Approved: January 31, 2007
Date

MINUTES OF THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

The meeting was called to order by Chairman James Barnett at 1:30 P.M. on January 25, 2007 in Room 231-N of the Capitol.

All members were present.

Committee staff present:
Emalene Correll, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Jim Wilson, Office of Revisor of Statutes
Nobuko Folmsbee, Office of Revisor of Statutes
Morgan Dreyer, Committee Secretary

Conferees appearing before the committee:
Senator John Vratil
Mark Stafford, Kansas Board of Healing Arts
Dr. Carl Cleveland, Cleveland Chiropractic
Roderick Bremby, Secretary, Kansas Department of Health and Environment

Others attending:
See attached list.

Upon calling the meeting to order, Chairman Barnett asked that the Committee review the Minutes for January 23, 2007 for approval at the end of the meeting.

The Chair then asked the Committee to look at requested information from El Centro, Inc., Melinda Lewis, regarding high rates of uninsured individuals among Kansans' Hispanic/Latino population. A copy of this information is (Attachment 1) attached hereto and incorporated into the Minutes as referenced.

Requested information from Sheldon Weisgrau's 'Uninsured Numbers' in a graph form for the Committee to view from the January 23, 2007 meeting. A copy of this information is (Attachment 2) attached hereto and incorporated into the Minutes as referenced.

Requested copies of the school screening forms for the Committee concerning **SB 116** from the January 23, 2007 meeting. A copy of this information is (Attachment 3) attached hereto and incorporated into the Minutes as referenced.

Requested research from Emalene Correll concerning information on hospital consent forms from the January 17, 2007 meeting. A copy of this information is (Attachment 4) attached hereto and incorporated into the Minutes as referenced.

Requested information from the Kansas Board of Nursing regarding **SB 116** from the January 23, 2007 meeting. A copy of this information is (Attachment 5) attached hereto and incorporated into the Minutes as referenced.

Written testimony the Chair passed to the Committee from Marty Turner MD, FAAFP regarding **SB 116** from the January 23, 2007 meeting. A copy of this information is (Attachment 6) attached hereto and incorporated into the Minutes as referenced.

Introduction of Bills

Chairman Barnett announced that he had a bill introduction for the Committee. The proposal concerns Kansas Health Care Connector Model. A draft of the bill was not available for the Committee at this time.

The motion was made by Senator Brungardt to adopt the introduced bill. It was seconded by Senator Jordan and the motion carried.

The Chair asked Nobuko Folmsbee to give a brief reading and explanation of **SB 82**. The Chair then

announced then next order of business would be to open a hearing on **SB 82**.

Hearing on SB 82 – An act concerning the healing arts act

The Fiscal Note for **SB 82** was available for the Committee to view. A copy of the fiscal note is (Attachment 7) attached hereto and incorporated into the Minutes as referenced.

Chairman Barnett called upon proponent conferee, Senator John Vratil who stated his support for the bill which would amend the Kansas Healing Arts Act to add certain healing arts schools to the list of entities covered by the act. A copy of his testimony is (Attachment 8) attached hereto and incorporated into the Minutes as referenced.

Questions came from Senator Brungardt regarding section (t).

Then Chair then called upon proponent conferee, Mark Stafford, Kansas Board of Healing Arts who stated that the Board has worked with representatives of the college for several months to determine whether the Kansas Healing Arts Act includes legal barriers to relocation. A copy of his testimony is (Attachment 9) attached hereto and incorporated into the Minutes as referenced.

Questions came from Senators Palmer and Brungardt regarding other medical care facilities, and section (t).

Chairman Barnett then called upon proponent conferee, Dr. Carl Cleveland, III D.C., President Cleveland Chiropractic College who stated that the Cleveland Chiropractic College respectfully proposes that **SB 82** be adopted so that an organization that operates such as a student internship clinic and meets the criteria set forth in SB 82 can operate its student clinical training center within its existing non-profit, Section 501(c)(3) corporate structure. A copy of his testimony is (Attachment 10) attached hereto and incorporated into the Minutes as referenced.

Questions came from Senator Schmidt regarding relocation and length of program.

The Chair requested Dr. Cleveland to tell the Committee what is unique about the Cleveland College and why the legislation is needed for it to come to Kansas. Dr. Cleveland stated that the accredited program requires that there be a clinical training component of the curriculum. That program at minimum is one year, its generally the last year or the fourth year. In order to operate a clinical program treating patients in the State of Kansas the college or any non-profit healthcare organization offering a clinical training program would need to be exempted in part from this corporate practice of medicine act. Because as a not-for-profit corporation, there is no ownership for the shareholders, so they would technically be in conflict with internal revenue requirements for their organization to be non-profit.

With no more conferees and no more questions from the Committee the Chair closed the hearing on **SB 82**.

The motion was made by Senator Jordan to delete the word 'rendering' once from the amendment in which it occurs twice. It was seconded by Senator Schmidt and the motion carried.

The motion was made by Senator Jordan to move the bill out favorably. It was seconded by Senator Palmer and the motion carried.

Presentation on Kansas Department of Health and Environment Overview

Chairman Barnett then called upon Roderick Bremby, Secretary, Kansas Department of Health and Environment who presented the agency overview with information and statistics for the Committee. Highlight of the presentation included:

- Agency Budget
- Notable 2006 Public Health Accomplishments
- Key Initiatives
- Legislative Initiatives

- Division of Health
- Summary of Division of Health Responsibilities
- Healthy Kansans 2010: Progress to Goals
- Kansans Performance on 10 Leading Health Indicators
- Division of Health Organizational Structure
- Office of Health Promotion
- Office of Local and Rural Health
- Office of Oral Health
- Bureau of Child Care and Health Facilities
- Bureau for Children, Youth and Families
- Bureau of Disease Control and Prevention
- Office of Surveillance and Epidemiology
- Bureau of Consumer Health
- Center for Health and Environmental Statistics
- Center for Public Health Preparedness
- Center for Health Disparity
- The Division of Health and Environment Laboratories

A copy of the presentation is (Attachment 11) attached hereto and incorporated into the Minutes as referenced.

Questions came from Senator Palmer regarding areas of concern in her community like drugs and alcohol.

With no more time the Chair asked that the representative from Kansas Department of Health and Environment come back to the next scheduled meeting to finish their presentation.

Chairman Barnett announced that the final item on the agenda was for the Minutes to be approved for the Senate Public Health and Welfare Committee for January 23, 2007.

The motion was made by Senator Haley to approve the Minutes. It was seconded by Senator Schmidt and the motion carried.

Adjournment

As there was no further business, the meeting was adjourned at 2:30 p.m.

The next meeting is scheduled for Wednesday, January 31, 2007.

Senate Public Health and Welfare Committee

January 25, 2007

Please Sign In

Name	Organization
Sen. John Vratil	
DAN MORIN	KS Medical Society
Emily Geier	
MARK BORANYAK	CAPITOL STRATEGIES
Mary Ellen Conlee	Via Christi Health System
Mary Blubaugh	KSBN
Mark Stafford	Bd of Healing Arts
LARRY BUENING	
Chip Wheelen	Ass'n of Osteopathic Med.
MARK KNIGHT	KSBN
Dick Morrissey	KDHE
Mark Gilgus	Seigfreid, Bingham
Bill Sneed	Cleveland Chi College
Carl Cleveland III	Cleveland College
[illegible]	KDHE
Susan Kang	KDHE
[illegible]	KDHE
John Kiefhaber	Ks. Chiropractic Assn.
EDWARD MCKENZIE, DC	KANSAS CHIROPRACTIC ASSN

El Centro, Inc.

The Center for Continuous Family Improvement

.dministration and
:omputer Learning Center
50 Minnesota Avenue
:ansas City, KS 66101
13-677-0100
'ww.ElCentroInc.com

he Academy for Children
·30 S. 30th Street
ansas City, KS 66106
3-677-1115
3-677-7090 fax

:ademy for Children,
100 Choo Child Care
9 S. Mill Street
insas City, KS 66101
3-371-1744
3-371-1866 fax

:ademy for Children,
ınnelly College
8 North 18th Street
.nsas City, KS 66102
3-281-1700

sa de Rosina Apartments
l Barnett
nsas City, KS 66101

:I Development, Inc.
)0 Metropolitan Ave.
nsas City, KS 66106
5-677-1120
5-677-0051 fax

Centro, Inc. Argentine
;3 S. 27th Street.
nsas City, KS 66106
·-677-0177
·-362-8520 fax

Centro, Inc. Family Center,
ınson County
:5 Metcalf Avenue
erland Park, KS 66212
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-381-2914 fax

cías-Flores Family Center
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ısas City, KS 66102
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odland Hills, Inc.
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ısas City, KS 66103
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-362-8203 fax

January 22, 2007

Chairman Jim Barnett and Honorable Members of the Senate Public Health and Welfare Committee,

Thank you for the opportunity to provide some comments on the important issue of high rates of uninsured individuals among Kansas' Hispanic/Latino population. Certainly I would never pretend to know the answer to how to solve this pervasive and, by some reports, growing problem, but I do hope that the information below may be of some assistance to you as you examine possible strategies. I would of course be happy to visit with the committee about this issue and to answer any questions. Thank you again for your attention to the health care needs of Hispanics in our state.

What factors contribute to the low rate of insurance among Hispanics in Kansas? How might Kansas begin to address those factors over which it has some influence?

1. **Poverty**

While most uninsured Hispanics are in working families, they often work in low-paying, low benefit jobs (often slightly less than full-time) that lack employer-provided health insurance. When health insurance coverage is offered through their employers, it often is at such a high premium cost that those in low-income families cannot afford it. Given that uninsured Hispanics are more likely to be in the labor market than other uninsured populations, a cost-effective way of bridging their access to health care coverage would be in the form of <u>subsidies to pay premiums and/or meet out-of-pocket expenses</u> associated with their health care plan, perhaps in the form of a refundable tax credit. However, given very low median incomes (El Centro's research finds a median annual income of $19,200 per year for Hispanic families of four in the Kansas City metropolitan area) and high insurance costs (average monthly premium of $273.03 in 2005), such a credit would have to be significant in order to make health care coverage truly affordable. Many Hispanics in Kansas work at relatively small businesses, also, which are, of course, less likely to offer affordable health insurance coverage than large employers. Efforts that <u>encourage small businesses to offer health insurance</u>, including incentives for such offerings and potentially penalties for failing to provide coverage, will have a disproportionately significant impact on Hispanic workers than less targeted measures. This may include regulatory intervention if there are problems (as employers sometimes report) with insurance firms denying insurance to small businesses or effectively locking them out of the market with very high costs.

Senate Public Health and Welfare committee
Attachment #1
January 25, 2007

2. **Immigration/citizenship status**

Immigrant Hispanics often lack eligibility for public health care programs, such as Medicaid, even long after they have secured Lawful Permanent Residency in the

United States. Changes included in the 1996 welfare reform measure require these 'green card' holders to wait for at least five years before becoming eligible for Medicaid (and most other federally-funded benefits). Although some states (for example, Texas, Florida, California, Illinois, and New York) have closed this eligibility gap by offering state-funded health care coverage for these legal immigrants (or, in some cases, subsets of them, including pregnant women and children), Kansas has not done this. While this would obviously only assist those individuals falling within the eligibility category, it would ensure that no legal immigrant who is income eligible falls through the cracks. Additionally, the Kansas Legislature should weigh in on the national conversation with Congress urging the federal government to allow states to enroll legal immigrant pregnant women and children in Medicaid and S-CHIP programs (as the National Governors' Association has repeatedly requested).

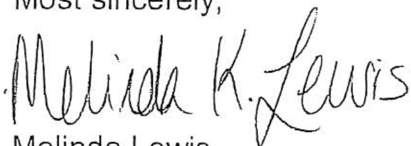
3. Lack of information

Research suggests that many Latinos lack information about three important components of health care coverage: the benefits of securing health care coverage, their eligibility for coverage, and the specifics of available plans (both public and private). At work, much of this lack of information stems from poor outreach by human resource specialists; in El Centro, Inc's research, only 27% of Latino respondents reported that their information about available benefit offerings came from a bilingual human resource professional. Given the complexity of benefit offerings and the associated decisions, this is clearly an example of an occasion when even English proficient individuals would benefit from information available in their native language. Only 45%, still a minority, reported that any human resource professional provided information to them about available benefits (in any language), with the rest depending either on coworkers whose information is likely to be incomplete, or on only printed material, likely to be somewhat confusing to navigate. The public charge exclusion in the naturalization process creates additional confusion and may lead to some Hispanic immigrants not accessing services for which they are eligible, even though neither employer-based nor publicly-funded health care counts against citizenship applicants as evidence of public charge. Finally, there is some evidence that, as individuals on limited incomes make difficult decisions about resource allocation, health insurance premiums may be seen as an 'expendable' item when individuals lack complete information about the potential liability of failing to maintain adequate insurance coverage. State assistance to human resource professionals in the private sector, in the form of targeted information campaigns, would help to communicate some of these key messages to Latino employees. Direct social marketing campaigns that utilize ethnic-specific media would also help to address this particular barrier to insurance coverage. Clearly, some of this must include Spanish-language materials, but English-language communication that is culturally-appropriate is just as important, and just as lacking. Texas has been particularly aggressive in Hispanic-targeted outreach for Medicaid and children's health insurance programs, and some of its radio, print, and community-based methods may help in Kansas. Finally, it is essential that the health care system itself addresses the needs of Hispanic consumers so that they receive quality, timely, culturally-appropriate health care that keeps costs down and maintains their engagement with health care professionals. To this end, Kansas can recognize

best practices in minority health, provide resources for training, and work with institutions of higher education to support new practitioners and to encourage more Hispanics to consider health care as a career.

Clearly there are no magic answers to this growing and vexing problem. The U.S. health care system is complex, and Kansas' Hispanic population is diverse, with many interlocking factors contributing to the barriers that keep Latinos from obtaining and maintaining health insurance coverage. While beginning to tackle this problem in a creative and serious way is daunting, the benefits are obvious—mainly, a healthier population that will be less likely to incur medical emergencies that will cost our health care system dearly. Thank you again for your attention to this important issue. As always, if there is additional information that I can provide or any way in which I can be helpful to your exploration of this topic, please do not hesitate to ask.

Most sincerely,



Melinda Lewis
Director of Policy Advocacy & Research
El Centro, Inc.

Morgan Dreyer - Uninsured numbers

From: "Sheldon Weisgrau"
To: "Morgan Dreyer" ,
Date: 1/18/2007 3:16 PM
Subject: Uninsured numbers
CC: "Emalene Correll" , "Terri Weber" , "Tony Wellever" , "Robert St. Peter" , "Jim McLean" , "Mike Shields" , "Dave Ranney"

Senator Barnett,

At Wednesday's hearing of the Senate President's Task Force, you asked for data on the number of uninsured Kansans in various groups. I did not have the figures at the time, but said that I'd get them for you. Below is a table that shows number and percentage of uninsured and insured Kansans, broken out in various ways. These data are from the U.S. Census Bureau Current Population Survey, which was released in August 2006. The figures are for 2004-2005 (years are combined to enhance statistical validity).

If you have any questions, please contact me.

Sheldon Weisgrau

	Number Uninsured	Percent Uninsured	Number Insured	Percent Insured
All Kansans	293,217	10.9%	2,391,283	89.1%
Children				
Age 0 to 5	16,161	6.8%	220,686	93.2%
Age 6 to 11	11,776	5.3%	209,653	94.7%
Age 12 to 17	18,178	7.9%	212,920	92.1%
All Children 0-17	46,115	6.7%	643,259	93.3%
Adults				
Age 18 to 25	79,732	23.8%	255,648	76.2%
Age 26 to 34	58,628	18.3%	261,689	81.7%
Age 35 to 44	46,323	13.6%	293,310	86.4%
Age 45 to 54	31,165	8.4%	338,861	91.6%
Age 55 to 64	27,369	9.5%	261,486	90.5%
"Working Age" Adults Age 18-64	243,219	14.7%	1,410,994	85.3%
Age 65+	3,883	1.1%	337,031	98.9%
Race/Ethnicity				
Non-Hispanic White	202,828	9.1%	2,027,616	90.9%
Non-Hispanic Black	21,588	14.6%	125,973	85.4%
Hispanic	48,089	29.5%	115,110	70.5%
Other/Multiple	20,712	14.5%	122,584	85.5%
Household Income				
< $25,000	121,184	22.0%	428,845	78.0%
$25,000-$49,999	95,796	13.2%	629,056	86.8%
$50,000-$74,999	39,066	7.0%	518,787	93.0%
$75,000+	37,171	4.4%	814,595	95.6%

Senate Public Health and Welfare Committee
Attachment #2
January 25, 2007

Federal Poverty Level				
< 100%	91,218	28.2%	232,533	71.8%
100%-199%	84,245	17.7%	391,415	82.3%
200%-299%	52,027	10.6%	439,057	89.4%
300% +	65,727	4.7%	1,328,278	95.3%

KAN Be Healthy (EPSDT) Screening Form

I.D. Number:_______________

Please note the Mandatory Blood Lead Questionnaire is a separate document. It is required at each screen 6 to 72 months.

Name	Date of Birth	Age	Date of Screen

PHYSICAL GROWTH

T ________ Weight __________ (lbs/kg) ________ th% Weight/Length ________ %

P ________ Length (Birth to 36 months) ________ cm/in Standing Height (2 - 20 years) ________ cm/in

R ________ BMI __________ ________ th%

BP ________ BMI ≥ 85%: recommend appropriate nutrition input and physical activity.

Update Growth Chart (required at each screen)

Head Circ (≤ 24 months) ________ cm/in ________ th%

BENEFICIARY & FAMILY HISTORY

- ☐ Refer to completed history form in chart.
- ☐ No changes in medical Hx unless indicated.
- ☐ Previous Hx reviewed from______________ visit.
- ☐ Patient currently in Foster care, no previous hx available.

Present Concern: ________________

Medications: ________________

Serious Illness/Accidents: ☐ No ☐ Yes (date & type) (including Hospital or ER visits) ________________

Allergies (food & drug) ________________

Birth History (Length, weight, complications, etc. - if known) ________________

Operations: ☐ No ☐ Yes (date & type)

(Circle and indicate the relationship with disease / problem. **P**-Parent, **G**-Grandparent, **B**-Brother, **S**-Sister, **Self**)

Allergies (food & drug)	______	Drug or ETOH Abuse	______	Mental illness	______
Asthma	______	Earaches	______	Obesity	______
Birth defects	______	Epilepsy/Seizures	______	Scoliosis/Arthritis	______
Blood Disorder/ Sickle Cell	______	Headache	______	Speech, Visual, Hearing	______
Cancer	______	High Blood Pressure	______	Ulcers/Colitis	______
Colds/sore throat	______	Kidney/Liver Disease	______	Urinary/Bowel	______
Diabetes	______	Lung Disease	______	Heart Disease/Stroke	______

BODY SYSTEMS

SYSTEMS	WNL	ABN	Comments (Describe any Abnormal Findings)
General Appearance	☐	☐	
Integumentary	☐	☐	
Head-Neck	☐	☐	
Eyes/Ears/Nose & Throat	☐	☐	
Oral/Dental	☐	☐	
Pulmonary	☐	☐	
Cardiovascular	☐	☐	
Abdomen/Gastrointestinal	☐	☐	
Genitourinary	☐	☐	
Trunk / Spine	☐	☐	
Musculoskeletal	☐	☐	
Neurological	☐	☐	

Senate Public Health and Welfare Comm.
Attachment #3
January 25, 2007

Vision Screen

Last eye exam date: ______ Eye tracking (< 4 yrs old) Pass ☐ Refer ☐ Comments:______________________

Corneal Light Reflex Present: Yes ☐ No ☐ Distance Acuity(4-20 yrs) Tool used:__________ Score: Left____ Right___ Both___

Outer Inspection: Normal ☐ Abnormal ☐ Near Acuity(4-20) Tool used: :____________ Score: Left____ Right___ Both___

NUTRITION

☐ WIC participant

☐ Referred to WIC

☐ Breast Feeding ☐ Formula

Amount & how often: ____________

Number of Servings per day

Bread/Cereal ________ Dairy ________

Fat/Sweet/Sugar ________ Fruit ________

Meat/Bean/Egg ________ Vegetable ________

Fluid Intake: water ________ oz. Soda ________

Milk ________ oz. Juice ________

PHYSICAL ACTIVITY

☐ Biking ☐ Basketball ☐ play outside

☐ Skating ☐ Walking ☐ other sports

How many hours screen time/Day? (i.e. TV, Games, PC)

☐ 0-1 hr ☐ 1-2hr ☐ 3-5hrs ☐ 5+hrs

KBH participant currently pregnant? ☐ Yes ☐ No

If "yes", then complete following :

1. Prenatal Record initiated? ☐ Yes ☐ No
2. On prenatal vitamins? ☐ Yes ☐ No
3. Referred for OB/GYN cares? ☐ Yes ☐ No

Referred to:

LABORATORY

HGB or HCT (required at 12 mths, start of menses in girls, 11-20 yr in boys)

HGB results:_________ or HCT results:____________ Date obtained:___________

WIC results?: Yes ☐ No ☐ Date:______ Other Lab?__________________

IMMUNIZATIONS

Copy of record in chart

Current ☐

Behind ☐

Unknown ☐

Requested from Parent ☐

Referred to VFC provider ☐

Needs: (circle)

HepB DTaP Flu

Hib IPV MMR

MCV4 MPSV4 PCV

Varicella HepA

Other:

DEVELOPMENTAL / EMOTIONAL

Developmental Screening Tool: (required for all children < 6 yrs of age)

Tool Used (in file): ____________

Results Pass ☐ Delayed ☐

Not Screened (Comments Required)____________________

Interpretation of screen: ____________________

Referred to :

Developmental Emotional Observations or Tool: __________ **(Age 6-20 yrs)**

Sleep Habits ____________ Tired / overactive? ________

Discipline: ____________ Vocational concerns? ________

Peer Interaction: ____________

Grade Level ____________ Average Marks ________

Special Education/Needs: ____________

Any emotional or behavioral problems? ____________

Emotional Observations:____________________

DENTAL

Sees Dentist? Yes ☐ No ☐

Last dental exam date: ____/____/_____

times brushes/day: __________

Dental Referral (annualy at a minimum 0-20yr)

Yes ☐ No ☐

HEARING SCREEN

Minimally must document completion and findings of paper hearing screen or audiometric sweep screen

Hearing Health History ≥ 5: Pass ☐ Refer ☐

Risk Indicators for Hearing Loss < 5 Pass ☐ Refer ☐

Hearing Developmental Scales < 5 Pass ☐ Refer ☐

Audiometric Sweep Screen: Left_____ Right_____

HEALTH EDUCATION AND ANTICIPATORY GUIDANCE

Circle Those Reviewed/ Handouts Given

1. Behavior/Discipline
2. Oral /Dental
3. Development
4. Physical Activity
5. Family Planning
6. Immunizations
7. Lifestyle
8. Nutrition
9. Parenting
10. Safety/Poisions
11. Substance Abuse
12. Self Testicular Exam
13. Self Breast Exam
14. Sexuality
15. Exercise
16. Weapon Safety
17. Other:____________________

RESULTS/PLAN OF CARE

Screening Results: ____________________

Plan/Referrals (dental, vision, hearing, dietary, etc):____________________

Recommended:__________

Return Date: / /

Parent/caregiver informed of KBH screen findings and verbalizes understanding of teachings.

Yes ☐ No ☐

Date: / /

Screening Providers Signature: ____________________

KANSAS LEGISLATIVE RESEARCH DEPARTMENT

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kslegres@klrd.state.ks.us http://www.kslegislature.org/klrd

January 24, 2007

To: Senate Committee on Public Health and Welfare

From: Emalene Correll, Research Associate

Re: Hospital Consent Forms

As requested by the Committee, I contacted the two Topeka general hospitals to request copies of the consent forms given to patients on admittance to the hospital. Since the Committee discussion centered on newborn testing, I also asked for any consent forms specific to newborns. An administrator at St. Francis Medical Center promised to have the appropriate person call me, I have not had a reply to the request, nor have I received a call from the individual who was to have contacted me. Stormont-Vail Health Care provided consent forms, copies of which are enclosed.

The first enclosure is the general consent form used by Stormont-Vail Health Care. Note: Item number 2 on the form relates specifically to newborn testing. Also enclosed is a specific form used to document refusal of Hepatitis B vaccination for a baby.

Stormont-Vail also provided other types of consent forms such as anesthesia consent, consent to surgery, and an information sheet on transfusions. Should any member of the Committee wish to see these forms, please contact me.

EGC/kal

Enclosures

Senate Public Health and Welfare Committee
Attachment #4
January 25, 2007

H:\02clerical\ANALYSTS\EGC\45033.wpd

Attachment No. 1

#1

Stormont-Vail HealthCare

Authorizations and Agreements

1. **Consent to Treatment:** I understand I am under the care and supervision of my attending physician or designee and it is the responsibility of Stormont-Vail Health*Care* (SVHC) and its staff to carry out the instructions of such physician. I consent to x-ray examinations, laboratory procedures, anesthesia, medical or surgical or hospital services rendered to me under the general and special instructions of the physician. I recognize that some physicians furnishing services to me, including, but not limited to radiologists, pathologists, anesthesiologists, radiation oncologists, and emergency physicians are independent contractors and not employees of the hospital.

   Consent to Emergency Treatment: I understand if I require emergency department services, these will be provided by Emergency Physicians of Topeka, P.A. (EPTPA) and SVHC. I understand I will be medically screened and treated by the Emergency Physician/designee or a private physician at SVHC and it is the responsibility of SVHC and its staff to carry out the instructions of such physician/designee. I understand that I will be provided an emergency medical screening regardless of my ability to pay.

2. **Newborns:** If I am here for the purpose of delivery of my infant, I understand that certain blood tests may be recommended or required by state law, and give consent for SVHC to obtain the blood sample and forward it to the Kansas Health and Environment Laboratory, Department of Health and Environment (PKU, T-4, galactosemia, congenital hypothyroidism, hemoglobinopathies).

3. **Teaching Programs:** SVHC is a clinical training site for students, resident physicians and interns. I understand students, resident physicians and interns may provide care to me under the direction and supervision of my attending physician, his/her designee, or hospital employees.

4. **Personal Property:** I have been advised to entrust my personal property to a relative or friend upon admission for treatment at the hospital. I have also been advised that any personal property may be locked up in the Security Department while I am a patient in the hospital. If I prefer to keep my personal property, I release and absolve the hospital and its employees from any responsibility for loss or damage.

RELEASE OF INFORMATION:

5. **Subsequent Medical Care Providers:** SVHC complies with all federal and state laws regarding the disclosure of information. SVHC will provide medical information to my primary care physician, referring physician, and other health care providers including, but not limited to rehabilitation facilities, nursing homes, visiting nurses, and home health care agencies as necessary to continue my medical care after my hospital stay.

6. **Your Authorization:** In other situations, SVHC will not release patient-identifiable medical information outside this hospital without my written authorization. I may revoke authorization at any time by notifying SVHC in writing.

7. **Insurance Companies/Third-Party Payers/Third-Party Medical Assistance:** SVHC and EPTPA will provide medical information and any other billing information to my insurance companies and/or third-party payers, including Workers' Compensation if applicable, and/or third-party medical assistance screeners, as necessary to bill and substantiate my hospital stay and the service I received in order to obtain payment for services provided.

8. **Assignment of Benefits:** If I have health care insurance or am entitled to Workers' Compensation benefits, I agree that SVHC and EPTPA may bill these insurers. I hereby authorize payment directly to SVHC and EPTPA of the benefits otherwise payable to me.

9. **Medicare Patient's Certification:** I certify that the information given by me in applying for payment under T XVIII of the Social Security Act is correct. I authorize release to the Social Security Administration or its intermediaries any information needed for this or a related Medicare claim and request that payment of authorized benefits be made on my behalf.

Patient Name: ______________________ **MRN:** __________ **Acct #:** __________
(Initials)

_____ **Advance Directives for Healthcare Decisions Acknowledgment:** SVHC is required by federal law to make you aware of your right to be involved in decisions regarding your medical care. Specifically, you have the right to execute an Advance Directive for Healthcare Decisions either in the form of a Living Will or a Durable Power of Attorney for Healthcare. I understand that I am not required to have an Advance Directive in order to receive medical treatment at SVHC.

_____ I have_____ have not_____, executed an Advance Directive. If I have not, I have received an Advance Directive informational brochure, which includes the documents and instructions to initiate Advance Directives.

_____ **Patient Rights:** I have received a copy of SVHC's statement of "Patient's Rights and Responsibilities" included in the Patient and Visitor Guide.

_____ **An Important Message From Medicare:** I acknowledge that I have been provided a copy of the notice entitled "An Important Message from Medicare" detailing my rights as a Medicare hospital patient and procedures for requesting a review by Kansas Foundation for Medical Care, the Peer Review Organization for Kansas.

_____ **An Important Message from Medicare for Non-PPS Hospitals and Non-PPS Hospital Units:** I acknowledge that I have been provided a copy of the notice entitled "An Important Message from Medicare for Non-PPS Hospitals and Non-PPS Hospital Units" detailing my rights as a Medicare hospital patient and procedures for requesting a review by Kansas Foundation for Medical Care, the Peer Review Organization for Kansas.

_____ **An Important Message from Tricare/Champus:** I acknowledge that I have been provided a copy of the notice entitled "An Important Message from Tricare/Champus" detailing my rights as a Tricare/Champus hospital patient and procedures for requesting a review by the Peer Review Organization.

_____ **Financial Responsibility/Precertification/Referral:** I agree to be responsible for all SVHC and EPTPA charges which are not covered/paid by my insurance. In the event this obligation of payment is not met, the undersigned agrees to pay the "reasonable" costs of collection of the charges incurred, including (but not limited to) court costs, attorney fees and collection agency fees. I understand that obtaining insurance precertification/referral is my responsibility and that SVHC will assist me whenever possible.

Acknowledgment of Notice of Privacy Practices (NPP):

_____ I acknowledge that I have received SVHC's NPP; **OR**

_____ I acknowledge that I decline to receive SVHC's NPP and that I was provided an opportunity to receive SVHC's NPP, and that I am aware I can request an NPP at any time.

I have read and understand the information above and I have had the opportunity to ask questions and have them answered to my satisfaction. I agree to all of the Authorizations and Agreements to SVHC as described above. If I am not the patient, I certify that I am authorized by law to agree to these Authorizations and Agreements on the patient's behalf.

______________________________ __________
Signature of patient or authorized agent (relationship) Date

______________________________ __________
Witness Date

Attachment No. 2

#3

REFUSAL OF HEPATITIS B VACCINATION

I have been informed of any and all risks of refusing the hepatitis B vaccine for my baby. I hereby release Stormont-Vail Regional Medical Center, its nurses and employees, together with Dr. (s) ______________________________ and all other physicians in any way connected with me as a patient from liability for respecting and following my expressed wishes and direction.

On behalf of my child, I hereby refuse the administration of the hepatitis B vaccine.

INFANT'S NAME ______________________________

Witness to Signature

____

Signature of Person authorized to consent

____

Authority to consent relationship

____

Date ______________________

DISPOSITION OF INVESTIGATIVE CASES

Policy:

The Board will dispose of investigative cases in the shortest time frame possible. The Board will dispose of investigative cases with consistency as a basis.

Purpose:

The Kansas State Board of Nursing, in keeping with its mission to protect the public health, safety and welfare, is charged with investigating adverse reports against individual licensees alleging a violation of the unlawful practices specified in K.S.A. 65-1120 and K.A.R. 60-3-110. The Board is required to investigate adverse reports that are sworn by the reporter. Attached is Exhibit A, a listing of unlawful acts identified in statute and regulations.

Procedure:

The Board has established a standing committee of three members, the Investigative Committee, to review the reports, information collected and to direct the disposition of the reports. If the investigation reveals reasonable grounds for believing the applicant or licensee is guilty of the charges, the Board shall fix a time and place for proceedings, which shall be conducted in accordance with the provisions of the Kansas Administrative Procedures Act. The Kansas Administrative Procedures Act does not preclude informal settlements of matters that may make unnecessary more elaborate proceedings under the act. The Board also has authority to enter into contracts as may be necessary to carry out its duties.

The Board recognizes that each report must be analyzed and decided on its individual merit. The Board recognizes and considers mitigating/contributing circumstances leading to violations of the Kansas Nurse Practice Act. The Board recognizes that the practice of nursing is not an exact science and that the human element will bring error on occasion. The Board recognizes that it is in the interest of judicial economy and the individual licensee to resolve the matter by agreement of the parties without formal proceedings. The Board does believe that a formal finding of guilt is warranted in some cases.

The Board desires to provide consistency in its directives while still recognizing that each case is an individual case. The Board examines specific factors in analyzing cases some of which were identified by the Supreme Court of Kansas in the <u>Vakas</u> case. Attached is Exhibit B, a listing of factors, not all-inclusive, considered by the board in directing disposition of cases. Also attached is Exhibit C, a rating continuum to be used to assist members in directing consistent disposition outcomes to similar classes of cases.

The Investigative Committee will make a finding of fact and law by identifying in writing the fact, ground /unlawful act, and how the facts relate to the legal violation. Second, the severity of the violation will be rated and a disposition appropriate to the rating selected. Licensees or applicants will be notified in writing of those outcomes.

Approved 12/08/99

Senate Public Health and Welfare Committee
Attachment #5
January 25, 2007

VIOLATIONS

Fraud or deceit in practicing nursing
Fraud or deceit in procuring a license
Fraud or deceit in attempting to procure a license
Guilty of a felony–Ø rehab established
Guilty of a misdemeanor involving illegal drug offense–Ø rehab established
Felony crime against person–Ø license
Current abuse of drugs–lack skill and safety to practice
Current abuse of alcohol–lack skill and safety to practice
Adjudged in need of guardian or conservator
Willful/repeated violations
Discipline action by a state/agency/U.S. Government/territory
Assisted suicide violates K.S.A. 21-3406
Professional incompetency

Ordinary negligence	=	duty, breach/reasonable probability of injury to patient
Gross negligence	=	reckless/willful-wanton conduct; see ordinary
Pattern of practice	=	demonstrates manifest incapacity or incompetence to practice
Other behavior	=	demonstrates manifest incapacity or incompetence to practice

Unprofessional conduct

- Practice beyond scope
- Assume duties without adequate preparation
- Assume duties when competency not maintained
- Fail to take appropriate action to safeguard the patient
- Fail to follow policy and procedure designed to safeguard the patient
- Inaccurate recording of any record of patient or agency
- Falsifying any record of patient or agency
- Altering any record of patient or agency
- Physical abuse of patient
- Verbal abuse of patient
- Assigning unqualified person
- Delegating to unqualified persons
- Violate confidentiality of info or knowledge of patient
- Willfully fail to take action to safeguard patient–from another incompetent nurse
- Negligently fail to take action to safeguard patient–from another incompetent nurse
- Failing to report action
- Diverting supplies of patient or agency
- Diverting drugs of patient or agency
- Diverting property of patient or agency
- Soliciting professional patronage/fraudulent advertisements
- Profiting by acts of those representing to be licensee's agent
- Advertising professional superiority or performance
- Sexual abuse related to practice
- Sexual misconduct related to practice
- Sexual exploitation related to practice

To practice nursing in Kansas unless licensed
To offer to practice nursing in Kansas unless licensed
To use any title, abbreviation, letters, figures, signs, card to indicate licensure unless licensed
To sell or fraudulently obtain or furnish a diploma, license record, or certification of qualification
To aid or abet the sale of a diploma, license record, or certification of qualification
To practice while suspended, revoked or lapsed
To represent that a school is accredited unless it is
To violate any provision of KNPA or rules/regs
To represent that a CNE provider is approved unless it is
Mental, Emotional or physical disability impairing practice
Patient abandonment
Conduct likely to deceive, defraud or harm the public
Exploitation–financial or physical
Fail to comply with Board order
Fail to comply with IPP requirements
Fail to furnish legally requested information
Using false or assumed names or impersonating another while practicing
Allowing another to use one's license

FACTORS FOR CONSIDERATION

(including but not limited to)

1. Violation ground

2. Nature of the incident
   Isolated, severity, person involvement, intent, mistake

3. Present moral fitness of licensee
   Past employment vs. current employment
   Past activities vs. current activities
   Past character vs. current character
   Past maturity vs. current maturity
   Past experience vs current experience

4. Demonstrated consciousness of wrongful conduct
   explanation, truth, veracity, admitting, blaming others, no understanding of wrongfulness, silence, fraudulent means to cover violation, intentional acts

5. Disrepute the action brings to the profession
   Exploitation of a patient

6. Rehabilitation
   Still under probation/parole
   Treatment, counseling, education, activities

7. Prior violations
   Criminal, licensing, civil
   Pattern, time proximity, nature, conduct following
   Currently under probation, parole, or IPP
   Current standing with probation, parole or IPP
   Types of treatment, counseling or education activities

8. Present competence/skill
   Subsequent reports, additional education
   Working conditions/environment
   New graduate or inexperience vs. experience
   Situational problem
   Burnout
   Attitude
   Knowledge deficit
   Aptitude
   System processes to working conditions
   Marginal practice

9. Mitigating circumstances
   Process problems, multiple players,
   understaffing, years experience total,
   years experience specialty

10. Aggravating circumstances

- Poor history
- Pattern of practice
- Repeated acts
- No corrective action taken
- Insufficient rehabilitation
- Failure to comply with IPP
- Great harm or potential harm to public

These consideration factors are guidelines for the disposition of investigative cases. They are guidelines only and are in no way binding on the committee when dealing with investigative cases.

DISPOSITION FOR A VIOLATION

(These are suggested guidelines only)

MILD

- Letter warning about further violation.
- Suggested CNE or in-service
- Suggested counseling
- Inactivate-already remedied; isolated
- Agreed fines for unlicensed practice (0-3 months)

Not considered or reported as formal discipline

MODERATE

- Letter Agreements for agreed outcome (example- CNE courses or referral to IPP)
- Interviews with agreed outcome: CNE, counseling, etc.
- Written diversion agreement, non-discipline requiring action
  - Community service
  - Fines
  - Education
  - IPP
  - Employment monitoring
  - Probation
- Agreed fines for unlicensed practice (4–10 months)

Not considered or reported as formal discipline

SEVERE

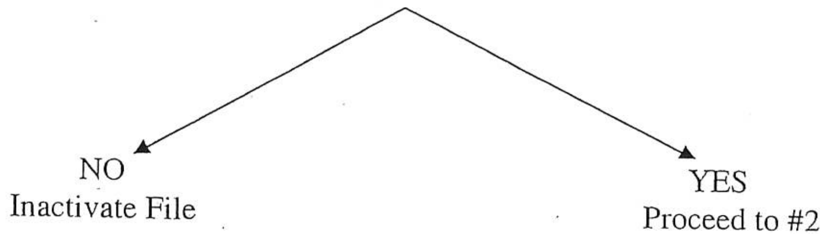
- Impact on license
- Discipline via hearing or consent agreement
  - No practice
  - Fines
  - Probation
    - Employer
    - IPP
    - PO
- Unlicensed practice (over 10 months)

Considered to be and reported as formal discipline

Exhibit C

Kansas State Board of Nursing
Investigative Case Disposition Model

1. Based on the evidence available is there reasonable belief that a violation occurred?



NO
Inactivate File

YES
Proceed to #2

2. Factors
(for rating severity level)

1. Violation type
2. Nature
3. Moral fitness
4. Consciousness
5. Disrepute
6. Rehabilitation
7. Prior violations
8. Skill
9. Mitigating
10. Aggravating circumstances

(including but not limited to)
After analysis proceed to #3

3. Severity Level

MILD MODERATE SEVERE

MILD

etter warning about further violation

uggested CNE or in-service

ggested counseling

activate- already remedied; isolated

greed fines for unlicensed practice
– 3 months)

co ed or reported as formal discipline
estea ines only

MODERATE

* Letter Agreement for agreed outcome (example-CNE courses or referral to IPP)
* Interview with agreed outcome: CNE, counseling, etc.
* Written Diversion Agreement; non-discipline requiring action
  - Community Service
  - Fines
  - Education
  - IPP
  - Employment monitoring
  - Probation
* Agreed fines for unlicensed practice (4 – 10 months)

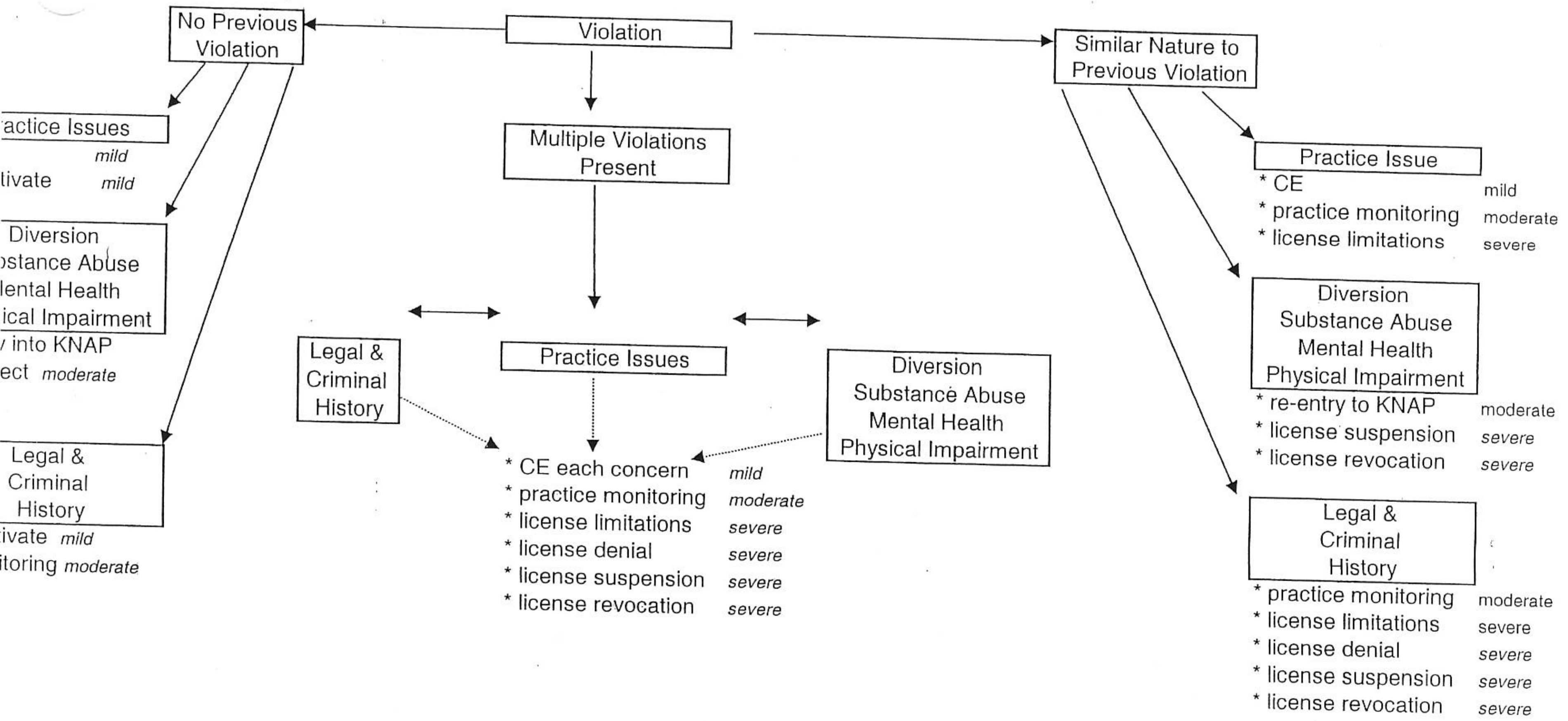
Not considered or reported as formal discipline

SEVERE

* Impact on license
* Discipline via hearing or consent agreement:
  - No practice
  - Fines
  - Probation
    - -Employer
    - -IPP
    - -PO
* Unlicensed practice (over 10 months)

Considered to be and reported as formal discipline

PROCESS ILLUSTRATION



Investigative Committee
Case Disposition Work Sheet

Date: ______________________

Case #: ____________________

Licensee Name: ____________________________

Members Present: TH SF JJ

Violation(s): ________________________________

____

____

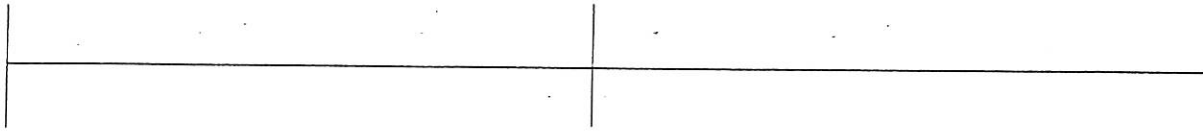
____

____

Factors
(for rating severity level)

1. Violation type
2. Nature
3. Moral fitness
4. Consciousness
5. Disrepute
6. Rehabilitation
7. Prior violations
8. Skill
9. Mitigating

Severity rating:



Mild Moderate Severe

Disposition choice(s): ________________________

____

____

____

____

Kansas State Board Of Nursing

The KSBN is a regulatory agency that licenses Registered Nurses, Licensed Practical Nurses and Licensed Mental Health Technicians. The role of KSBN is to protect the citizens of Kansas. The regulatory process and licensing assures citizens of Kansas that nurses and licensed mental health technicians have met minimum competence requirements. Testing establishes minimum competence. Statutes and regulations found in the Kansas Nurse Practice Act (KNPA) define your scope of practice and outline unacceptable conduct. There are actions for which your license may be called into question. When a licensee's conduct is questioned, KSBN has authority to investigate and collect information. If a sworn complaint is received KSBN is required to investigate you.

How Do Investigations Start?

Most reports received by KSBN come from employers as a result of the peer review process under the Risk Management Act. Employers must report to KSBN any nursing actions that fall below the standard of care. These acts must have a reasonable probability of causing injury to a patient. They must also report any actions that may be a ground for discipline.

Reports can originate from any source. Other sources include the court system, law enforcement, newspapers, TV or radio reports, patients, neighbors, relatives, other agencies, individual health care providers, etc.

By law the agency may not/does not identify any reporters or sources.

Note: website www.ksbn.org

Who Investigates Me?

KSBN staff includes investigators who are licensed nurses. Cases are assigned to these four investigators.

What Happens During An Investigation?

Investigators collect information from many sources. Medical records, personnel records, agency record, and records of discipline on licensing from other states are reviewed. Investigators interview witnesses and take statements. Investigators interview licensees that are being investigated. During investigations licensees may offer evidence and statements to be considered. Investigators collect all information available, both positive and negative. The investigators organize, review and summarize all available information.

How Long Does The Process Take?

As a rule the process will be completed within 6 to 9 months. This process may be lengthened by other factors. These factors include reports received after the incident actually occurred or locating witnesses or clients that may have moved. Uncooperative witnesses or licensees, slow response to record requests or subpoenas by agencies or other states lengthen the process also.

What Happens If I Apply During An Investigation?

We receive applications for initial licensure, endorsement, renewal and reinstatement. Your completed application is a request for an order or a license. KSBN must acknowledge receipt and status of your application within 30 days. If a question is raised and you are investigated, KSBN must complete the process in 90 days or "as is practicable". KSBN licenses over 40,000 people and investigates an average of 750 cases per year. The majority of requests/applications are processed immediately and you receive your license card in the mail. If not immediately processed you will receive a letter of notification from KSBN on your application status

What Happens After The Investigation?

The Investigative Committee reviews all summaries and files. That committee is made up of three Board Members. They meet at every Board meeting (4 times a year) and sometimes between Board meetings. The committee decides what should be done with the file. The decisions include, but are not limited to 1) inactivation, 2) call for hearing or summary denial (resulting in formal discipline), 3) inactivation due to in-house/facility or self imposed education actions, 4) non-discipline probation agreements, 5) agreements to obtain specific CNE courses, and 6) referrals to the impaired provider program.

After the committee makes their decision, licensees are notified in writing of the Board's request/action. Not all actions result in formal discipline.

Disclaimer

The information provided in this pamphlet is not intended to be legal advice or a complete explanation of legal rights.

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KANSAS STATE BOARD OF NURSING

THE INVESTIGATIVE PROCESS

Kansas State Board of Nursing
900 SW Jackson, Suite 1051
Landon State Office Building
Topeka, Kansas 66612-1230
785-296-4325

Investigative Committee

Judith Hiner, R.N., B.S.N., C.N.A., Chair
Coffeyville, Kansas
Tamara Hutchison, R.N., B.S.N., Vice Chair
Quinter, Kansas
Janet Jacobs, L.P.N.
Derby, Kansas

Rev. 11/3/06

Staff

Diane M. Glynn, J.D., R.N.
Practice Specialist
Inge Reed
Senior Administrative Assistant
Kathleen D. Chalkley, L.P.N.
Special Investigator II
Karen Peschka, R.N.
RN Senior Investigator
Betty Stewart, R.N.
RN Senior Investigator
Sheri Gregory, R.N.
RN Senior Investigator
Kimberly Quintin
Administrative Assistant
Mark Knight, J.D.
Assistant Attorney General

Kansas State Board of Nursing

The KSBN is a regulatory agency that licenses Registered Nurses, Licensed Practical Nurses and Licensed Mental Health Technicians. The role of KSBN is to protect the citizens of Kansas. The regulatory process and licensing assures citizens of Kansas that nurses and licensed mental health technicians have met minimum competence requirements. Testing establishes minimum competence. Statutes and regulations found in the Kansas Nurse Practice Act (KNPA) define your scope of practice and outline unacceptable conduct. There are actions for which your license may be called into question. When a licensee's conduct is questioned, KSBN has authority to investigate and collect information. If a sworn complaint is received KSBN is required to investigate you.

K.S.B.N.'s Scope of Authority

If the KSBN believes a violation of the KNPA (K.S.A. 65-1120) has occurred it may commence an administrative action against your license. The Board through an administrative action may deny, revoke, suspend, limit, or publicly or privately censure a license. The Board may also levy fines (K.S.A.74-1110) against a license. The first offense is not to exceed $1,000.00, second offense is not to exceed $2,000.00, and third and subsequent offenses are not to exceed $3,000.00.

Kansas Administrative Procedure Act

The KSBN is a regulatory agency. Being licensed is a privilege not a right. A license once obtained, is a form of a property right. The Board takes action against this property right not the person, but the action against the license may affect the licensee. Because the license is a property right the KSBN must afford you certain constitutional protections. All disciplinary actions before the KSBN are subject to the Kansas Administrative Procedure Act (KAPA). The KAPA is a set of statutes that outline the procedures the KSBN must follow. It provides for due process. This includes things such as reasonable notice, fair and impartial hearing, and right to representation, right to question witnesses or present evidence. KAPA is applied to all regulatory agencies of varying sizes.

What Happens If I Apply During An Investigation?

We receive applications for initial licensure, endorsement, renewal and reinstatement. Your completed application is a request for an order or a license. KSBN must acknowledge receipt and status of your application within 30 days. If a question is raised and you are investigated, KSBN must complete the process in 90 days or "as is practicable". KSBN licenses over 40,000 people and investigates an average of 750 cases per year. The majority of requests/applications are processed immediately and you receive your license card in the mail. If not immediately processed you will receive a letter of notification from KSBN on your application status.

Informal Resolutions

The committee may request the licensee to sign an agreement and/or meet conditions designed to impose an educational remedy. In this way the Board's primary purpose of protecting the public is met and the licensee's practice is improved and maintained.

Formal Discipline Process

The process can begin one of two ways. First, an applicant may receive a document called "Summary Denial". This document states the facts and legal reasons for denial of a license. If the licensee disagrees he/she may request a hearing. Second, a licensee may be served with a petition stating facts and law and asking for action upon the license.

The request for hearing by the licensee or petition filed by the Attorney General is followed by a notice of hearing which sets a time and date for the licensee to appear and defend. The notice gives directions on how to ask for additional time (called a continuance) if a licensee is unable to appear on the date set. The notice also warns that if a licensee fails to appear or contact the KSBN the matter will proceed and judgement may be entered in the matter affecting the license. Documents and statements may be requested by the licensee or the Board's attorney and are exchanged in a process known as discovery.

You may appear in front of the entire Board, a panel of Board members or the Board's appointed hearing officer. A licensee may represent yourself or be represented by an attorney. The proceeding is recorded. Oaths are administered to those who testify. Each party can require witnesses to appear and testify. Each party may cross-examine witnesses presented by the other side. Each party may submit exhibits. The hearing officer / panel may also ask questions. Evidence may be written or oral and must be relevant to the claim. Hearsay can be introduced and is to be weighed appropriately. Evidence submitted varies from case to case. If your fitness to practice nursing is in question, factors to be considered include but are not limited to: (1) danger to the public health safety and welfare, (2) the present moral fitness, (3) your consciousness of what

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you did wrong and the effect on profession, (4) what you did and are doing for rehabilitation (5) nature and seriousness of misconduct, (6) current conduct, (7) time elapsed since prior discipline or criminal activity, (8) character, maturity and experience (9) present competence and skill. These points are not all inclusive.

At the conclusion the hearing officer/panel weighs and considers the evidence and renders a decision. A written order, which consists of findings of fact, conclusions of law, and any sanctions imposed, is served upon the parties after the decision. Costs of the proceeding may be charged to the applicant or licensee. The written order will state the time when it becomes effective and provide notice to both sides of their appeal rights.

Appeal Process

Within a set period of time the parties have the right to request to have a decision reviewed by the Board. If the Board affirms the decision, or if the Board declines to review the decision, or makes a decision not liked by either party, either party may appeal to District Court. An appeal in District Court is subject to an act called the Kansas Judicial Review Act (KJRA).

Appeals to District Court for the KSBN are not tried again. The KJRA sets out the court's scope of review. The court considers the party's stated appeal grounds and decides whether the KSBN's order/record is supported by substantial evidence. Once the District Court enters its order either party, if not satisfied, has one more opportunity for appeal to the Court of Appeals or Supreme Court of the State. There are established time lines in which such requests or notices must be filed.

Disclaimer

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Note: Statutes available at www.ksbn.org and www.accesskansas.org.

Investigative Committee

Judith Hiner, R.N., B.S.N., C.N.A., Chair
Coffeyville, Kansas
Tamara Hutchison, R.N., B.S.N., Vice Chair
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RN Senior Investigator
Sheri Gregory, R.N.
RN Senior Investigator
Kimberly Quintin
Administrative Assistant
Mark Knight, J.D.
Assistant Attorney General

Rev. 11/3/06

KANSAS STATE BOARD OF NURSING

YOUR RIGHTS BEFORE THE

KANSAS STATE BOARD OF NURSING

Kansas State Board of Nursing
900 SW Jackson, Suite 1051
Landon State Office Building
Topeka, Kansas 66612-1230
785-296-4325

---------- Forwarded message ----------
From: Marty Turner MD <mturnermd@yahoo.com>
To: Senator Barnett <senatorjb@sbcglobal.net>
Date: Mon, 22 Jan 2007 12:39:27 -0800 (PST)
Subject: SB116
Dear Jim,

I understand your committee will be reviewing SB116 tomorrow. The KAFP was just asked to give written and/or verbal testimony for this bill. Unfortunately, the late notice to us from the American Lung Association precludes us from providing either. Therefore, I am providing you this note.

On my read of the bill, it looks like the words "predisposition for asthma" are added. The ALA would like it changed to just "asthma". I really don't see any difference between either wording. My main concern would be is how does this change what we as physicians are currently doing. Will this bill require every child to perform spirometry in office or Wright Peak Flows? Is just asking screening questions enough like we currently do on sports physicals?

I think the concept behind this is great, but the bill seems very generic to me. So as long as there are no unforseen consequences or expensive requirements like mandatory spirometry, then this bill should be fine. Again, the KAFP has no official stance on this as we haven't had time to run it through our committees, but from my perspective as our committee chair it is supportable with the above limitations.

Marty

Marty W. Turner MD FAAFP
1625 Tiara Pines Ct
Derby, KS 67037
316-788-6284

Senate Public Health and Welfare Committee
Attachment #6
January 25, 2007

KANSAS
DIVISION OF THE BUDGET

Kathleen Sebelius, Governor
Duane A. Goossen, Director
http://budget.ks.gov

January 25, 2007

The Honorable Jim Barnett, Chairperson
Senate Committee on Public Health and Welfare
Statehouse, Room 120-S
Topeka, Kansas 66612

Dear Senator Barnett:

SUBJECT: Fiscal Note for SB 82 by Senate Committee on Public Health and Welfare

In accordance with KSA 75-3715a, the following fiscal note concerning SB 82 is respectfully submitted to your committee.

SB 82 would allow unlicensed healing arts schools that are approved by the Board of Healing Arts and the Board of Regents to practice the healing arts. The unlicensed healing arts school must be non-profit organizations that provide clinical training to their students under the supervision of persons who are licensed by the Board of Healing Arts.

The Board of Healing Arts and the Board of Regents state that the passage of SB 82 would have no fiscal effect on their operations.

Sincerely,

Duane A. Goossen
Director of the Budget

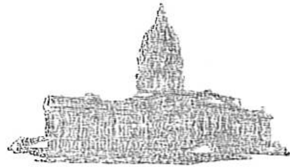
cc: Cathy Brown, Healing Arts
Kelly Oliver, Board of Regents

Senate Public Health and Welfare Committee
Attachment #7
January 25, 2007

900 S.W. Jackson Street, Room 504-N, Topeka, KS 66612 • (785) 296-2436 • Fax: (785) 296-0231
e-mail: duane.goossen@budget.ks.gov

JOHN VRATIL
SENATOR, ELEVENTH DISTRICT
JOHNSON COUNTY
LEGISLATIVE HOTLINE
1-800-432-3924

State of Kansas



COMMITTEE ASSIGNMENTS
CHAIR: JUDICIARY
VICE CHAIR: EDUCATION
MEMBER: FEDERAL AND STATE AFFAIRS
ORGANIZATION, CALENDAR AND RULES
SENTENCING COMMISSION
INTERSTATE COOPERATION

Vice President
Kansas Senate

Testimony Presented To
The Public Health & Welfare Committee
by Senator John Vratil
January 25, 2007
concerning Senate Bill 82

Good afternoon. Thank you for the opportunity to come before the Senate Public Health and Welfare Committee in support of Senate Bill 82 which would amend the Kansas Healing Arts Act to add certain healing arts schools to the list of entities covered by the act.

The Cleveland Chiropractic College of Kansas City, Missouri, is recognized as a major chiropractic institution. It holds both regional and specialized accreditation and offers both baccalaureate and Doctor of Chiropractic degree programs. In order to accommodate anticipated growth, the College purchased property in Overland Park.

Currently, the Kansas Healing Arts Act identifies approximately 18 types of different entities which are lawfully allowed to present themselves publically as having the authority or skill to practice the healing arts in our state. The current Act would prevent an institution, such as the Cleveland Chiropractic College, from offering a clinical program. Senate Bill 82 proposes to rectify the situation by adding to the list of lawful entities two additional categories.

The first category includes any healing arts school which meets three criteria: 1. It is a nonprofit entity under section 501 (c) (3) of the internal revenue code. 2. It is approved by the State Board of Regents. 3. Its academic requirements include clinical training supervised by persons who are licensed under the Kansas Healing Arts Act.

The second category includes any professional corporation or limited liability company lawfully organized and operated under either the Professional Corporation Law of Kansas or the Kansas Revised Limited Liability Act, whichever is applicable. Additionally, the corporation or company must be operated for the specific purpose of rendering professional services covered by the healing arts act.

Senate Public Health and Welfare Committee
Attachment #8
January 25, 2007

Passage of Senate Bill 82 will enable the Cleveland Chiropractic College to move its campus to Overland Park.

John Vratil

HOME
9534 LEE BLVD

DISTRICT OFFICE
10851 MASTIN BLVD

STATE OFFICE

KANSAS BOARD OF HEALING ARTS

LAWRENCE T. BUENING, JR.
EXECUTIVE DIRECTOR

KATHLEEN SEBELIUS
GOVERNOR

January 18, 2007

The Hon. Jim Barnett
Senator, 17th District
Kansas State Capitol, Room 120-S
300 S.W. 10th
Topeka, KS 66612

Re: 2007 Senate Bill No. 82

Dear Senator Barnett:

Thank you again for your time on January 11 when we visited about the efforts of Cleveland Chiropractic College to relocate to Kansas. As I indicated, the Board supports this effort. We have worked with representatives of the college for several months to determine whether the Kansas healing arts act includes legal barriers to relocation.

We understand Cleveland Chiropractic College is a not-for-profit general corporation that has been approved by the State Board of Regents to confer degrees in this state. The school will provide clinical training to students by allowing them to provide services under the supervision of licensed chiropractors.

In our opinion, there is a potential legal issue that should be resolved through legislation so that the college may engage in the clinical aspects of training. Kansas has long adhered to the "corporate practice doctrine." That common law doctrine prohibits a general corporation from engaging in learned professions, including the healing arts, either by employing or by contracting with licensed professionals to provide professional services on behalf of the corporation. Kansas courts do not distinguish between for-profit and not-for-profit corporations in discussing the prohibition. This principle finds support in Kansas statutory law, which provides that only licensed individuals may practice the healing arts, and only licensed individuals may own or operate an office or location for such professional practice. See K.S.A. 65-2803, 65-2867.

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Senate Public Health and Welfare Committee
Attachment #9
January 25, 2007

235 S. Topeka Boulevard, Topeka, Kansas 66603-3068
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There are strong policy reasons for enforcing the corporate practice prohibition, even though many states have abandoned it over the years. A general corporation is usually led by a board of directors having a duty to make a profit for shareholder investors. But this duty to investors would not always be in the interests of public health and safety, where the duty is owed to the patient. Also, the courts noted decades ago that individuals attend professional school and pass licensing exams, which respectively teach and measure the duties of a professional relationship, in order to obtain permission from the state to offer professional services. The members of a general corporation's board of directors do not always have that benefit.

Our statutes do allow licensed individuals to practice through professional business entities, such as professional corporations or limited liability companies. Forming a professional business entity does not change the professional duty that the licensee owes the patient, and does not insulate the licensee from civil liability. The statutes limit ownership of professional business entities to "qualified persons," a term that is defined in the statutes. Generally, licensed individuals, other professional entities, and specific inter vivos trusts are "qualified" to own shares of a professional corporation. Thus, unlicensed persons are not allowed to invest in a professional business entity.

The corporate practice prohibition does not apply to hospitals. The state licenses hospitals to provide medical care, and their duty to patients is well established. Also, the doctrine has not been applied to organizations such as the Kansas University Medical School, which is established by statute.

The Board continues to support the policy decision that corporations should not practice the healing arts without specific and narrowly crafted statutory authority. We also recognize that the evils that the corporate practice doctrine seeks to prevent would not arise by the operation of a clinic in Kansas by an approved non-profit healing arts college. The services provided by students would not be motivated by profit or duty to investors, and the services would be supervised by persons who are trained, examined and licensed.

We urge the adoption of specific authority for appropriate teaching facilities to give students clinical experience in Kansas. We will be happy to provide additional assistance as we are able.

Respectfully,

Mark W. Stafford
General Counsel

*(t) A professional corporation lawfully organized and operated under the professional corporation law of Kansas or a limited liability company lawfully organized and operated under the Kansas revised limited liability company act for the purpose of rendering rendering ~~the~~ professional service***s* *~~incident to a branch of the healing arts~~* ***for which its shareholders or members are licensed under the healing arts act.***

Cleveland Chiropractic College

Kansas City | Los Angeles

To: The Honorable Jim Barnett
Chairman, Senate Health & Welfare Committee
From: Dr. Carl S. Cleveland, III D.C., President
Cleveland Chiropractic College
RE: SB 82
Date: January 25, 2007

Mr. Chairman and members of the Senate Health & Welfare Committee:

As President of Cleveland Chiropractic College, it is my pleasure and honor to provide this written testimony to the Senate Health & Welfare Committee.

Cleveland Chiropractic College (of Kansas City) is seeking to relocate its administrative offices, educational facilities and on-campus student clinical training center from its current site in the Southtown neighborhood of Kansas City, Missouri to a new facility in order to accommodate forecasted enrollment growth and space needs related to its program expansion.

Cleveland Chiropractic College and its limited liability company have entered into agreements for the purchase of the Farmers' Insurance building and the surrounding acreage on which it is located in Overland Park, Kansas, at 10850 Lowell Avenue and an adjacent office building at 8205 W 108th Terrace. These acquisitions represent a total combined acquisition of 175,000 square feet on approximately 34 acres. It is the intent of Cleveland Chiropractic College to relocate its administrative offices, educational program, and student services to these buildings in Spring 2008. The College operations will include an on-campus student clinical training center that operates under a public clinic model, at which students will receive practical experience providing chiropractic care under the direction of Kansas-licensed Doctors of Chiropractic as part of the College's curriculum.

Cleveland Chiropractic College, founded by the Cleveland family in 1922, is a multi-campus system with campuses located in Kansas City, Missouri and Los Angeles, California. Cleveland Chiropractic College is accredited by the North Central Association of Colleges and Schools and offers degree programs leading to an Associate of Arts in Biological Sciences, a Bachelor of Science in Human Biology, and a Doctor of Chiropractic degree, which is a four-year program.

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The Doctor of Chiropractic program prerequisites for admission include at minimum, 90 semester hours of undergraduate coursework leading to a baccalaureate degree, with one academic year in each of the science areas of Biology, General Chemistry, Organic Chemistry, Physics, and additional hours in humanities and social sciences.

The chiropractic program at Cleveland Chiropractic College is accredited by the Council on Chiropractic Education. Upon graduation, Cleveland Chiropractic College students are eligible for licensure in all 50 states including eligibility for licensure by the Kansas State Board of Healing Arts. Cleveland Chiropractic College has received degree-granting authority in the State of Kansas through the Kansas Board of Regents, effective December 28, 2004.

Cleveland Chiropractic College is incorporated as a Missouri non-profit corporation and is exempt from taxation pursuant to Section 501(c)(3) of the Internal Revenue Code of 1986, as amended. Cleveland Chiropractic College is qualified to do business as a foreign corporation in the State of Kansas.

Approximately 8000 graduates of the Cleveland Chiropractic College multicampus system practice in 50 states and 14 foreign countries. The current combined undergraduate and Doctor of Chiropractic enrollment consists of 864 students. Currently 472 students are enrolled at the Kansas City campus, of which approximately 84% are from outside of the Kansas City metropolitan area. These students will generate revenue for local businesses by renting apartments, and frequenting restaurants, grocery stores, and entertainment venues within in the Johnson County, Kansas community. The Cleveland Chiropractic College Kansas City student clinical training center provides nearly 45,000 patient visits annually. Currently, the Kansas City campus employs over 100 staff and faculty members, and generates approximately $16 million in federal financial aid, which directly impacts the local Kansas City community. The yearly gross revenue for the Kansas City campus is $9.5 million. Over $5 million is paid annually in wages and benefits to employees. Cleveland Chiropractic College donates $285,000 in health services to the Kansas City community annually.

The College's total investment in the Overland Park properties will represent in excess of $26 million and will provide a facility to accommodate the College's projection for increased enrollment to 750 students by 2010.

Cleveland Chiropractic College requests your support of SB 82, which would exempt the student clinical training center operated by Cleveland Chiropractic College from the "corporate practice of medicine doctrine", which is more fully discussed herein. Cleveland

Chiropractic College has worked with Mark Stafford, the general counsel for the Kansas Board of Healing Arts, on SB 82, which would accomplish this result for Cleveland Chiropractic College and other Section 501(c)(3) educational institutions granting degrees in the healing arts that are similarly situated.

The following is a summary of the "corporate practice of medicine doctrine" and how its application prevents Cleveland Chiropractic College from operating its student clinical training center within its existing non-profit, Section 501(c)(3) corporate structure.

As a general rule, the corporate practice of medicine doctrine under Kansas law prohibits a corporation from employing physicians to render professional services (e.g. medical or chiropractic care). The rationale for prohibiting employment of physicians by a corporation is derived from the concept that individual physicians, and not corporations, should be licensed to practice medicine, chiropractic or any other healing arts. The basic premise is that the interests of a corporation and the needs of a patient result in a divided loyalty of the physician which impairs the patient's confidence in the physician. Kansas Statute Annotated 17-2708 relating to professional corporations, however, takes precedence over any law which prohibits a corporation from rendering any type of professional service such as chiropractic care. Under the Kansas statutes, a professional corporation (but not a non-profit corporation) can be established to practice medicine, chiropractic or any other healing art provided that the stockholders of such corporation are licensed to practice the applicable healing art under the laws of Kansas.

As discussed above, Cleveland Chiropractic College is a non-profit corporation and an organization qualifying under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, that is an educational organization which maintains a faculty and a curriculum and has a regularly enrolled body of students. Cleveland Chiropractic College confers a Doctor of Chiropractic degree and, as part of its curriculum, operates a student clinical training center at which its student interns, under the supervision of licensed chiropractors, perform chiropractic patient care for the public in order to obtain practical experience necessary to graduate and be eligible for state chiropractic licensing examinations. The State of Missouri, where Cleveland Chiropractic College is currently located, has not adopted the "corporate practice of medicine doctrine"; and therefore, Cleveland Chiropractic College is able to operate the student clinical training center within its existing non-profit, Section 501(c)(3) corporate structure.

Due to the corporate practice of medicine doctrine, however, Cleveland Chiropractic College will not be able to operate the student clinical training center within its existing corporate structure. As a Section 501(c)(3) organization and a Missouri non-profit corporation, it cannot qualify as a professional corporation under Kansas law (and this would also be the case if it became a Kansas non-profit corporation) since it cannot have individuals as stockholders. At a significant cost to Cleveland Chiropractic College, it would have to form a professional corporation under Kansas law to operate the student clinical training center, find (and continue to have throughout its existence) Kansas licensed chiropractors to serve as nominal stockholders of the new corporation, and qualify the new corporation as a Section 501(c)(3) organization with the Internal Revenue Service. A management contract would need to be established between Cleveland Chiropractic College and the new corporation, and the faculty, who are currently employed by Cleveland Chiropractic College, would also have to become employees of the new corporation. Legal issues relating to continued qualification of tax-exempt bond financing under federal tax law of the facility owned by Cleveland Chiropractic College

(tax-exempt bond financing is being used by Cleveland Chiropractic College to acquire and rehab the Farmers' facility it is acquiring in Overland Park) in which the student clinical training center would be operated and real estate property tax exemptions would also need to be addressed.

In order to avoid the uncertainties and costs relating to the application of the corporate practice of medicine doctrine to the student clinical training center, Cleveland Chiropractic College respectfully proposes that SB 82 be adopted so that an organization that operates such a student internship clinic and meets the criteria set forth in SB 82 can operate its student clinical training center within its existing non-profit, Section 501(c)(3) corporate structure.

Respectfully submitted by

Dr. Carl S. Cleveland, III
President of Cleveland Chiropractic College

DEPARTMENT OF HEALTH
AND ENVIRONMENT

Kathleen Sebelius, Governor
Roderick L. Bremby, Secretary

www.kdheks.gov

Agency Overview
To
Senate Public Health and Welfare Committee

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

January 25, 2007

Chairman Barnett and members of the Committee, I am pleased to appear before you today to provide an overview of the Kansas Department of Health and Environment (KDHE). After my overview, Susan Kang, our Policy Director, will provide an overview of our legislative initiatives. Then Dr. Howard Rodenberg, the Director of the Division of Health, will talk more specifically about the Health Division.

The agency's mission is to protect the health and environment of Kansans by promoting responsible choices. This is a mission we take very seriously and one that challenges us every day. The agency is comprised of three operational divisions: Health, Environment and the Health and Environmental Laboratories. Supporting the operational division are the Office of the Secretary and the Division of Management and Budget.

Dr. Rodenberg will outline the responsibilities of the Health Division, but I want to give you a brief description of the duties of the other two operating divisions. The Division of Environment, among many other duties, conducts regulatory programs for public water supplies, industrial discharges, wastewater treatment systems, solid waste landfills, refined petroleum storage tanks and others. In addition, it administers programs to remediate contamination and evaluate environmental conditions across the state. The Division of Health and Environmental Laboratories, among other duties, provides clinical and environmental testing to help diagnose and prevent disease, and provides laboratory test results to help guard public drinking water, ambient air and surface/ground water quality. The Laboratories perform over 1 million analyses on some 250,000 samples each year. I encourage you to visit our website at *www.kdheks.gov* for a comprehensive view of the agency.

Agency Budget

The Kansas Department of Health and Environment FY 2008 requested operating budget is $212,361,397, which is about 2.4% more than our FY 2006 actual operating budget and 3.2%

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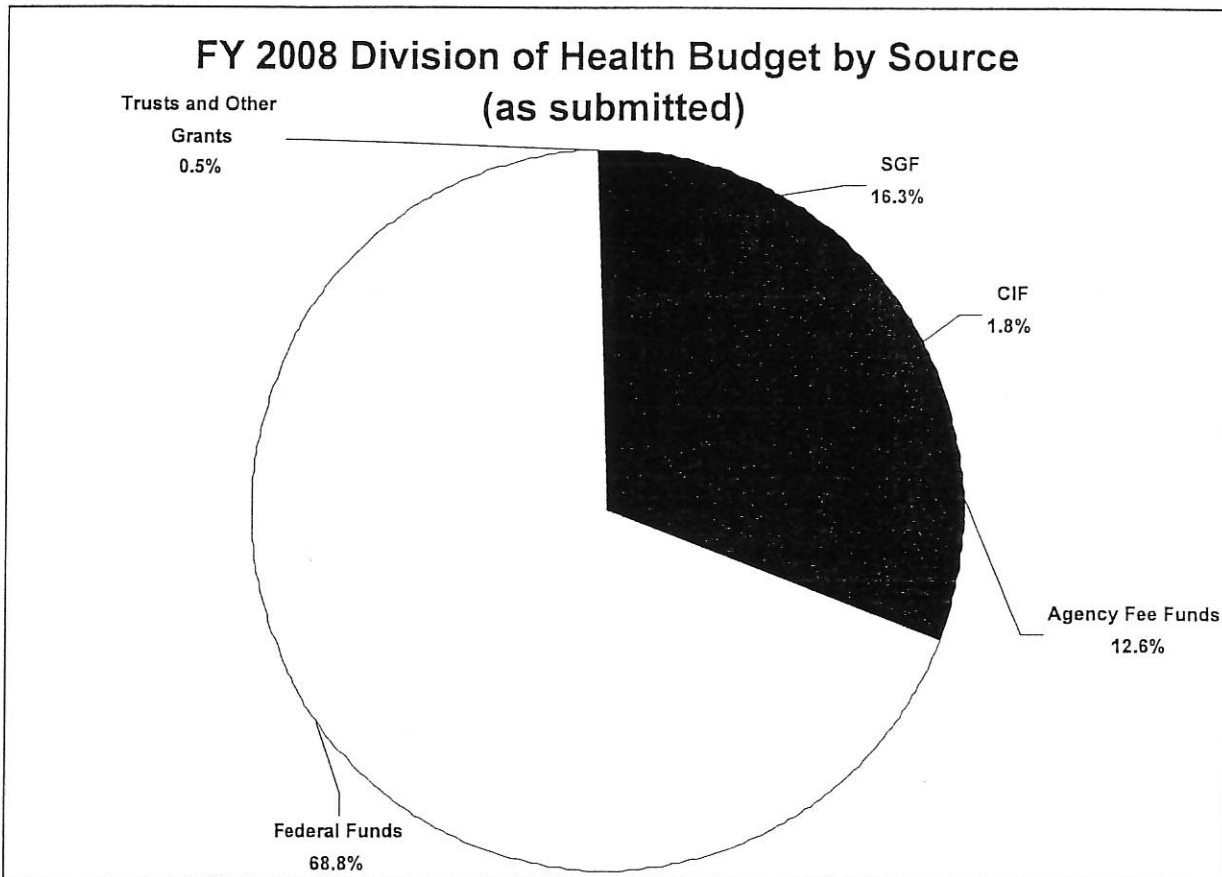
below our FY 2007 estimated expenditures. The decrease in the FY 2008 budget is largely due to a projected reduction in federal funds related to Homeland Security; we are currently projecting a $3.4 million reduction in these funds between FY 2007 and FY 2008. The requested budget allows the agency to continue our current operations. KDHE's budget is split between the Health and Environment functions in the State Budgeting System. The Health budget ($146.5 million) consists of the Division of Health and Central Administration, while the Environment budget ($65.8 million) accounts for the Division of Environment and the Division of Health and Environmental Laboratories. Our requested Health budget for FY 2008 is allocated to the programs as follows: Administration 8.6% and the Division of Health 91.4%.



There are five primary funding source categories within the Health budget. The largest source of funding for the operating budget is federal funds, which total $100.8 million or 68.8%, with the largest of these funds constituting the Women, Infants and Children Health Program Fund ($53.2 million). State General Fund (SGF) resources provide 16.3% of the funding for the Division of Health portion of the Health budget. Of the total SGF, 60.5% fund aid to locals and other assistance, 25.3% fund salaries and wages, and 14.2% fund other operating costs.

As we look to the out years, the agency is anticipating impacts from the increasing federal deficit. Reductions in domestic spending to address the deficit could have a catastrophic impact on our budget and service capability due to our strong reliance on federal resources.

Notable 2006 Public Health Accomplishments

Overall Health Improvement

Kansas was recognized as one of the states with the highest overall health improvement in 2006 by the United Health Foundation's national study. According to the 17th annual edition of America's Health Rankings, Kansas experienced the fourth highest overall health improvement in the nation from 2005 to 2006. Kansas moved up six places in this year's report to 17th place overall. Kansas's strengths include a low rate of uninsured population, low adult smoking rate, low incidence of infectious disease, ready access to adequate prenatal care and high childhood immunization coverage rates.

Decrease in Tobacco Use

Tobacco use is the leading cause of preventable death in Kansas and the nation. Statewide efforts have driven a 2.0% decrease in the adult smoking rate, to an all-time low of 17.8%. Kansas improved from 11th in last year's ranking to sixth this year (in contrast, Kansas ranked 27th in 1990 when over 30% of the state's population used tobacco).

Increase in Immunization Rates

Raising childhood immunization rates has been an important goal. Kansas made its most dramatic improvement in 2006, moving from 43rd to 12th nationally after four years of steady improvement. Implementing the recommendations of the Governor's 2004 Blue Ribbon Panel, including advancing immunization schedules, linking immunization to WIC services, and providing parental incentives accounted for the improvement. Immunization rates will increase and be sustained through the KSWebIZ system, a statewide immunization registry, expansion of current efforts, and the Immunize Kansas Kids Project, a unique partnership among the Kansas Department of Health and Environment, the Kansas Health Foundation, the Kansas Health Institute, and dozens of participating organizations.

Improved Public Health Preparedness

Preparing for pandemic flu, bioterrorism and natural disasters continues to be a major priority. Kansas met 9 out of 10 preparedness criteria and ranked 2nd second in the nation in the Trust for America's Health annual report on public health preparedness. In August, we partnered with 26 local health departments, 13 hospitals and other partner organizations to conduct the state's first full-scale, exercise of the Strategic National Stockpile (SNS), a federal cache of medical supplies available to states upon request. The Kansas-HEAT exercise tested the state's ability to detect and track disease; request, receive, store and ship medicines and supplies from the SNS to local communities; and community capacity in emergency response, community containment, and mass dispensing of medications. Completion of this exercise successfully meets the 10th preparedness criteria.

Key Initiatives

Healthy Kansas Initiative

The Governor's Healthy Kansas initiative features a significant commitment to wellness by encouraging increased levels of physical activity, eating a healthy diet, and avoiding tobacco products. Efforts will target children in schools, adults in the workplace, and seniors in communities. The agency has been actively engaged in this effort, developing a Healthy Kansas website, promoting the Healthy Kansas pledge, and raising the visibility of the initiative through Healthy School awards. The Healthy Kansas effort has also produced development of Healthy Community and Hometown Health Hero recognition programs, a Healthy Restaurant toolkit, and the convening of both the Governor's Child Health Advisory Committee and the Governor's Council on Fitness. The two groups have made recommendations to the Governor addressing the childhood obesity issue. We are working to outline an implementation process for those recommendations.

To further the goals of the initiative, the KDHE Healthy Kansas team has spearheaded the following activities:

- Conducting a 2006 statewide healthy tip postcard contest for all ages with various corporate sponsor partners;
- Promoting the 'Healthy Kansas' pledge on line, through the web site, at appropriate venues, i.e. – trade shows, civic groups, school functions, etc., or using the mail-in pledge card. In 7 months, more than 3,000 Kansans have taken the pledge, and have received a letter of recognition and a certificate of support from the Governor;
- Offering to Kansans a personal health manager software package called Check Up, which was developed by a Kansas software manufacturer, as a free download from the Healthy Kansas Web site (www.healthykansas.org)
- Promoting the Healthy Kansas brand at invited speeches, related conferences and talks by challenging participants to 'Take the Pledge.'

In addition:

- Since May 2006, the Governor's Healthy School program has recognized and awarded healthy school flags to 12 Kansas school districts, representing 91 individual school buildings for planning and implementing programs that incorporate physical activity, healthy food choices and tobacco free schools;

- The Governor's Hometown Health Hero award has recognized and honored three Kansans for distinguished service to their respective communities for living and promoting the Healthy Kansas credo;

Healthy Kansans 2010
Throughout 2005, a group of Kansans representing multiple disciplines came together to identify and adopt health priorities to improve the health of all Kansans. This examination provided the impetus for setting priorities and identifying proven and promising recommendations to encourage change and improve the health of all Kansans in 2010 and beyond. Healthy Kansans 2010 is the corollary to Healthy People 2010, a comprehensive, nationwide health promotion and disease prevention agenda with two main goals: to increase quality and years of healthy life, and eliminate health disparities. Dr. Rodenberg will further elaborate on this endeavor in his portion of the testimony. We've distributed to you a copy of the Healthy Kansans 2010 report. We'd be glad to answer any questions you might have after you've had a chance to review it.

Environmental Health
We are excited to introduce a new dimension to the agency. We received a grant from the United Methodist Health Ministry Fund to develop an Environmental Health program. Specifically, the funding is to retain an Environmental Health Director (EHD) whose goal is to formalize and make visible the link between our physical and environmental health. In pursuit of this goal, the EHD will inventory current environmental health programs within KDHE and identify common interests between the Health and Environment Divisions and maximize expertise, efforts, and resources within current KDHE operations. This new position will identify, prioritize, and initiate new environmental health initiatives based on an assessment of need within the state. In addition, environmental health responses will be integrated into emergency preparedness planning efforts and publish an annual report on environmental health status.

Excellence in Service
Internally, KDHE is in the process of implementing a newly developed strategic plan. The strategic plan is known as Excellence In Service, or EIS. EIS uses the Balanced Scorecard approach to translate mission into actions and actions into outcomes. The KDHE strategy focuses on creating a vibrant, stable, and respected organization that can respond, anticipate and provide leadership on public health and environment issues for Kansans.

Legislative Initiatives

This session, KDHE has proposed an expanded newborn screening (XNBS) bill to increase the number of newborn metabolic screening tests from the current 4 to 29. This proposal results from a collaborative process among stakeholders, including insurance groups, Kansas Hospital Association and the Kansas Chapter of the American Academy of Pediatrics. The proposal is to charge $30 per live birth to conduct the expanded screening tests and any follow-up tests or repeat tests that may be necessary. To address treatment of any conditions that may be found, the department requested an SGF budget enhancement of $191,000.

In addition, KDHE has proposed a number of bills concerning the Child Care Licensing Act. Most of the proposals are designed to modernize and enhance the agency's enforcement remedies, which will result in providing the agency with greater flexibility when dealing with child care providers. The existing statutes require the agency to suspend or revoke licenses as

the main enforcement tool; we are moving to obtain intermediate enforcement mechanisms that are less drastic but designed to encourage compliance without jeopardizing families needing child care services.

We again introduced legislation to share KBI background checks with child placement agencies, and again requested to expand the uses of confidential data in the Kansas Cancer Registry to conduct follow-up on cancer cases to identify any correlation between various cancers and risk factors, to help prevent cancer by establishing more effective means for addressing those risk factors. In addition, we have also introduced legislation to create a dedicated Lodging Inspection Fee Fund, which will enable us to increase the inspection of lodging facilities in the state.

Last week, a citizen initiative called the Driving Force, introduced a legislative proposal (HB 2136) designed to reduce the number of deaths caused by motor vehicle crashes. The Departments of Transportation, Health and Environment along with the Kansas Highway Patrol have partnered in support of the recommendations for a primary seat belt law. In Kansas, on average, a person is killed every day in motor vehicle-related crashes and every 21 minutes, someone is injured. Many of these deaths and injuries are preventable through increased seat belt use. Kansas ranks 43rd in the nation in seatbelt use. The public pays for 13% of emergency department crash injury costs, 26% of injuries requiring hospitalization and 48% of injuries requiring rehabilitation hospitals stays. Last year, that cost totaled more than $3B in Kansas.

A Clean Indoor Air bill (SB 37), which proposes to enact a statewide smoking ban, was introduced last week by Senator Wysong and is being heard in the Senate Judiciary Committee. We urge your support of this bill because it will keep Kansans healthier and over time significantly reduce healthcare costs associated with smoking and it is key to success in cancer prevention.

Tobacco use is the most preventable cause of death and disease in Kansas. Cigarette use alone is responsible for killing nearly 4,000 Kansans each year. As the Secretary mentioned earlier, over the past four (4) years, cigarette use rates in Kansas have dropped from 22.1% to 17.8%. However, the negative health impact of tobacco use affects many more people than just smokers. The 2006 United States Surgeon General's report on the health effects of secondhand smoke has effectively shut the door on the debate regarding the harmful health effects of secondhand smoke—the report concluded that there is no safe level of secondhand smoke.

Cigarette use alone currently costs Kansas $927 million in direct medical costs per year. This includes $196 million in Medicaid program expenditures. With respect to the ill effects of secondhand smoke, we know that approximately two percent of all lung cancer cases in Kansas are attributable to secondhand smoke (about 27 cases per year) and 18% of heart disease cases are connected to secondhand smoke. In 2003, more than 4000 Kansans died of coronary heart disease and it is estimated that approximately 320-570 of those cases were caused by exposure to secondhand smoke. Up to two deaths each day in Kansas are due to such exposure. The statewide smoking ban is one measure the state can take to begin reducing these enormous healthcare costs and deaths, which will continue or increase into the second quarter of this century if we fail to take action to reduce tobacco use and exposure.

Division of Health

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. 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.

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 public health emergencies within 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, physical activity, and preventing tobacco use. The Division provides assistance to Kansas communities in establishing or modifying health care delivery, and is responsible for ensuring the special needs of women and children are addressed through specialized screenings, treatments, and more general programs in Family Planning (FP), Maternal and Child Health (MCH), 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, food service facilities, and lodging establishments. A wide range of health care workers also receive credentials and certifications through the KDHE Division of Health. A critical function of the Division is the management of all vital statistics records for Kansas and the gathering and analysis of health and environmental data.

Healthy Kansans 2010: Progress to Goals

One of the major accomplishments of 2006 has been the culmination of the planning phase for the Healthy Kansas 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. These indicators are used as markers of progress to the desired state of health for Kansas. While not all KDHE DOH programs link directly to Healthy Kansas 2010 goals, there are areas in which progress can be measured.

Kansans Performance on 10 Leading Health Indicators

Objective	Kansas Rate (Previous Rate)	Kansas Rate (Most Current Rate)	HP2010 Goal
Physical Activity			
Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardio-respiratory 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)	38% (2005 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)	24% (2005 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)	17.8% (2005 KS BRFSS)	12%
Substance Abuse			
Increase the proportion of adolescents *not* using alcohol or any illicit drugs during the past 30 days.	-	69% (6th, 8th, 10th, and 12th graders *not* using alcohol at least once in the past 30 days) 91% (6th, 8th, 10th, and 12th graders *not* using marijuana at least once	89%

		in the past 30 days) (2005 Kansas Communities That Care Survey Youth Survey)	
Reduce the proportion of adults engaging in binge drinking of alcoholic beverages during the past month.	13% (2004 KS BRFSS)	12% (2005 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.	No Kansas data available that is directly comparable to HP2010 target.	50%
Injury and Violence			
Reduce deaths caused by motor vehicle crashes.	17.1 deaths per 100,000 population (2003 Vital Statistics, KDHE)	17.5 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 (2003 KS Vital Statistics)	4.3 homicides per 100,000 population (2004 KS Vital Statistics)	3.0 homicides per 100,000 population
Environmental Quality			
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% (EPA Aerometric Information Retrieval System)	0%
Immunization			
Increase the proportion of young children who are fully immunized (4:3:1:3:3 series)	77.5% (4:3:1:3:3 series - 2004 National Immunization Survey)	83.8% (4:3:1:3:3 series - 2005 National Immunization Survey)	90% (4:3:1:3:3 series)

Increase the proportion of non-institutionalized adults aged 65 years and older who are vaccinated annually against influenza.	68% (2004 KS BRFSS)	66% (2005 KS BRFSS)	90%
Increase the proportion of adults aged 65 years and older ever vaccinated against pneumococcal disease.	63% (2004 KS BRFSS)	67% (2005 KS BRFSS)	90%
Access to Health Care			
Increase the proportion of persons with health insurance.	85% (2004 KS BRFSS)	87% (2005 KS BRFSS)	100%
Increase the proportion of persons who have a specific source of ongoing primary care.	84% (2004 KS BRFSS)	84% (2005 KS BRFSS)	96%
Increase the proportion of pregnant women who begin prenatal care in the first trimester of pregnancy.	88% (2003 Vital Statistics, KDHE)	87% (2004 Vital Statistics, KDHE)	90%

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.

Division of Health Organizational Structure:

The Division of Health is organized into four distinct bureaus, four offices, and two centers. 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.

Coordinated School Health Program (CHSP) – The CHSP is a collaborative project between KDHE and Kansas State Department of Education (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. From July 2005 through June 2006, the program served approximately 7,300 eligible women.

Diabetes - A Diabetes Quality of Care Initiative provides funding and training to health care providers for implementation of a Chronic Care Model. The Project provides funding to 90 organizations/satellite providers (representing 50% of Kansas counties) throughout the state and serves approximately 8,500 diabetes patients. 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. About 282 pregnant callers have contacted the Kansas Tobacco Quit Line from June 1, 2005 to November 30, 2006, The Tobacco Use Prevention Program provides technical assistance and funding to communities across Kansas who are working to implement comprehensive tobacco use prevention programs. The program provides 1 million dollars in funds to 12 communities through 7 comprehensive tobacco use prevention grants.

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 SAFE KIDS Kansas coalition, and provides local grants and technical assistance to communities to address fire and burn related injuries. Safe Kids Kansas has received several National Safe Kids awards including the Outstanding Public Policy Achievement award in 2006 and the Coalition of Year award in 2005.

They have also received the Bell Sportsmanship Award in 2000, 2001, 2004, 2005 and 2006. 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. Some 17,014 schoolchildren participated in 2006 event. In past 3 to 4 years, on average 17,000 kids have participated in this event each year. 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. Twenty counties are provided with $150,800 in funds through 17 Chronic Disease Risk Reduction grants.

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 local primary care clinics for low-income, uninsured and underserved Kansans. Last year, the Legislature increased state aid to $2,520,840 and the number of state funded clinics increased from 15 to 24. Clinics now serve patients in 20 counties with sites in more than 35 locations across the state. These safety-net clinics reported providing 270,000 patient visits to nearly 95,000 patients in 2005.

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 communities. Applications for additional CHCs (also known as Federally Qualified Health Centers, or FQHCs) have been submitted by clinics in Hutchinson and Newton.

Prescription Drug Assistance Program- In 2005, the Legislature appropriated $750,000 in the KDHE budget to improve access to prescription medication in clinics and health centers through patient assistance programs and implementation of 340B federal drug purchasing programs.

Renewed at the same level in 2006, twenty-two clinics currently receive 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 31 primary care "safety-net" clinics; 1,715 physicians, physician assistants, and nurse practitioners; 331 dentists and dental hygienists; and 653 nursing professionals.

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 2006, 29 primary medical care, 4 dental care and 23 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. Over the past decade, 109 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 83 facilities within 20 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 100 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 (OOH):

The Office of Oral Health 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. The Office of Oral Health was re-established at KDHE and in April of 2006, Dr. Katherine Weno, D.D.S., J.D. was

hired as the Office's Director. Dr. Weno, a dentist and a Medicaid attorney, joins Deputy Director Dawn McGlasson, RDH, BSDH at KDHE. In the last nine months they have begun to build the infrastructure of the Kansas program by designing projects to obtain and analyze state-specific oral health data and providing education and leadership on oral health issues.

Data Collection - Data collection is one of the primary functions of a state oral health office. The Office of Oral Health (OOH) currently has two statewide oral health surveys in progress. First, in order to provide more data on the oral health status of Kansas' children, OOH has mounted its second statewide open mouth survey. Following up on the 2004 Smiles Across Kansas survey, this spring dental hygienists will be visiting schools across the state collecting oral health data on third graders. A second survey is underway regarding the state of Kansas' dental workforce. Information is being collected from Kansas dentists regarding their practice location, patient pool and plans for retirement. Both the open mouth survey and the workforce survey will be complete by September of 2007 and will be widely distributed to all interested parties.

School - Based Sealant Programs - The OOH is working under a $195,000 Health Resources and Services Administration (HRSA) grant to provide school based preventive services including cleanings and sealants to Medicaid eligible children in the Flint Hills Community Center catchment area of Lyon, Chase, Coffey, Osage, and Greenwood counties. In 2007, this project will be expanded to schoolchildren in Barton and Pawnee counties in collaboration with the We Care Clinic in Great Bend.

Fluoride Varnish - OOH received a $100,000 private grant to support the promotion of Fluoride varnish in medical settings. In order to improve the oral health of children under five, two dental hygienists are traveling the state providing education to physicians' offices on importance of oral health preventive services and the application of fluoride varnish at well baby checks.

2007 Oral Health Survey - Using HRSA funds, in 2007 a follow-up to the 2004 survey of Kansas third graders will be done, focusing on specific underserved populations. The new open mouth survey will provide more data on the oral health status of Hispanic and African American children in Kansas.

State Oral Health Plan - In 2006 a Director for the Office of Oral Health was hired. With technical assistance from the Association of State and Territorial Dental Directors and in collaboration with the state oral health coalition, Oral Health Kansas, a statewide oral health plan will drafted in the upcoming year. A State Oral Health Plan is a public health strategic plan to provide an overarching direction or roadmap to systematically address the burden of oral diseases and to enhance oral health of all Kansas citizens. On February 23, 2007, a public oral health planning summit will be held in Topeka to provide public input on the process.

Advanced Education in General Dentistry (AEGD) Program - One of the major successes for oral health advocates last year was the funding of the AEGD program. In order to attract more new dentists to Kansas, last year the legislature appropriated three years of funding for an AEGD program. An AEGD is a post graduate dental residency that gives new dentists another year of advanced training under the supervision of experienced dental faculty. The Kansas AEGD will be located at GraceMed Clinic in Wichita. Another benefit to the Kansas program is that the dental residents will be providing dental services to underserved patients in this clinic. This program is still in the start up phase, with Oral Health Kansas taking the lead as the fiduciary

agent, and Wichita State University as the program administrator. Nearly one million dollars in private matching funds have been raised, and active recruitment is underway for a Program Director. Additional legal and administrative tasks have been completed to clear the way for the first class of residents in fall of 2008.

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 and home health agencies. The programs exist to assure quality care through two primary means -- establishing licensing standards and inspecting facilities to assure both state and federal 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. New inspectors have been added to ensure that both routine licensure inspections and complaint *foster home* investigations are conducted in a timely and professional manner. The number of pending surveys has been reduced from 490 to zero, and at this time all newly assigned surveys are being completed within 90 days, with 80% of initial surveys being completed within 30 days.

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) database to partner agencies. 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 last year to address consistency and effectiveness of actions. The number of administrative orders issued by the department continues to increase. In FY 06, 1,108 orders were issued. The quality of the inspection process and improving consumer relations are being addressed through written protocols and staff training.

Hospital and Medical Program – This program regulates 893 health care facilities, conducting 300 inspections and issuing nearly 50 letters of enforcement each year. This section successfully restructured after the transfer of adult care home responsibility to KDOA. Since FY 04 over 70 new providers have become licensed or certified, with 67 applications pending. CMS has also significantly increased the number of Emergency Medical Treatment and Labor investigations (17 in FY 06).

Health Occupation Credentialing – This program licenses or certifies the following occupations: Adult Care Home Administrators (634) , Dietitians (734), Speech-Language Pathologist (1,553), Audiologist (200), Certified Nurse Aides (45,160),Certified Medication Aides (7,910), Home Health Aides (6,443) Operators (1,591). In addition, this program processed 305,098 inquiries to the Nurse Aide Registry and 26,069 criminal record checks. The credentialing program continues to upgrade systems to provide more and quicker access to credentialing records, including on-line license verification for adult care home administrators, speech-language pathologists, and dietitians.

In the coming months software development will allow online criminal record checks, and for licensees to renew and update information online.

Bureau for Children, Youth and Families (BCYF):

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 Supplemental 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 $7.2M in contracts with 41 local agencies that provide nutrition education/counseling and about $50 million in checks for supplemental food from grocers and other 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 and 50,000 children received well-child checkups and screenings through these programs.

Newborn Screening and Children with Special Health Needs – The state Newborn Screening Program (NBS) assures that every infant born in Kansas (≅ 39,000/yr) obtains screenings for phenylketonuria (PKU), galactosemia, hypothyroidism, sickle cell and hearing. Follow-up on abnormal results is assured with providers and families. KDHE has been working this year in collaboration with public and private entities to develop a plan for expanding the NBS to encompass nearly 30 total conditions. In SFY 06, Children's Developmental Services Section contracted almost $8.6 million to 36 local agencies and organizations to provide Part C of IDEA (tiny-K) early intervention services for over 6,000 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 plus in-house nursing case management, 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 – The purpose of the Senator Stan Clark PMI program is to award grants to non-for-profit organizations for services to enable pregnant women to carry their pregnancies to term. BCYF developed regulations and contract procedures for this initiative. Five organizations were funded for services in 2006.

Bureau of Disease Control and Prevention (BDCP):

The Bureau of Disease Control and Prevention was formed from the previous Bureau of Epidemiology and Disease Prevention. The activities of the bureau encompass programs in Immunization, HIV/AIDS/Sexually Transmitted Diseases (STD), and Tuberculosis Services.

Immunization - Improving childhood immunization rates has been a priority for the Division of Health. KDHE is continuing to follow-up on recommendations made by the 2004 Governor's Blue

Ribbon Task Force on Immunization. As a result of actions taken, Kansas immunization rates for the primary childhood immunization series have moved from 43rd in the United States to 12th. One specific note illustrating progress is the implementation of the statewide immunization registry in Kansas. As of December 2006, 47 local health departments and 67 private providers were using the Kansas web based immunization registry (WEBIZ). There are presently over 700,000 individual patient records documenting over 3.3 million vaccinations within the WebIZ system.

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.

HIV/AIDS/STD - The Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) and Sexually Transmitted Diseases (STD) prevention and control programs provide direct services to persons afflicted with HIV and other sexually transmitted diseases. These sections also perform HIV/AIDS and STD surveillance, allowing accurate monitoring of infection patterns and trends in Kansas, and promoting timely delivery of vital health information to the sex and needle sharing contacts of persons. The HIV/AIDS section administers federal grant programs assuring that persons with HIV disease receive critical medical, social, and pharmaceutical services. The HIV/AIDS and STD sections both support prevention activities within local health departments and other community-based organizations. Through distribution of STD medications, these programs assure that optimal treatment is administered to persons with syphilis, gonorrhea, and chlamydia.

At the end of 2005, Kansas ranked 36th in the U.S. with 2,680 total AIDS cases reported over time and 38th in cases per hundred thousand population. As of June 2006, the Centers for Disease Control and Prevention estimated Kansas rates of infection for HIV without an AIDS diagnosis at 52 per hundred thousand population and for those with an AIDS diagnosis at 53.6. The Kansas Ryan White Title II AIDS Drug Assistance Program served approximately 55% of all known diagnosed cases in the state.

As of 2004 (most recent CDC data), Kansas' 24 cases of syphilis ranked 38 among 50 state and territories. The rate of 0.9 cases per hundred thousand population ranked 37th. The U.S. rate was 2.7 cases per hundred thousand.

Tuberculosis - The Tuberculosis program seeks to assure that proper screening and treatment for tuberculosis occur in Kansas. Program staff serve as expert resources for local health departments and other providers who deliver care to persons with tuberculosis and their contacts. Program staff conduct training courses across the state to maintain a high degree of competence in tuberculosis care. The program provides medications to assure proper treatment of patients with infectious tuberculosis. The program has also taken on Hepatitis responsibilities for the state.

As of the end of 2005, Kansas ranked 34th in the United States with a case rate of 2.2 per hundred thousand population. This compares to the national rate of 4.8 per hundred thousand.

Office of Surveillance and Epidemiology (OSE):

The Office of Surveillance and Epidemiology was created from the previous Bureau of Epidemiology and Disease Prevention. The Office is charged with investigating clusters of diseases and disease outbreaks, and tracking reportable infectious diseases. 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. Staff in the OSE also work with public health preparedness staff to develop response plans to pandemic influenza and other public health emergencies.

The OSE was responsible for the investigation, follow up and recommendations for containment of a large, multi-state mumps outbreak that infected more than 900 Kansans. OSE staff also led in the investigation of several enteritis outbreaks (characterized by vomiting and diarrhea), including one that involved 850 participants of Bike Across Kansas.

A new web-based, user-friendly disease investigation system, which will maximize efficiency at the state and local levels when communicable diseases are found, in currently in development. Test sites have been selected for deployment in early 2007. An environmental epidemiology program to track indicators of environmental health is also in progress.

Bureau of Consumer Health (BCH):

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 provide 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. 10,490 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 40% of food service establishments. A total of 16,844 inspections were conducted in food service establishments statewide. 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 treat poisoned adults and children, and educates the public about exposure to lead hazards. In 2006, the Childhood Lead Prevention Program served approximately 27,717 children between 0-6 years old in blood lead screening and prevention activities. 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. To date, 313 environmental inspections have been conducted and 302 homes have been cleared of lead paint hazards.

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, is studied to determine trends. The goal of the Center for Health and Environmental Statistics is to provide vital records, data and information to the agency, the public, policymakers, program managers, and researchers.

Office of Vital Statistics- The core of the Vital Statistics system is a web-based application for internal and external processing, providing access to hospitals, funeral homes, and courts across the state. Phase II of the re-engineering of the Vital Statistics Integrated Information System (VSIIS) has been completed, and fully 90% of Kansas birthing facilities and 50% of Kansas funeral homes are using the VSIIS system for filing vital records. Phase III of the VSIIS, the Electronic Death Registration System (EDRS), is underway. The EDRS will permit electronic filing of death certificates with electronic signatures, expedite notification of fact of death to the Social Security Administration (SSA) and other external partners, and provide more timely customer service to funeral homes and families requesting certified copies of death certificates. Over 10 million vital records are maintained in the Vital Statistics database. In FY 2006, over 93,000 new vital records were added and over 390,000 certified vital record copies were issued.

Office of Health Assessment- During FY 2007, the Office of Health Care Information (OHCI) experienced a change in role and function as a health data collection and dissemination entity for Kansas State government. During 13-year tenure, OHCI was responsible for vital statistics analyses, publication and dissemination, trauma registry development, and health insurance, Workers Compensation, health professional and hospital discharge data collection and analysis. With the creation of the Kansas Health Policy Authority (KHPA), KDHE's responsibility to collect data identified for the health care database and the Kansas Health Insurance Information System (KHIIS) was transferred January 1, 2006. Subsequently, the Office of Health Assessment was created with the responsibility to provide support to the Division of Health and the public health community with research and analysis of the various sources of health data within Kansas. Current efforts involve continued publication of Kansas health reports, as well as expanding health information available to the public through the Kansas Information for Communities (KIC) internet query tool, developing interfaced health and environment GIS capabilities, and preparing district-specific data for legislators on local health status.

Center for Public Health Preparedness (CPHP):

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. The Center continues its work in all-hazards preparedness in close collaboration with the state's local health departments, hospitals, the Adjutant General's Department, and the Kansas Highway Patrol. The work of the Center and our partners has been nationally recognized, as the 2006 Trust for America's

Health Report "Ready or Not? Protecting the Public's Health from Diseases, Disasters, and Bioterrorism" ranked Kansas as second in the nation in public health preparedness.

Two supplemental pandemic influenza planning grants totaling $3.3 million were received from the Centers for Disease Control and Prevention (CDC) during 2006. Priorities included work in improving disease surveillance and laboratory capacity; planning, training, and exercising at all levels; public education focusing on seasonal influenza; and outreach with the state's four Native American Tribes, which, for the first time, have started to collaborate with CPHP staff for pandemic flu and all-hazards preparedness.

The Cities Readiness Initiative (CRI) was launched in Kansas during 2006. CDC funding was provided to the Kansas City Metropolitan Statistical Area (MSA), which includes Franklin, Johnson, Leavenworth, Linn, Miami, and Wyandotte Counties, and to the Wichita MSA, which includes Butler, Harvey, Sedgwick, and Sumner Counties. The CRI mission is to rapidly improve the readiness of metropolitan areas to receive and dispense life-saving antibiotics/vaccines to all residents within 48 hours of a disaster.

Center for Health Disparity (CHD):

Formerly known as the "Office of Minority Health," CHD was established as a multidisciplinary function to address health disparities in racial and, ethnic populations throughout the state. The Center's mission is "to promote and improve the health status of racial, ethnic and tribal populations in Kansas by advocating for and coordinating access to primary and preventive services that are effective, efficient and culturally and linguistically appropriate."

Along with a 23 member Advisory Committee to provide input in the strategic planning process, the Center has completed its first phase of infrastructure development with an award from the National Offices of Minority Health State Partnership Infrastructure Planning Program. The CHD has been charged with a leadership role in the mobilization of available health resources, programs and initiatives that equitably serve racial, ethnic and tribal populations in Kansas.
Many initiatives have been planned for 2007:

Annual MLK Health Disparities Breakfast - January 2007
Health Equity Conference - April 2007
Cultural Competency Training - August 2007
Building Coalitions Among Communities of Color - November 2007

Other Divisions within KDHE

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 five bureaus and the division as a whole. The Bureau of Water, conducts regulatory programs for public water supplies, waste water discharges both industrial and municipal and confined animal feeding operations. These activities are performed under the Clean Water Act and Safe Drinking Water Act and corresponding state statutes. The Bureau of Waste regulates solid and hazardous waste facilities. This work is performed under the Resource

Conservation and Recovery Act and state statutes. The Bureau of Air and Radiation regulates air emissions and asbestos under the federal Clean Air Act and state statutes. The use of radioactive materials is regulated according to the Nuclear Energy Development and Radiation Control Act under agreement state status with the federal Nuclear Regulatory Commission. The Bureau of Environmental Remediation primary regulatory function is for storage of refined product under RCRA. In addition, this bureau also functions as the primary environmental cleanup program under the Comprehensive Environmental Response, Compensation and Liability Act, CERCLA and related federal and state statutes. Activities in remediation of mining legacy sites are conducted under the Surface Mining Control and Reclamation Act and state statutes. The Bureau of Environmental Field Services conducts most of the regulatory inspections for the other four bureaus. They also conduct activities to assess water quality and stream classification in surface waters.

In addition to regulatory programs, 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. The Division of Environment also provides financial assistance for infrastructure across the state through the Public Water Supply Revolving Loan Fund and the Water Pollution Control Revolving Fund. These loan programs provide approximately $100 million in new loans each year. The Pollution Prevention Program provides technical assistance to the regulated community to help ensure compliance. Many of the regulatory programs also routinely work with the regulated community to assist with compliance issues. The Division of Environment works closely with the federal agencies including the Environmental Protection Agency, and other state partners to preserve the state's natural resources.

The Division of Health and Environmental Laboratories (DHEL)

The Division of Health and Environmental Laboratories provides clinical and environmental testing in support of KDHE programs. The clinical laboratories also serve as a reference laboratory for local public health laboratory facilities and are a member of the national laboratory response network. The services provided include newborn screening for genetic disorders, infectious disease detection, chemical and radiological environmental testing, childhood blood lead prevention analysis, and emergency preparedness for detection of biological, chemical and radiological agents.

The DHEL provides certification for clinical and environmental laboratories providing services to Kansas and support for law enforcement agencies through the breath alcohol program.