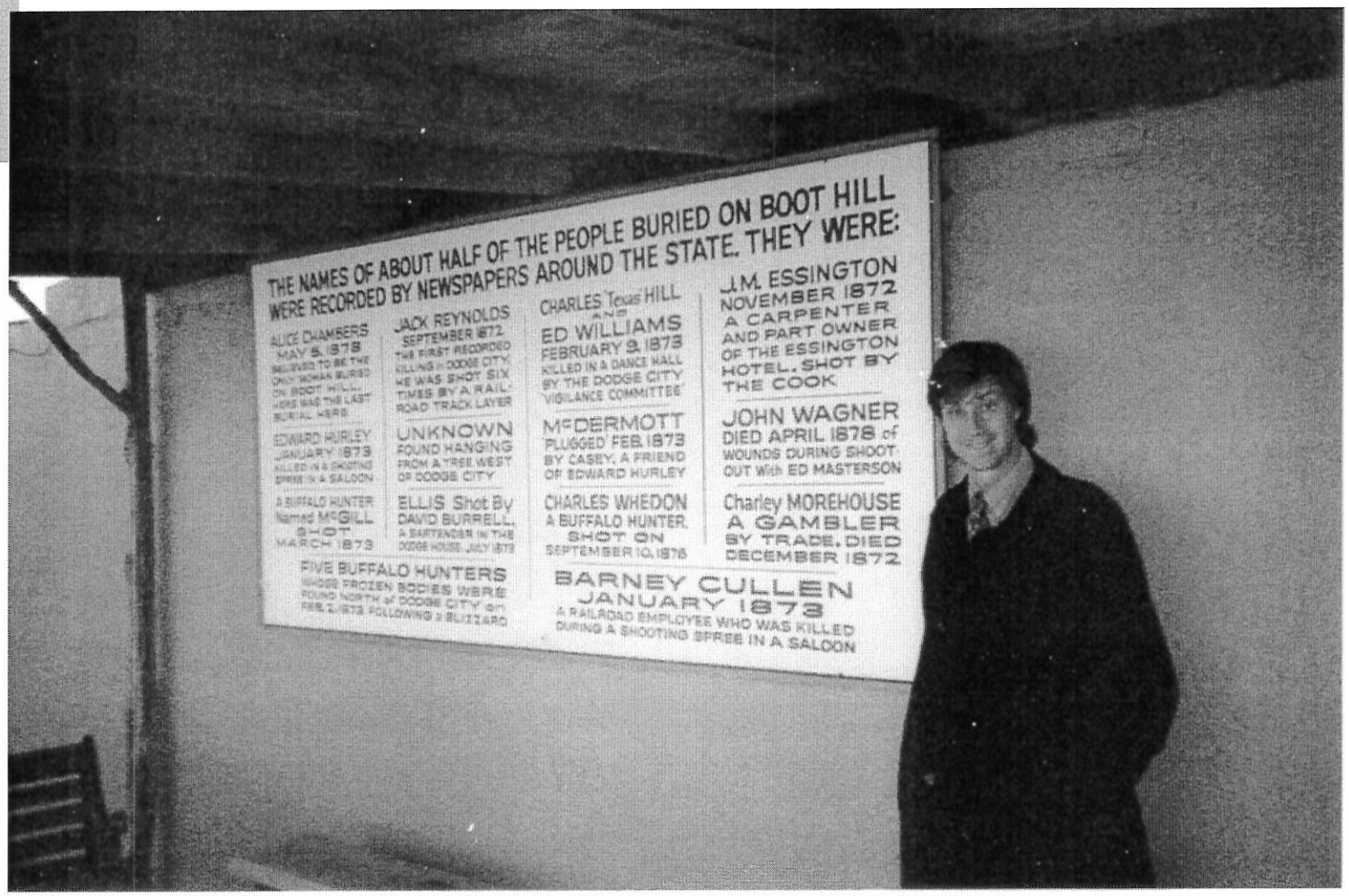
EDR=Estimated Cancer Rate
AADR= Age-Adjusted Death Rate
CDR=Crude Death Rate

Source: Health Care State Rankings, 2005
Morgan Quitno, Lawrence, Kansas

Preventable Causes of Death

Preventable Causes of Death

- Tobacco
- Overweight and Obesity
- Motor Vehicle Safety - Seat Belts


THE NAMES OF ABOUT HALF OF THE PEOPLE BURIED ON BOOT HILL WERE RECORDED BY NEWSPAPERS AROUND THE STATE. THEY WERE:
ALICE CHAMBERS MAY 5, 1878 BELIEVED TO BE THE ONLY WOMAN BURIED ON BOOT HILL. HERS WAS THE LAST BURIAL HERE.
JACK REYNOLDS SEPTEMBER 1872 THE FIRST RECORDED KILLING IN DODGE CITY. HE WAS SHOT SIX TIMES BY A RAIL ROAD TRACK LAYER
CHARLES Texas HILL AND ED WILLIAMS FEBRUARY 9, 1873 KILLED IN A DANCE HALL BY THE DODGE CITY VIGILANCE COMMITTEE
J.M. ESSINGTON NOVEMBER 1872 A CARPENTER AND PART OWNER OF THE ESSINGTON HOTEL. SHOT BY THE COOK
EDWARD HURLEY JANUARY 1873 KILLED IN A SHOOTING SPREE IN A SALOON
UNKNOWN FOUND HANGING FROM A TREE WEST OF DODGE CITY
McDERMOTT PLUGGED FEB. 1873 BY CASEY, A FRIEND OF EDWARD HURLEY
JOHN WAGNER DIED APRIL 1878 of WOUNDS DURING SHOOT OUT With ED MASTERSON
A BUFFALO HUNTER Named McGILL SHOT MARCH 1873
ELLIS Shot By DAVID BURRELL, A BARTENDER IN THE DODGE HOUSE, JULY 1878
CHARLES WHEDON A BUFFALO HUNTER. SHOT ON SEPTEMBER 10, 1876
Charley MOREHOUSE A GAMBLER BY TRADE. DIED DECEMBER 1872
FIVE BUFFALO HUNTERS THOSE FROZEN BODIES WERE FOUND NORTH of DODGE CITY ON FEB. 2, 1873 FOLLOWING a BLIZZARD
BARNEY CULLEN JANUARY 1873 A RAILROAD EMPLOYEE WHO WAS KILLED DURING A SHOOTING SPREE IN A SALOON

3-11

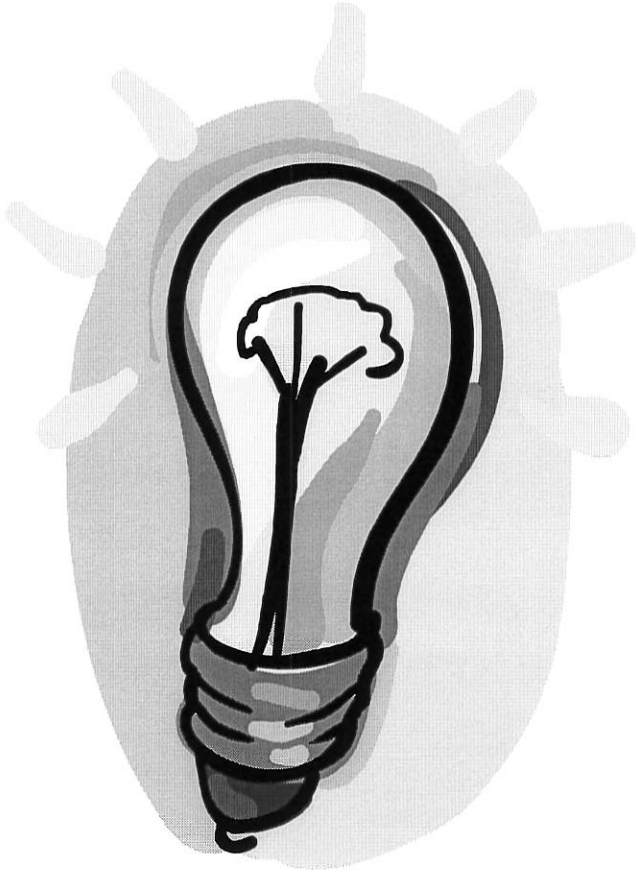
Immunizations…

…a tale of improvement!

Key Issues for Kansas

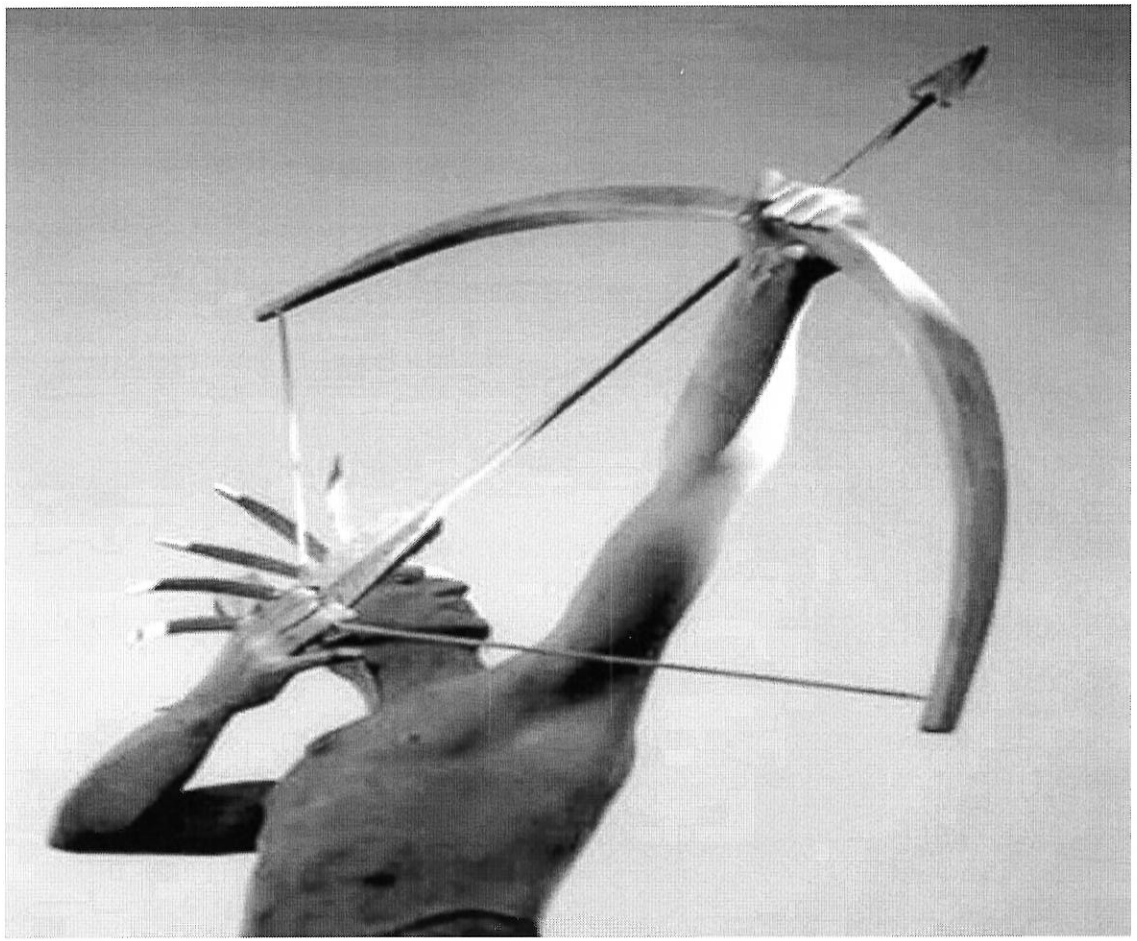
- Health Disparities
- Public Health Preparedness

Moving Ahead in 2006



- Information sharing with our communities
- Exploring the wide range of best practices for health
- Insuring we always measure outcomes

Aiming High

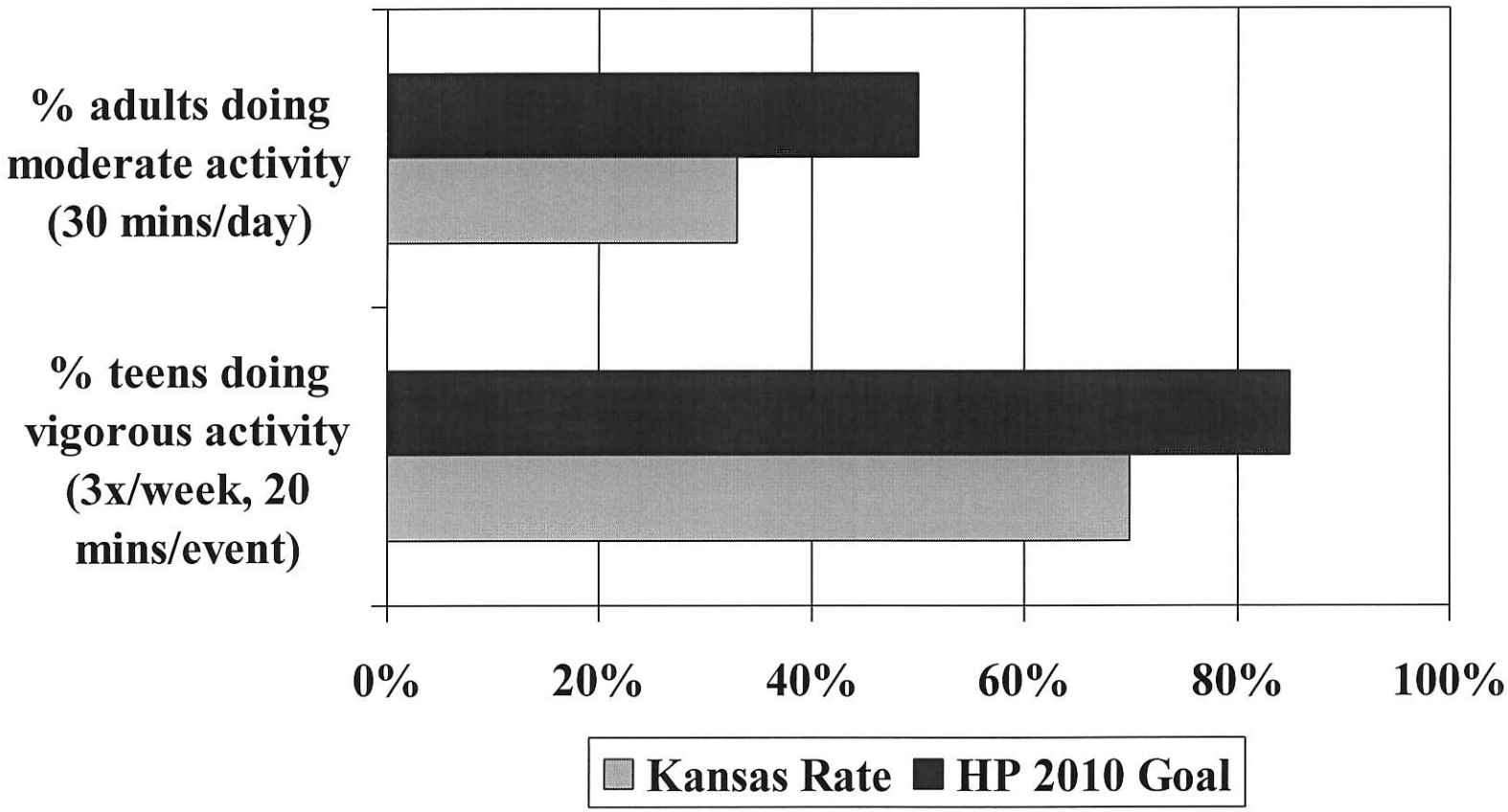


3-15

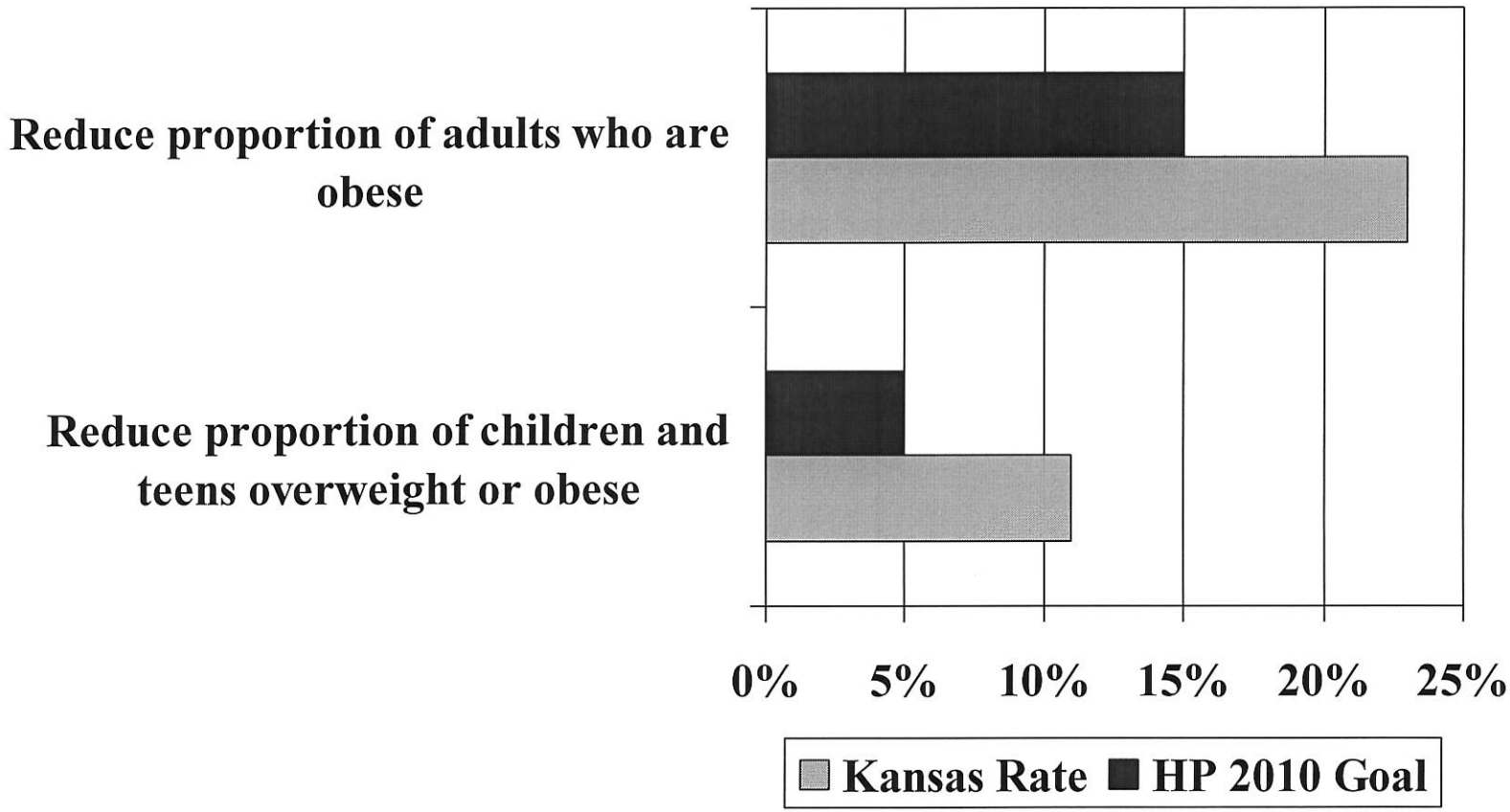
Healthy Kansans 2010

Setting Our Sights on Health

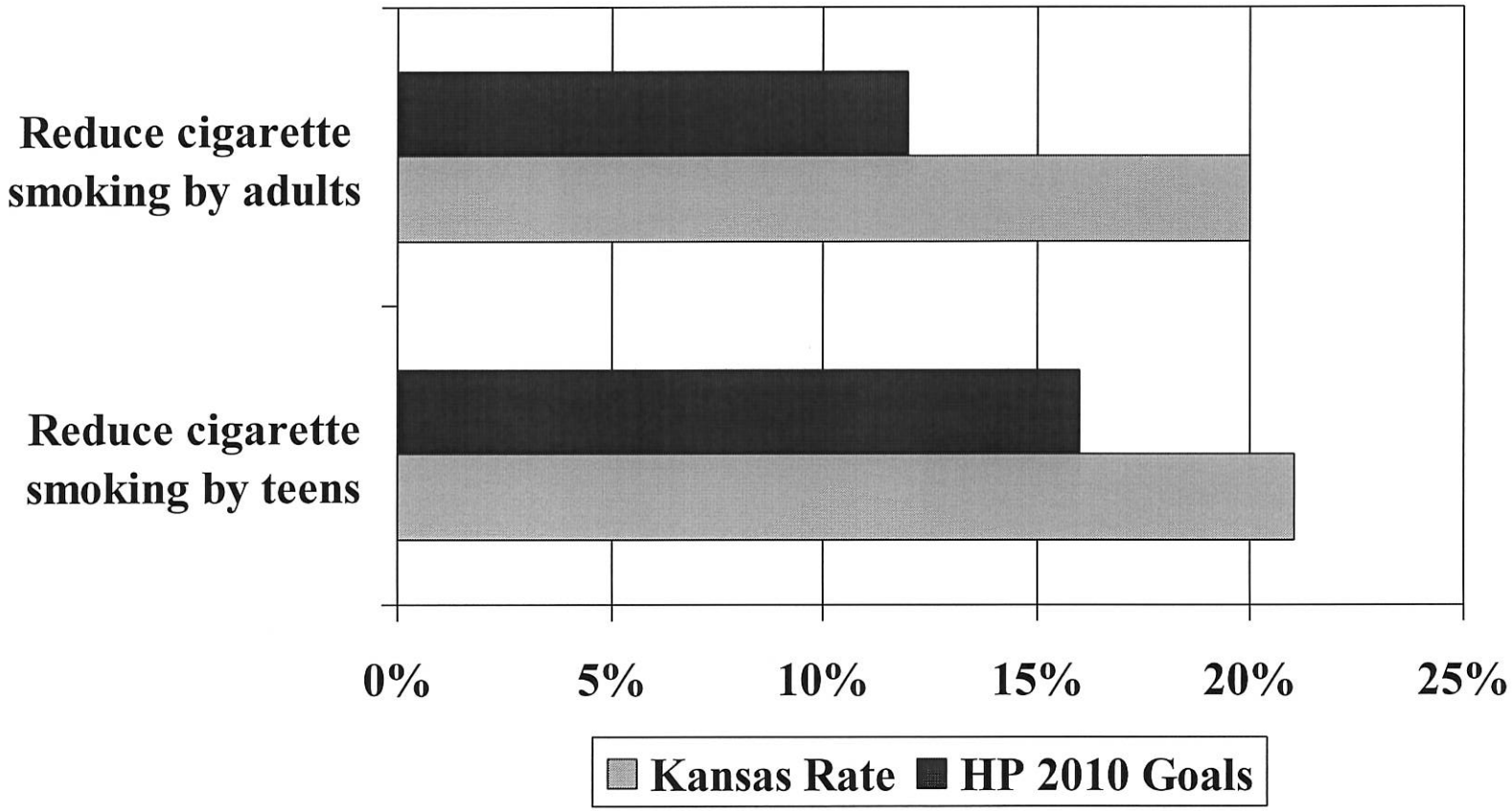
HK 2010: Physical Activity



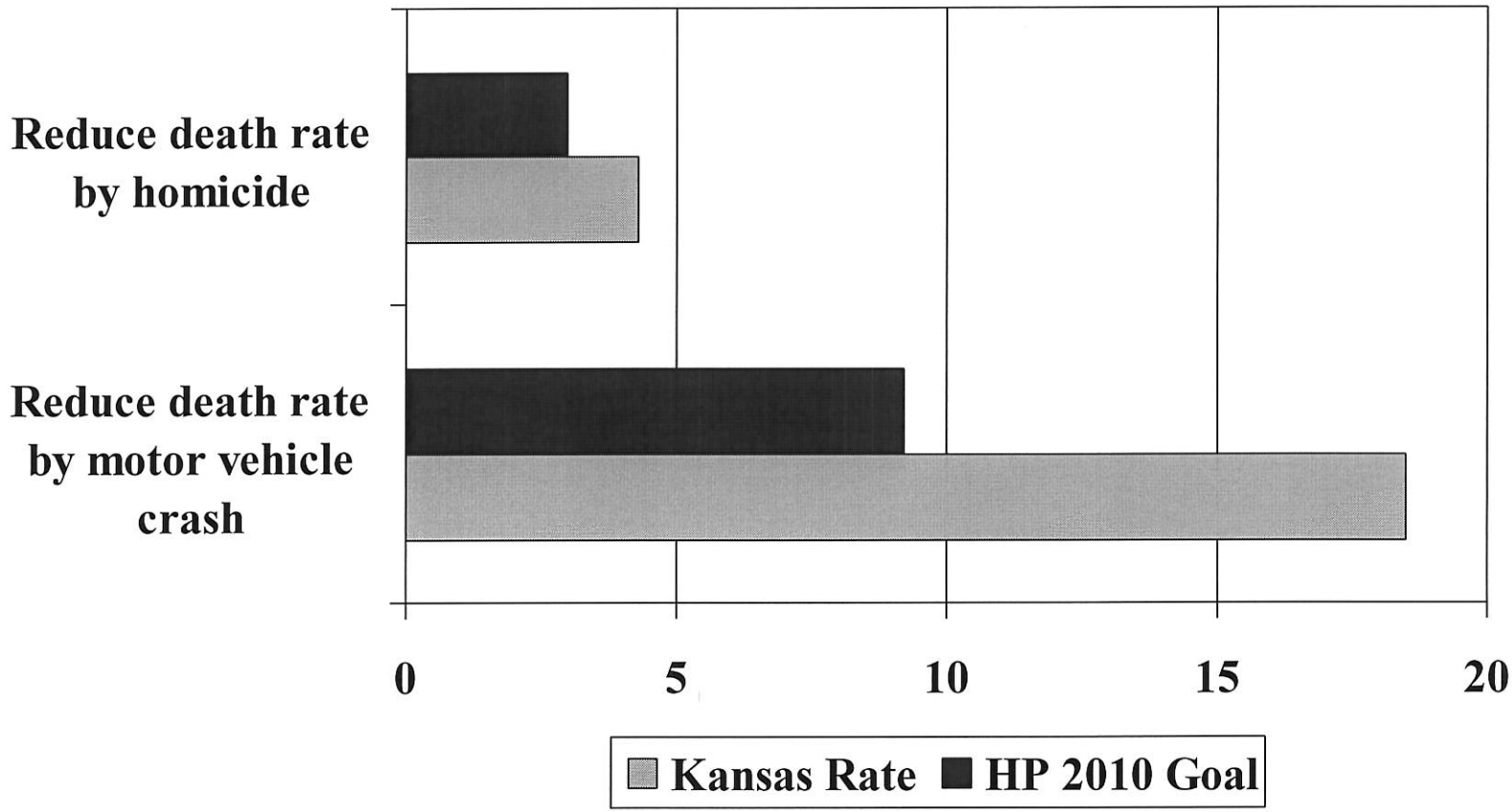
HK 2010: Overweight and Obesity



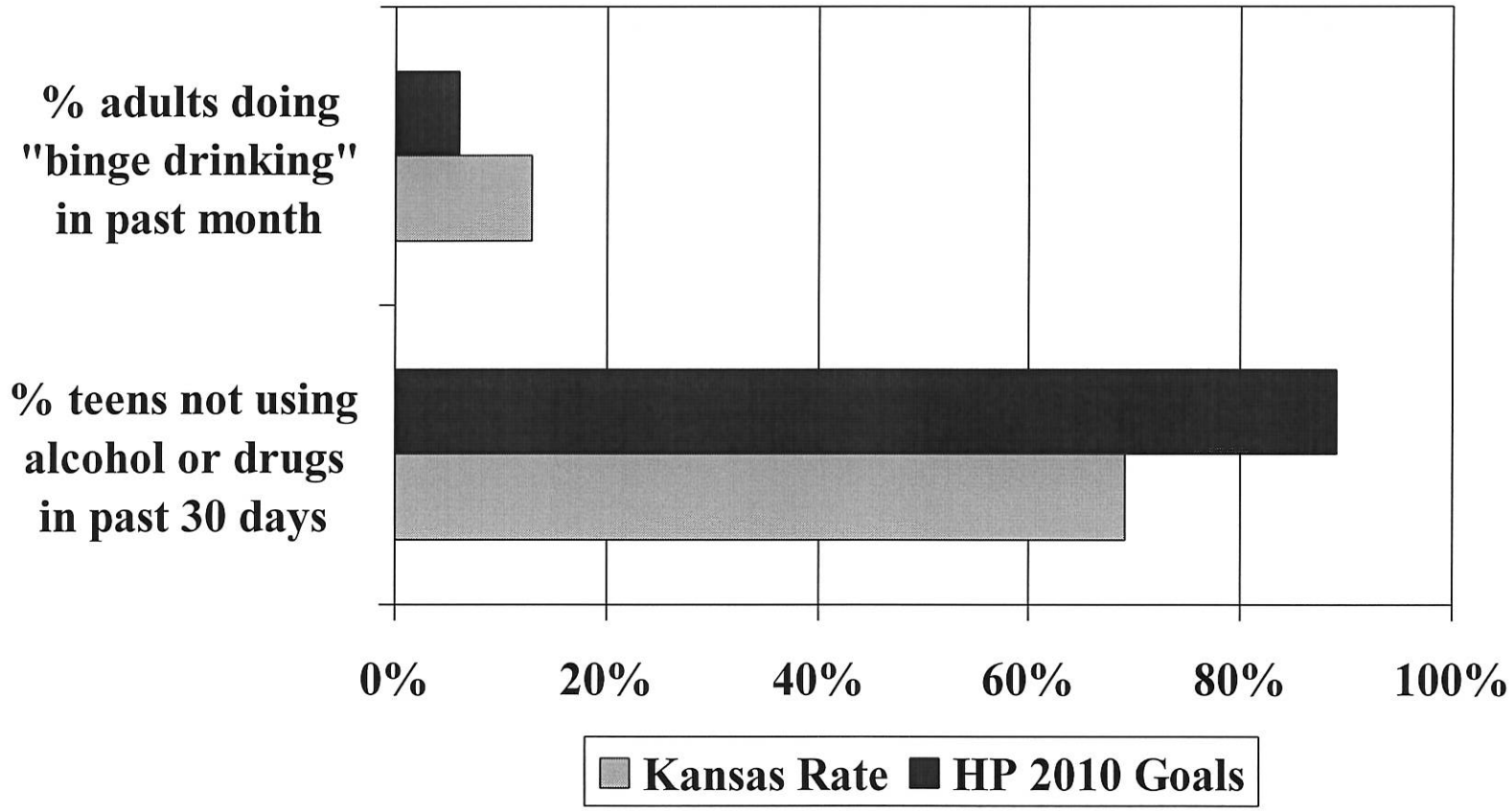
HK 2010: Tobacco Use



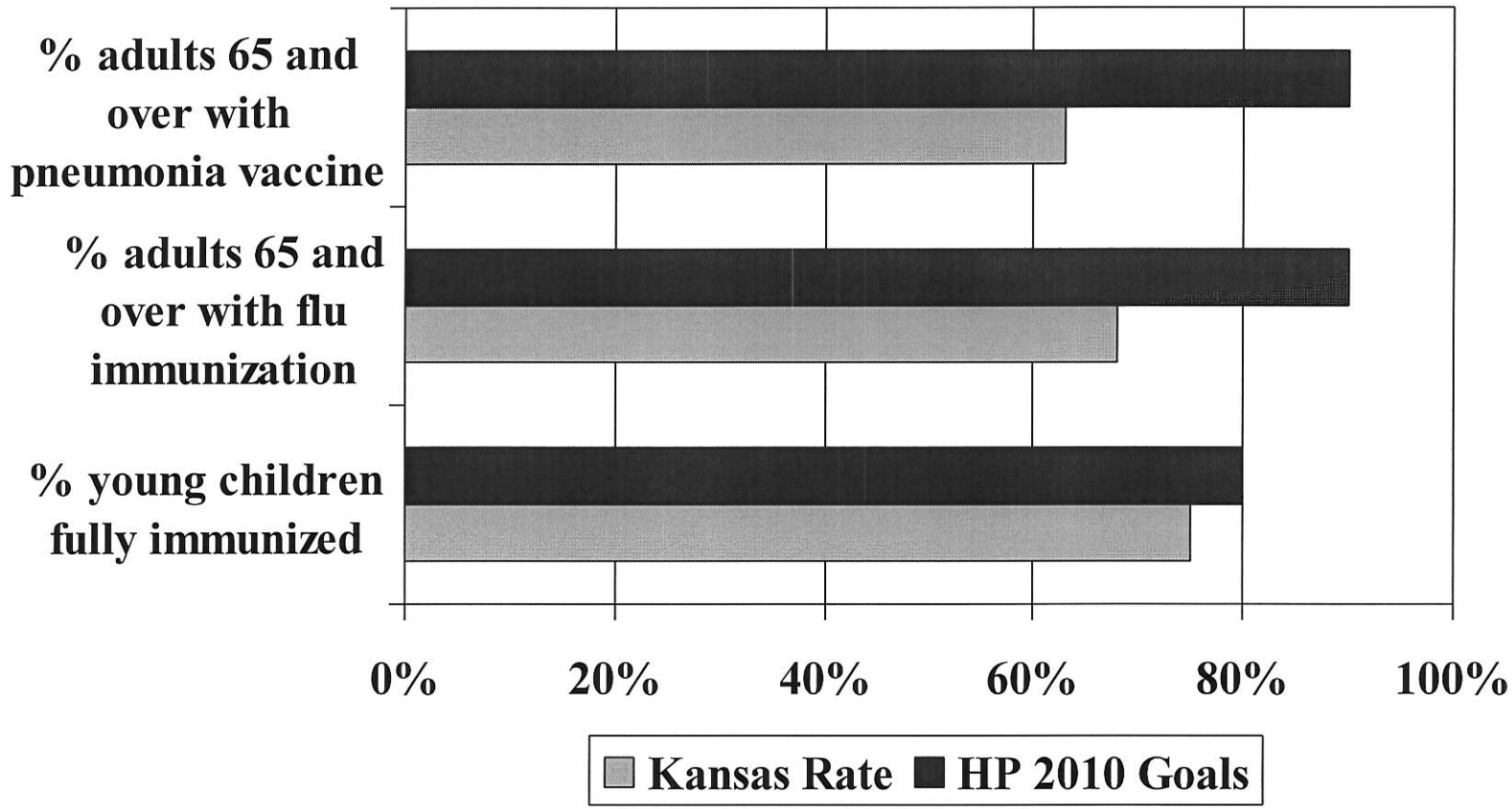
HK 2010: Injury and Violence



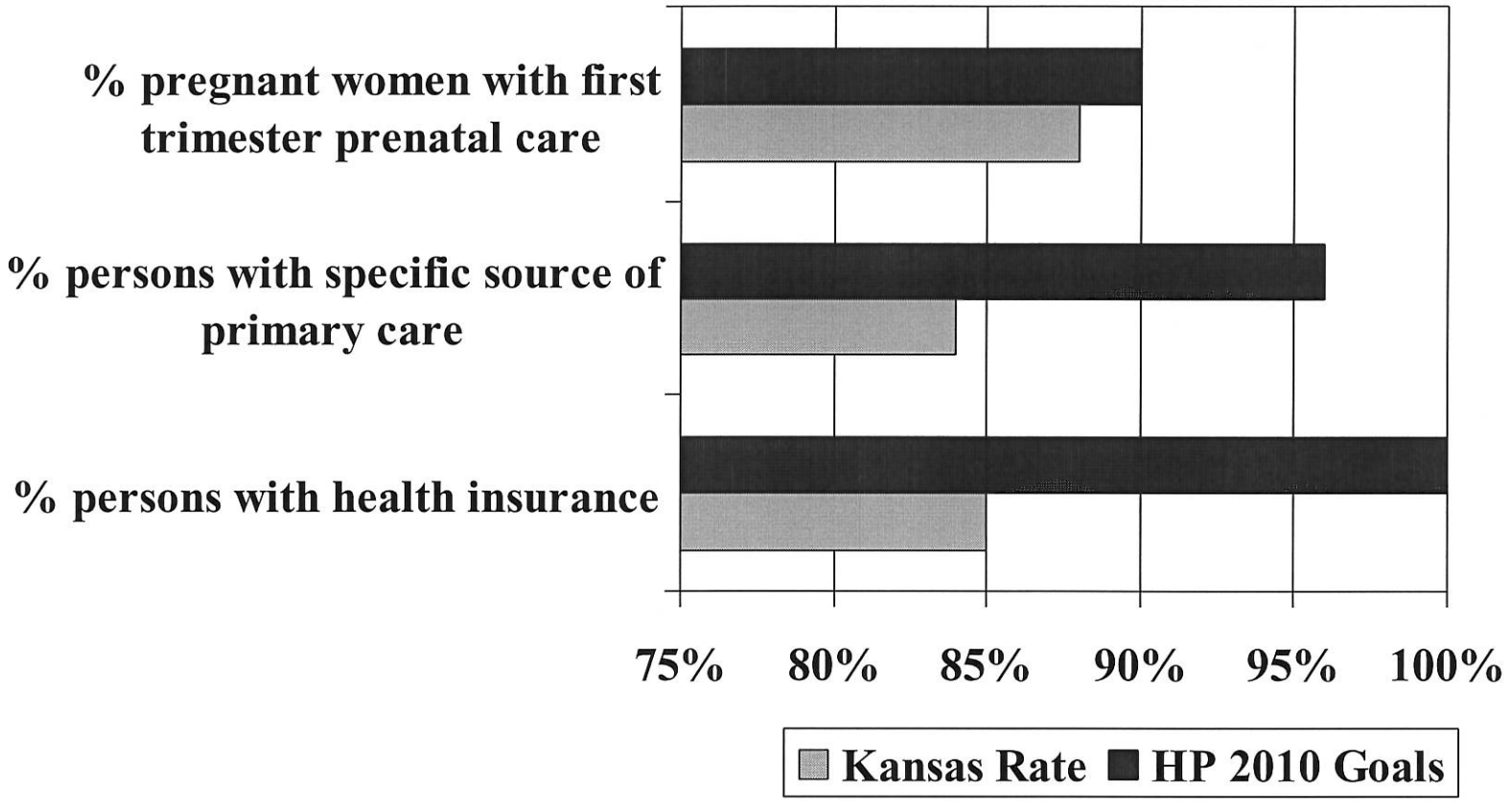
HK 2010: Substance Abuse



HK 2010: Immunizations



HK 2010: Access to Care

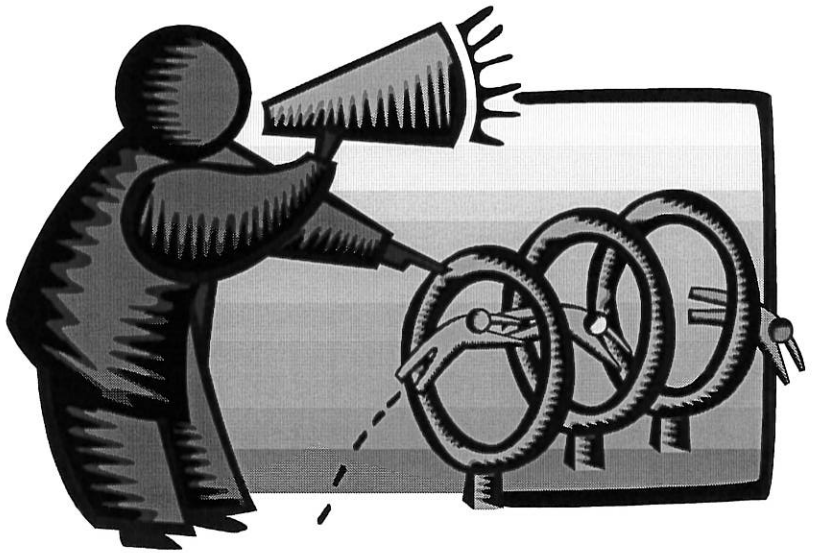


HK 2010: Common Themes

- Risk identification and disease prevention in women and children
- Addressing social determinants of health
- Elimination of health disparities between racial and ethnic groups

HK 2010: Action Plans

- Tobacco control
- Enhancing healthcare provider cultural competency
- Improved characterization of health disparities
- Markers of progress



Ad Astra

Frank Wu

Attachment 4
HHS 1-26-06

Influenza and Pandemic Influenza

Dr. Howard Rodenberg, State Health Director

Dr. Gail Hansen, State Epidemiologist

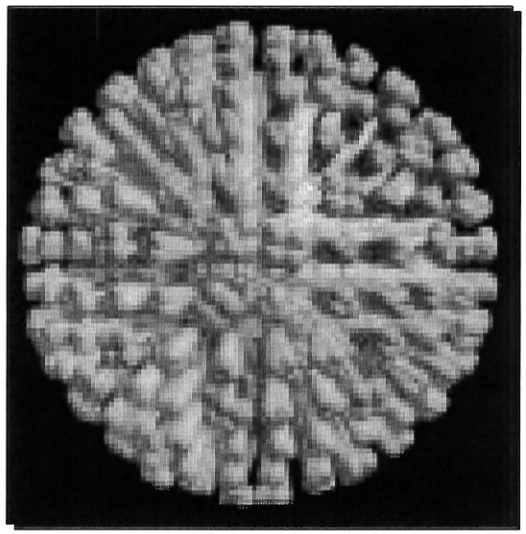
Kansas Department of Health and Environment

Overview

- Influenza
- Pandemic influenza
- Kansas Pandemic Influenza Plan
- Question and answers

The Influenza Virus

- Virus
  - Different types (A and B)
  - Named strains (H and N)
  - Affects respiratory tract
  - Changes (mutates) rapidly
  - Antibiotics don't help



Influenza: Who, where, and when?

- Nearly everyone susceptible every year
  - Illnesses, hospitalizations, deaths
  - Usually older, younger and those with chronic illness
  - Influenza and complications (pneumonia)
  - Most of us have some immunity from repeated exposures
- Everywhere
  - Can't predict with certainty
- Seasonal
  - Winter

Influenza: Signs and Symptoms

- Sudden onset
  - Lasts a few days
- Symptoms
  - Fever
  - Body aches
  - Headache
  - Cough
  - Excessive tiredness (malaise, fatigue)
- Rare complications (pneumonia)
- Rarely vomiting, diarrhea, or "stomach flu"
- Differs from the "common cold"

Prevention

- Basic hygiene (handwashing, covering the cough, staying home when sick)
- Vaccination
- New trivalent vaccine every year
  - Injectable forms (adults and children)
  - Nasal spray (FluMist™)
- "Priority Groups" for vaccination based on immune status

Treatment

- Treat symptoms
  - Fluids
  - Rest
  - Medication to reduce fever and body aches (avoid aspirin!)
- A virus, so antibiotics don't work
- Antiviral medications
  - Tamiflu™ (oseltamivir)
  - Symmetrel™ (amantadine)

"YA WANNA SEE HIM COMPLETELY FREAK?... SNEEZE!"

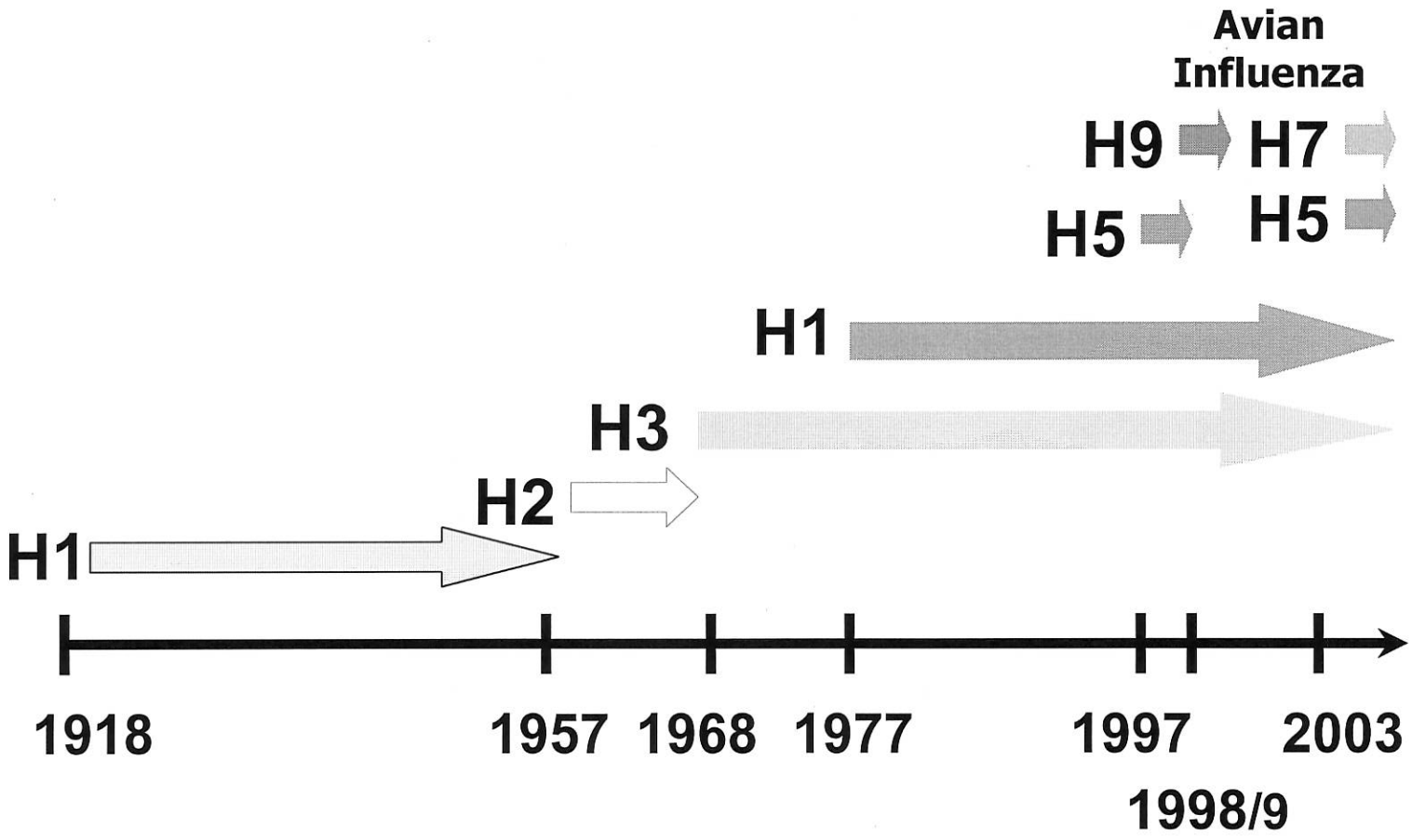
Viral Change: Drift and Shift

- Antigenic drift
  - Point mutations in virus
  - Continual process
  - Results in yearly epidemics
  - Vaccine updated yearly
- Antigenic shift
  - Replacement of H or H + N (i.e. new subtype)
  - Sporadic event
  - Can result in a pandemic

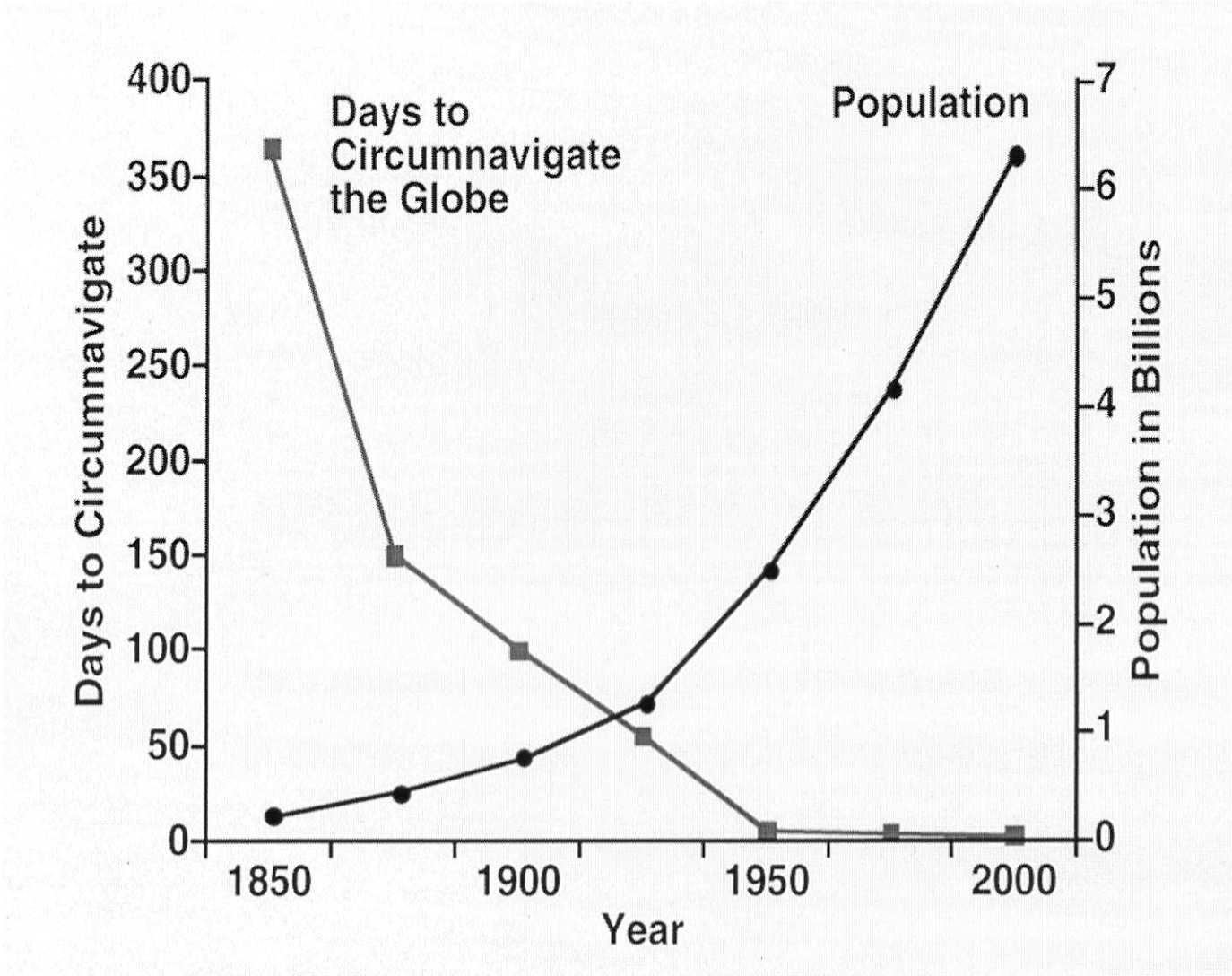
Pandemic Influenza

- Global outbreak with:
  - Novel virus
    - Something humans have never seen
    - All or most people susceptible
    - Root of the "pandemic evil" is based on immunity!
  - Wide geographic spread
- Spread can be rapid
  - Transmissible from person to person
  - Spread before signs of illness
  - Overwhelm health care

When Will the Next Influenza Pandemic Occur?



How Fast Can Pandemic Spread?



4-B

A Pandemic Bird Flu?

- H5N1 Influenza has the potential to become a pandemic strain
- From December 30, 2003- November 25, 2005
  - 132 human cases
  - 68 deaths
- Virus is now endemic in bird population in SE Asia, seen in Europe
- Virus can infect humans

First Case of Bird Flu in US

Avian Influenza 2005

- No H5N1 Avian Influenza in Western hemisphere
  - No birds or humans
  - Everyone is looking for it !

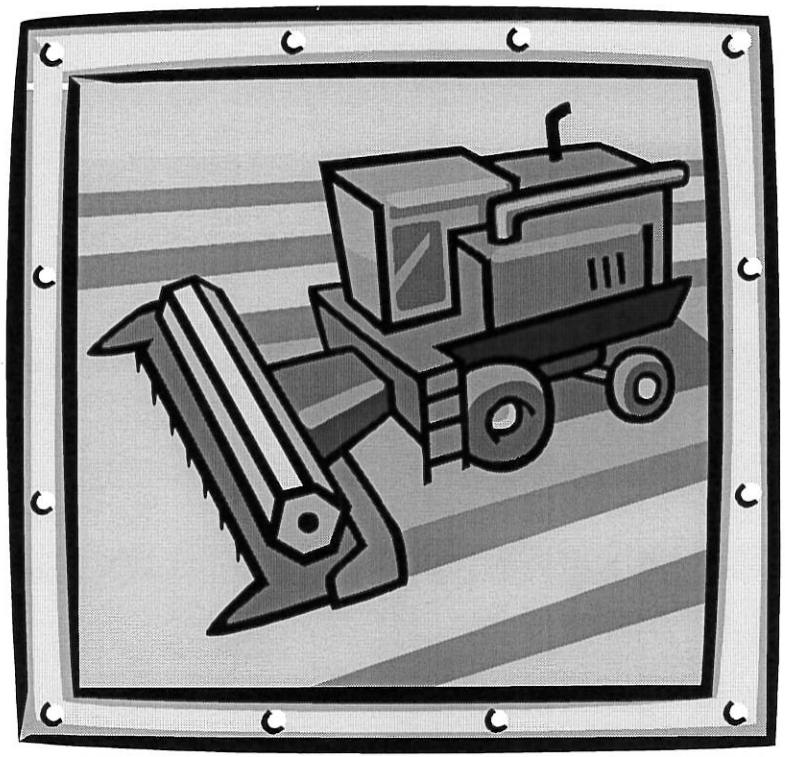
Pandemic Influenza: Where Are We?

- Interpandemic Period
- Phase 1
- Phase 2
- Pandemic Alert Period
- Phase 3—current → • Report of new strain in humans • Rare human-to-human spread
- Phase 4
- Phase 5
- Pandemic Period
- Phase 6

Pandemic Impact: USA

- Attack rate ranging from 15% to 35%:
- Outpatient care: 18 – 42 million
- Hospitalizations: 314,000 - 733,000
- Deaths: 89,000 – 207,000

Pandemic Impact: Kansas



- Attack rate ranging from 15% to 35%
- Outpatient care: 208,000 – 486,000
- Hospitalizations: 4,600 - 10,700
- Deaths: 1,100 – 2,500

Influenza

Pandemic Effects

- Equipment shortages
  - Vaccine / Antivirals
  - Hospital beds / equipment
  - Masks
- Personnel shortages
- Disruption of essential society functions
- Panic

Kansas Pandemic Influenza Plan

What's in it?

Goals of Pandemic Plan

- Limit burden of disease
- Minimize social disruption
- Minimize economic impact

Influenza

State Plan: Focus Areas

- Surveillance
  - Tracking the disease
- Emergency Response
  - Health care providers, public health systems, and community agents must partner at all levels to ensure effective response
  - Vaccines and antivirals (risk groups change)
  - Isolation and quarantine
- Communications/informing the public
  - Right time, right information, truth always

4-23

The Plan is a Living Document…

…we need your input!

www.kdheks.gov

What Else Are We Doing?

- Pandemic Influenza Working Group
- "Flu Tour 2005"
- Planning tools for communities, businesses, agencies, and institutions
- Educational materials

Federal Efforts and the Kansas Plan

Areas of note...

Funding issues

- States "encouraged" to purchase and stockpile vaccines and antivirals
- 100 million federal funding for planning assistance
- Kansas estimate: $80 million

Vaccine Supply

- Vaccine distribution
- What's the right vaccine?
  - Is it avian influenza?
  - Right vaccine needed
    - Experimental vaccine now for "bird flu"
    - Need 2 doses of vaccine
    - 6-8 months to develop
    - Federal funding for development of new vaccine technology

Antivirals

- Clinical use…and limits…of antiviral medications (Symmetrel, Tamiflu)
- Production issues
- "Stockpiling"
- Holding back supply vs. treating the ill now…a delicate balance

What Can We Do?

- Empowerment: "The Flu is Still the Flu"
- Prevention is key
- Planning is priceless
- Be concerned, but be confident

Questions?