State Title V Block Grant Narrative

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Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (http://www.mchdata.net).

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Federal Form 424

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1.4 Overview of the State

Geographic Characteristics Kansas has a land area of 82,282 square miles that includes lakes, major river basins, and a land of geologic diversity producing oil and gas, helium, large salt deposits, and areas previously mined for coal and lead. The land is relatively dry, but has large underground aquifers that have allowed irrigation and abundant agricultural productivity. It is bordered on the East by Missouri, on the North by Nebraska, on the South by Oklahoma, and West by Colorado. There are two time zones in Kansas with the western most counties in the mountain zone. Visitors to Kansas are impressed with the wide openness of the Kansas plains and apparent flatness. In fact the topography is quite varied with elevations starting at 700 feet in Eastern Kansas and rising to nearly 5,000 feet in the West towards the Rockies.

Population Kansas' population of about 2.5 million is about 1% of the U.S. population. Although the population of Kansas grew 2.9 percent from 1994 to 1998 (2,554,047 to 2,629,067), the growth across the state is not even, ranging from a high of +11% in Butler County to a low of -18.4% in Geary County. The rate of natural increase has decreased over this period of time. There are approximately 32 people per square mile in Kansas compared with about 72.4 in the U.S. Thirty-one of the state's 105 counties have population density less than six persons per square mile. The four counties with major population centers make up 28% of the state's population. The ethnic/racial distribution for the State is 86.7% White Non-Hispanic, 5.9% African American, 4.8% White Hispanic, 1.8% Asian/Pacific Islander, and 0.9% American Indian/Alaska Native. (1998 Census estimates)

Per Capita Income and Poverty About 13% of Kansas families live at or below the federal poverty level. Poverty is more common in families headed by single females. This is particularly true if there are children under the age of five in the household, regardless of race or ethnicity. The percentage of school age children below the poverty level is 13% for Kansas. Most children in poverty live in three population centers: Sedgwick Co. (Wichita), Wyandotte Co. (Kansas City, KS) and Shawnee Co. (Topeka). Educational attainment for Kansans is favorable compared to the U.S. at 87.7% and 81.7% respectively.

Health Care Delivery Environment The goals for health care delivery in Kansas are: to engage communities in prevention and improvement of health, to expand health care insurance coverage for all of the citizens who are uninsured or underinsured, and to make health services available through a medical home to people in even the more remote areas of the state while maintaining

services of high quality. Kansas strives for a seamless system, coordinated locally, but with the potential of applying the most sophisticated and highly technical skills. Since 1995, the health care delivery environment has been altered through capitation programs, the privatization of certain services, and a managed care environment. It is in the context of this backdrop that the Title V programs function.

Historically public health clinical services in Kansas have been delivered in large part by local county or multi county health departments (97 county health departments in 105 counties). Services are moving away from the health departments as a result of funds shifting to MCO's through the State's Medicaid and State Child Health Insurance Program (SCHIP).

Role of the Kansas Maternal and Child Health Program The Kansas Department of Health and Environment (KDHE) as the state Title V agency is continuing to play an essential role in assuring that services to mothers and children are both accessible and of high quality. As the State Title V Agency, KDHE has the responsibility for monitoring the changes in health care delivery, reviewing the impact of Medicaid and CHIP as they are modified and implemented, and making recommendations to assure that infants, youth and mothers receive comprehensive, needed, and appropriate services in a timely and effective manner.

The KDHE directs its programs to local communities focusing on causes of poor health rather than the specific problems themselves and to the extent possible, with broad community involvement. Some examples follow:

1. Kansas Children's Cabinet
2. State Child Death Review Board
3. Advisory Commission on Children with Special Health Care Needs
4. Kansas Commission on Disability Concerns (ADA)
5. Kansas Council on Developmental Disabilities
6. Public Health Improvement Plan
7. Kansas Association of Local Health Departments
8. SAFE Kids
9. Coordinating Council on Early Childhood Developmental Services
10. Kansas Chapter, American Academy of Pediatrics
11. Perinatal Association of Kansas
12. American College of Obstetrics and Gynecology, Kansas Chapter

Current Priorities or Initiatives

Tobacco Litigation Settlement The 1999 Legislature passed HB 2558 which established the Kansas Endowment for Youth (KEY) Fund, a trust fund administered by the Board of Trustees of the Kansas Public Employees Retirement System. One hundred percent (100%) of the funding received from the tobacco litigation settlement will be deposited into the KEY Fund.

It established the Children's Initiatives Fund, which will receive fund transfers from the KEY Fund. Expenditures from the Children's Initiatives Fund will be used for additional funding for programs, projects, improvements, services, and other purposes directly or indirectly beneficial to the physical and mental health, welfare, safety, and overall well-being of Kansas children.

Allocations from the Children's Initiatives Fund will emphasize programs and services that are data-driven and outcomes-based and may target programs and services that combat community-identified risk factors associated with children and youth becoming involved in tobacco, alcohol, drugs or juvenile delinquency.

Programs funded must have a clearly articulated objective and must demonstrate that the program's design is supported by credible research, that the program will constitute best practices in the field, that data is available to benchmark the programs desired outcomes, and that an evaluation and assessment component is part of the program design. Evaluations must be capable of determining program performance, needed program modifications to enhance performance, ways in which the program could be modified for transfer to other venues, and when performance no longer justifies funding.

Community programs must demonstrate the availability of sufficient community leadership and capacity to appropriately implement and administer the program that is funded. If community mobilization is necessary to achieve program objectives, a specific strategy must be demonstrated.

Moneys allocated or appropriated from the Children's Initiatives Fund cannot be used to replace or substitute for moneys appropriated from the State General Fund in the immediately preceding fiscal year.

The bill established the Kansas Children's Cabinet to review, assess, and evaluate all uses of the moneys in the Children's Initiatives Fund. The Cabinet will initiate studies, assessments, and evaluations, by contract or otherwise, through institutions of higher education and other appropriate research entities to identify best practices and to measure and otherwise determine the efficiency and efficacy of programs.

The existing Advisory Committee on Children and Families was abolished and those members comprise six of the 15 members of the Kansas Children's Cabinet.

Child Health Insurance Program (HealthWave) The 1998 Kansas legislature passed a law requiring the Secretary of the Department of Social and Rehabilitation Services (SRS) to develop and submit a plan for insurance coverage for Kansas children under the federal Title XXI program, otherwise known as CHIP or SCHIP. The statute specified that the Kansas plan contain the following: capitated managed care; coverage for children from zero to 19 years; benefit levels at least equal to those for the EPSDT program; continuous eligibility for 12 months; performance-based contracting with measurable outcomes indicating age-appropriate utilization of services (immunizations, vision, hearing and dental exams, emergency room utilization, annual physical exams and asthma).

The Kansas HealthWave program began providing services January 1, 1999, utilizing two health plans--Family Health Partners and Horizon Health (became First Guard Health Plan 4/1/99). Each plan subcontracts for dental services. Mental health services are provided statewide by the Mental Health Consortium. CSHCN staff work closely with both SCHIP health plans. The SHS health care plans are shared with the SCHIP plans when they are completed and SHS staff work to assure that families use the appropriate network providers.

KDHE staff have worked closely with SRS in providing outreach to eligible families through MCH/CSHCN programs, including Healthy Start Home Visitors program. KDHE staff have been involved in task forces such as "The integration of Medicaid and HealthWave." Both health plans allow clients to receive the following services from local health departments without referral: family planning, STD, TB, and immunizations.

Kansas Department of Social and Rehabilitation Services was awarded a grant from the Robert Wood Johnson Foundation. The "Kansas Covering Kids Project" provides comprehensive outreach strategies in order to maximize access to health care resources available to eligible children (Medicaid, HealthWave and private insurance).

Medicaid Managed Care The Kansas Department of Social and Rehabilitation Services (SRS) the state agency with responsibility for the Medicaid program was mandated by the Kansas Legislature to implement managed care programs statewide by July 1, 1997. To meet this goal, the Secretary of SRS established a statewide implementation Committee in January 1994 as well as local community workgroups, to solicit input and recommendations from the community, medical

providers and Medicaid beneficiaries and advocates. Responding to community input, SRS developed and is implementing two different programs: Health Connect Kansas and PrimeCare Kansas waivers. Implementation for the two approved programs which began in July 1995 is now complete. Goals of the managed care program are: improve service quality; increase access to care; contain cost increases; communicate with interested parties; ensure and protect beneficiaries dignity and rights.

Medicaid managed care contracts have language requiring the HMO to contact KDHE and follow CSHCN program advice on referral and coordination of care for those children enrolled in both Title XIX and Title V. Referrals are obtained from the HMO primary care physician to direct the care and the child's health care plan is shared with both the HMO and primary care physician.

Health Connect Kansas	***PrimeCare Kansas***
12/99 Enrollment - 78,506 (76%)	*12/99 Enrollment - 24,738 (24%)*
Primary Care Case Management Model	*Capitated Payment Model*
Fee-for-Service, plus Case Management Fee	*Contracts with Licensed HMOs*
Eligibility Groups	* *First Guard Health Plan*
* *TANF*	*Eligibility Groups*
* *Poverty Level PG Women/Children*	* *TANF*
* *SSI (Aged and Disabled)*	* *Poverty Level PG Women/Children*
* *General Assistance/MediKan*	*Beneficiaries Excluded*
Beneficiaries	* *Long-Term Care*
* *Long-Term Care*	* *Foster Care Children*
* *Foster Care Children*	* *General Assistance/MediKan*
* *3rd Party Insurance with Case*	* *SSI (Aged and Disabled)*
Management	* *HIPPS*
* *Spenddown*	* *Spenddown*
* *Medicare Eligible*	

Medicaid Managed Care for Pregnant Women With the implementation of HMO managed care for Medicaid beneficiaries, there was a need to assure the availability of collaboration between the

HMO's and local health departments and education of local public health prenatal care providers of the changes in managed care systems.

Collaboration has been between and among KDHE (Maternal & Infant and Healthy Start) Health Care Policy of SRS, and three HMOs until December 31, 1998. As of January 1, 1999, First Guard Health Plan is the only HMO contracting with the State of Kansas to provide services to Title XIX (Medicaid) beneficiaries. Information has stressed an orientation of HMO staff assuming the responsibility to develop methods to provide selected non-medical care components of comprehensive prenatal care services and post discharge mother/baby unit follow-up. HMO quality studies focus on prenatal care and prevention of first year of life problems.

Welfare Reform The Kansas social services agency (SRS) is responsible for implementation and monitoring of the federal Temporary Assistance for Needy Families (TANF) Welfare Reform Program. Kansas initiated its program in October of 1996. The program restricts families to a lifetime benefit limit of five years. Families who have been on the program continuously since 1996 have already used more than half of their 5-year lifetime benefit limit. A second group of families has received assistance sporadically. They find employment but for various reasons do not retain their jobs. These are also approaching their lifetime benefit limit as they cycle on and off assistance. Significant barriers to employment for both groups of families include disability, domestic violence, financial emergencies, poor work skills, housing instability, lack of health insurance, mental illness, substance abuse, inadequate transportation and lack of specialized child care. Beginning in October of 2001, families will begin losing welfare benefits having exceeded their 5-year lifetime benefit packages. They may seek resources elsewhere potentially posing a significant challenge to State service systems. To assess system capacity and to assure a coordinated system of service delivery for the challenges ahead, SRS is convening a diverse group of individuals representative of state and local government, business, educational organizations, emergency service providers, advocacy groups and community agencies. SRS has resurrected the KanWork Interagency Coordinating Committee (KWICC), established by legislation several years ago, adding ex-officio members and utilizing this meeting forum to promote necessary coordination. .

New Appropriations-2000 Session During the 2000 legislative session, the legislature appropriated funds from the tobacco settlement money for Teen Pregnancy Prevention with an emphasis on program evaluation, and Health Start Home visitor program to complete the statewide

expansion. TeleKid Health Care, at Kansas University Medical Center was also funded by the tobacco settlement money. The legislature expressed a need to continue the Pregnancy Maintenance Services (provides enhanced supportive services for pregnant woman), but provided no funding.

1.5 The State Title V Agency

1.5.1 State Agency Capacity

1.5.1.1 Organizational Structure

There was no organizational structure changes in FFY99.

Legislation/Statutes relevant to Title V Program Authority

Federal Legislation BCYF administers the following federal programs:

- Title V of the Social Security Act, the Maternal and Child Health Services Block Grant as amended through January 1, 1991. Section 510 creating a "Separate Program for Abstinence Education."
- Title X of the Public Health Service Act -- Population Research and Voluntary Family Planning Programs, 1970.
- Section 17 of the Child Nutrition Act of 1966 as amended by P.L. 94-105 enacted October 7, 1975. USDA, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) as amended 1985, 1989, 1993, 1994.
- Part 247, Commodity Supplemental Food Program, Food and Nutrition Service Act, USDA, as amended August 1988.
- Title XIX, Part A of the Public Health Service Act – Preventive Health Block Grant (funding allocated to teen pregnancy prevention, child health, and home visiting).
- P.L. 99-457 Title I, Education of the Handicapped Act amendments of 1986: Part H - Handicapped Infants and Toddlers; P.L. 102-119 Individuals with Disabilities Education Act amendments of 1991: Part H - Early Intervention Program for Infants and Toddlers with Disabilities; P.L. 105-17 Individuals with Disabilities Education Act amendments of 1997: Part C - Early Intervention Program for Infants and Toddlers with Disabilities.

State Statutes relevant to BCYF program authority. For each of the following state statutes the BCYF directly administers and/or plays a key role in coordination and implementation.

- KSA 65-101 and 75-5601 - General supervision of the health of the citizens of the state by the Secretary of the Kansas Department of Health and Environment, BCYF is assigned responsibility for the general health and well-being of mothers and children.
- KSA 65-153 - The duties of the Division of Child Hygiene established by statute in 1915 were placed under the Division of Health in 1974 when the KDHE was reorganized. Functions include: issuance of educational literature on the health and care of infants and children, application of preventative measures for the prevention and suppression of the diseases of infancy and early childhood, and infant mortality studies. These general provisions of the law are the responsibility of the BCYF.
- KSA 65-5a01 et. seq. as amended - The original Crippled Children's Commission established in 1931 was transferred to the KDHE in 1977. In 1988 the law was changed replacing the term "crippled children" with "children with special health care needs." The definition of a special needs child according to KSA 65-5a01 is an individual under twenty-one (21) years of age, who has an organic disease, defect, or condition which may hinder the achievement of normal physical growth and development. BCYF administers this program.
- KSA 23-501 thru 23-502 - Kansas Family Planning Law (1965) requires the KDHE to conduct a program of family planning information and services in cooperation with local county health departments and the Department of Social and Rehabilitation Services (SRS). BCYF administers the Title X program and coordinates with Medicaid to ensure statewide availability of affordable services.
- KSA 65-501 thru 65-520 (1919) - Inspection, licensure, and supervision of all maternity homes and child care facilities. 65-503 was amended by the 1980 legislature to permit registration of day care homes caring for six or fewer children. BCYF coordinates with Child Care Facilities Inspections & Licensing to develop guidance, consultations and inspections.
- KSA 65-176 - Inspection of sanitary conditions and health supervision at state child institutions and reporting to the Governor and Legislature. BCYF coordinates with Child Care Facilities Inspections & Licensing in developing guidance, consultations and

inspections.

- KSA 65-153f thru 65-153h - Prenatal serological test for syphilis. BCYF provides consultation to hospitals.
- KSA 65-153b thru 65-153d - Prophylaxis for eyes of newborns against infection from gonorrhea. BCYF provides consultation to hospitals.
- KSA 65-177 thru 65-179 - Confidentiality of research studies relating to morbidity and mortality for maternal, perinatal, and anesthetic causes. BCYF conducts and assists Epidemiology in research.
- KSA 65-180 thru 65-183 - The newborn screening for PKU was enacted in 1965 and provides for newborn testing, educational programs, provision of diet, and required reporting of the disease to the KDHE. It was amended by the 1977 Legislature to include hypothyroidism and in 1984 galactosemia was added. The 1985 Legislature centralized testing in the State Laboratory. BCYF coordinates with the State Laboratory to administer the screening and followup of this program and provides diagnostic followup and provides treatment product for eligible individuals.
- KSA 65-1,105 thru 65-1,106 - Sickle Cell Program. The KDHE is required to establish a statewide sickle cell screening program and assure that diagnosis, counseling, follow-up research are provided (1973). In 1978 the law was expanded to include treatment for persons in financial need and to provide information through schools for the population at risk. BCYF administers this program.
- KSA 65-1,131 thru 65-1,134 - Hemophilia Program. This provides the factor for a home treatment program; no age limitations; consumers participate in the regional hemophilia program supported through MCHB. BCYF administers this program.
- KSA 74-7801 - Coordinating Council on Early Childhood Developmental Services established in 1986. This Council serves as the advisory body to both KDHE's 0-3 program under P.L. 99-457, initiated in 1987, and Part B of IDEA 3-5 administered by the Department of Education. .
- KSA 65-202 - Annual school inspections are required to be performed by local health officers. The Department coordinates the program and issues standards and reporting forms.
- KSA 72-5208 thru 72-5211 - Certification of immunization for school entrance. BCYF

coordinates with the state immunization program to assure availability at the local level (local Title V projects participate), and assist with training, development of guidance materials, and immunization promotion activities.

- KSA 72-5204 thru 72-5206 - Vision screening of school children. BCYF coordinates annual training and update of school nurse skills, development of guidance in cooperation with universities.
- KSA 72-5213 - Certification of health for school personnel. BCYF provides consultation to school districts and citizens, health assessment guidance and forms.
- KSA 72-5201 thru 72-5203 - Annual dental inspection of school children. BCYF coordinates with the State Dental Association to obtain data, with Epidemiology to assist providers in organizing local programs, provider education and health promotion strategies.
- KSA 72-1204 thru 72-1207 - Hearing screening tests of school children. BCYF provides annual school nurse training, consultations to providers and guidance materials.
- KSA 65-425 thru 65-433 - The hospital licensing act (relating to maternity, newborn nursery, and pediatric units). BCYF coordinates with Bureau of *Health Care Regulations* on perinatal issues and provides direct consultation to hospitals and other providers.
- KSA 65-2701 thru 65-2704 - Food and Drug Laws and Hazardous Article Law as they affect children. MCH coordinates with the Bureau of *Consumer Health* on lead poisoning prevention activities and other environmental concerns.
- KSA 65-2401 thru 65-2437 - The Uniform Vital Statistics Act as it relates to births, fetal deaths, maternal, infant and child deaths, adoptions and termination of pregnancy. MCH coordinates with the Office of Vital Statistics on MCH-related data, legislation and other information needs.
- Kansas Statutes and Regulations Regarding Communicable Disease and Control, (a compilation of laws and regulations published by KDHE). MCH assists Epidemiology in updates of this guide.
- KSA 21-3407 and 65-443 thru 65-445 - Abortion laws which include required reporting by hospitals on forms designated by KDHE. Reporting was expanded in 1998. MCH provides consultation to Vital Statistics as needed.
- KSA 38-1521 thru 38-1522 - Child Abuse Laws administered by Department of Social

and Rehabilitation Services. MCH coordinates with SRS in strategies to address child abuse including the planning committee for the annual Governor's Conference on Child Abuse and Neglect.

- KSA 8-1344 through 8-1347 - Child Passenger Safety Act restraining systems for children under the age of four; use of seat belts, by children between the ages of five and fourteen. MCH coordinates with the Office of Injury/Disability Program in Bureau of Health Promotion on this program.
- KSA 65-1,157a - Newborn Hearing Screening program, enacts the newborn infant hearing screening act, and repeals K.S.A. 65-1,149 thru 1,157. The general provisions of the newborn hearing screening act are the responsibility of the BCYF.
- KSA 65-1,158 (1991) Community-based teenage pregnancy reduction program. MCH provides grants, guidance and oversight to local agencies to conduct community programs.
- KSA 72-5125 (1992) School Breakfast Program for the establishment and maintenance of a school breakfast program under which breakfasts are made available to pupils in attendance at school. MCH through the WIC program provides coordination with this Education program.
- KSA 65-1,160 (1992) Preconception and Perinatal Programs establishing a public awareness program on effects of tobacco, alcohol, drugs; Educational materials and guidance for health care providers. In collaboration with local providers and the state Alcohol & Substance Abuse Program, MCH provides educational materials and programs for perinatal providers, assists with standards for treatment facilities that care for pregnant women.
- KSA 75-5648 - 49 (1993 Supp.) Infant Toddlers with Disabilities defining early intervention services; rules and regulations; duties of secretary of health and environment. MCH provides oversight and coordination with this program.
- KSA 72-5214 (1994) Child Health Assessment at School Entry. Every pupil who has not previously enrolled in any school in this state prior to admission to and attendance in school, shall present the appropriate school board results of a health assessment. MCH consults with providers, trains certified nurses, and provides sample health assessment forms.
- KSA 22a-233 thru 22a-238 (1994) - Autopsies by coroner required for any child (under

age 18) who dies of an unexplained death with reimbursement for expenses by BCYF, originally enacted in 1988 with focus on autopsies for SIDS determination. Established a state Child Death Review Board in Judicial Branch. MCH provides reimbursement to coroners and consultation to the Board.

- KSA 65-6701, Sect. 25-28 - Women's Right to Know Act. KDHE shall cause to be published and distributed widely easily comprehensible printed materials in English and Spanish informing a woman about her options prior to an abortion with an annual update. Originally passed in 1997 with revisions in the 1998 legislative session. MCH develops and distributes materials.
- KSA 65-508b - Smoke Detector Act (1998). Mandating smoke detectors in single family dwellings on every floor. MCH programs provide education and distribution of devices during home visits.
- KSA 65-1,201 through 1,214 - Residential Childhood Lead Poisoning Prevention Act (1999) Establishes a program and authorizes KDHE to establish rules and regulations. BCYF coordinates with this program in training of local health department personnel in risk assessments and screens.
- KSA 38-1808 and KSA 38-1808a addresses the disposition of the tobacco litigation settlement. See pp. 5-7 for the details of that legislation.

1.5.1.2 Program Capacity

The Division of Health, is one of four divisions within KDHE. The Bureau for Children, Youth and Families (BCYF) which administers Title V, Maternal and Child Health Block Grant is located in this Division. The Bureau is comprised of four Sections: Children & Families Section (Women's Health Services, Services for Pregnant Women & Infants, and Services for Children & Adolescents); Services for Children with Special Health Care Needs (CSHCN) called the Special Health Services (SHS) Section; Children's Developmental Services (Newborn Screening, Infant Toddler Services, and Newborn Infant Hearing Screening); and The Nutrition and WIC Services Section.

The Children & Families Section includes the following programs:

- Maternal and Infant/Perinatal Program - Improves pregnancy outcomes for mothers and infants, promotes early entry into and compliance with prenatal, postpartum and newborn

care, and decreases pregnancy recidivism, especially for adolescents.

- Child and Adolescent Health Program - Optimizes the health of Kansas children through access to primary and preventive services of high quality.
- Healthy Start Home Visitors - Enables families to become healthier and more self sufficient by improving their access to early intervention services through outreach and at-home interventions to reduce the incidence of abuse and neglect.
- School Health Program - Enhances the educational process by the modification or removal of health-related barriers to learning and by promotion of an optimum level of wellness among school age children, youth and school personnel.
- Teen Pregnancy Prevention Program - Reduces the negative economic, health, educational, vocational and social consequences of adolescent pregnancy and parenting for youth and their communities by reducing the incidence of first and subsequent pregnancies among Kansas adolescents.
- State Systems Development Initiative - Enhances the data capabilities of the State Title V MCH and CSHCN programs through assistance with needs assessment, surveillance systems, development of systems measurements and performance indicators, and through coordination of activities to inform the public and professionals about maternal and child health issues.
- Abstinence Education Program - Reduces out-of-wedlock live births, teen pregnancies and provides education regarding statutory rape through educational or motivational programs teaching abstinence from sexual activity.
- Women's Health Care and Family Planning Program - Provides individuals with the information and means to determine the number and spacing of their children through comprehensive women's health services with priority to those unable to afford them.
- Pregnancy Maintenance Initiative - Provides case management services for pregnant women for the purpose of assisting these women to carry their pregnancies to term.

The Special Health Services Section includes the following programs:

- Services for Children with Special Health Care Needs - Promotes the functional skills of young persons in Kansas who have a disability or chronic disease by providing or supporting a system of specialty care for children and families including specialized

services and service coordination, quality assurance, and community field offices.

- Make a Difference Information Network - Assists children and adults including those with disabilities, their families and service providers to access information and obtain appropriate resources. Serves as the MCH toll-free line.

The Children's Developmental Services Section includes the following programs:

- Infant-Toddler Services (Part C of IDEA) - Promotes the early identification of developmental delay and disorders through child find, services coordination (case management), resource referral and development, and direct service provision for eligible infants and toddlers and their families.
- Newborn Screening - Assures early identification and intervention for infants with PKU, galactosemia, hypothyroidism and sickle cell.
- Newborn Infant Hearing Screening - Assures early identification of significant hearing loss in newborn infants.

The Nutrition and WIC Services Section includes the following programs:

- Nutrition Services - Improves the health and nutritional well being of Kansans through access to quality nutrition intervention services including educational materials, consultation services, program coordination and referrals.
- The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) - This program, now in its 26th year, provides nutrition education, breastfeeding promotion and support, substance abuse education, nutritious supplemental foods, and integration with and referral to other health and social services.
- The Commodity Supplemental Food Program (CSFP) - This program improves the nutritional health status of eligible women, infants, children, and the elderly over age 60 through supplemental foods and nutrition education.

1.5.1.3 Other Capacity

See Section V, Supporting Documentation for organizational charts and listing of FTEs within the state agency that are funded by MCH Block Grant funds.

Brief biographies of senior level management employees in lead positions.

Clyde D. Graeber Secretary of the Department of Health and Environment. Mr. Graeber had formerly served as Acting Secretary of the Department of Health and Environment, State Treasurer, Legislative Liaison on the Governor's staff, a dozen years in the Kansas House of Representatives, six years on the Leavenworth City Commission including two years as Mayor. During his tenure in the Legislature, Mr. Graeber served as Chair of the Federal & State Affairs and Commercial & Financial Institutions Committees. He served as alternating chair of the Joint Committee on Indian Gaming Compacts and was a member of the special KPERS Investigative Committee. Mr. Graeber also chaired the House Republican Caucus. Mr. Graeber is retired as President & Chief Executive Officer of the Leavenworth National Bank & Trust Company. He earned an undergraduate degree and a law degree from the University of Tulsa, Oklahoma.

Dr. Michael Moser is the Director of Health, a position he has held since 1999. Previously, he served as the State Epidemiologist in both Kentucky and North Carolina. Dr. Moser has held faculty appointments as an Associate Professor at the University of Kansas and at the University of North Carolina School of Public Health, an Assistant Professor of Internal and Preventive Medicine at Ohio State University, and a Clinical Instructor at the University of Kentucky College of Medicine. He received his medical degree from the University of Kentucky, holds an MPH degree from the University of North Carolina, and a Bachelor of Science degree from the University of Dayton. Dr. Moser has been elected to Fellowship with the American College of Preventive Medicine.

Cassie Lauver*,* is the Kansas Title V Director. She has served as the Director for the Bureau for Children, Youth and Families at the KDHE since 1994. Before becoming Bureau Director in 1994, she directed the State CSHCN Program from 1984 to 1994. Prior to 1984, her work included Director of Missouri Division of Family Services for Omni Care Health Services, Inc., Child Protective Service Worker, Missouri Division of Family Services, and Communications Instructor, Taipei, Taiwan, Republic of China. Cassie has served on a variety of committees, boards and workgroups: Department of Defense/MCHB Task Force on CSHCN; Systems Development Workgroup; national CSHCN/SSI Workgroup; ACCESS-MCH Advisory Board; Kansas Commission for the Deaf and Hearing Impaired; Management Team for the LEND Program; and the Prevention of Disabilities Advisory Commission. She was elected as president-elect of AMCHP in 1999. In addition, she has served on both the planning committee and as faculty at the Public Health Social Work Institute, University of California, Berkeley.

Jamey Kendall is the State CSHCN Director. She has a Bachelor of Science degree in Nursing from Wichita State University. Since 1997 she has served as Director of CSHCN. Prior to 1997, she worked as a CSHCN nurse consultant (1989-1997), pediatric staff nurse at Stormont Vail Regional Medical Center in Topeka, case manager for a Visiting Nurse Service in Fort Wayne, Indiana, and home visitor for high risk infants and families with the Wichita health department. Jamey is involved with the Kansas Commission on Disability Concerns, the Kansas Chapter of American Academy of Pediatrics Subcommittee for Children with Special Health Care Needs, Kansas Executive Board for Emergency Medical Services for Children, Task Force for Local Education Agencies, EPSDT Advisory Board, Assistive Technology for Kansas Advisory Board, Kansas Asthma Coalition, Professional Development Institute, Head Start Collaboration stakeholder, Steering committee for office of Special Education Programs and Healthy Child Care Kansas.

Lori Michel has been the Director of Children's Developmental Services Section since 1994. From 1988 to 1994, she coordinated speech-language-hearing-vision services for the Infant-Toddler Program at KDHE. Prior to 1988 she worked as Assistant Director of the Student Assistance Center at the University of Kansas, and as Assistant Professor and Director of the Speech-Language-Hearing Clinic at the University of Kansas. She has served on a number of national and state committees through the American Speech-Language-Hearing Association, the Joint Committee on Infant Hearing, and through her work with Kansas' Infant-Toddler Services. Lori holds a Ph.D. degree in Speech-Language Pathology from the University of Florida. She represents KDHE on the Kansas Commission for the Hard of Hearing and the Governor's Commission on Autism.

David Thomason is the State WIC Director. He has served in that capacity since 1998. From 1989 to 1998, he managed fiscal services and reimbursement in the Kansas Medicaid Program. David holds a Master's degree in Public Administration from the University of Kansas and a Bachelor of Science degree in Human Service Agency Management from Missouri Valley College. David has been involved in the development of several federal/state human service programs including the Medicaid drug rebate program, Vaccines for Children, and Federally Qualified Health Center reimbursement. David's involvement in budgeting and fiscal management includes making several presentations at national meetings of government officials and pharmaceutical organizations. David is currently involved in designing and developing an automated WIC system

for Kansas. The new WIC system will allow local agency staff to spend more time on mission oriented educational activities and less time on administrative duties.

Number and Role of Parents with the Bureau for Children, Youth & Families The Bureau employs a parent of a child with special health care needs as a Benefits Coordinator. The job responsibilities of this parent include identification of services and programs for families. In order to do this effectively and be aware of what services are available, he works closely with a variety of advocacy groups and support systems. To maximize family involvement, he participates with the Interhab task force, is a liaison with Families Together (parent to parent organization), serves as a board member for the Assistive Technology for Kansans project, and attends various meetings and conferences.

Another parent is a member of the Advisory Commission for Services for Children with Special Health Care Needs and works to provide parental input on program issues related to CSHCN's.

"Veteran" parents are also identified and recruited to work with "new" parents of a child with disabilities. This happens often in the newborn period. Extended family members are also invited to be members of specialty clinic teams.

In addition to families working in the CSHCN program, parents and families provide critical input to the Bureau in a variety of other ways including but not limited to: participating as paid team members of the Infant-Toddler (Part C of IDEA) local site monitoring teams; being customarily invited to be presenters at Bureau Sponsored events; providing peer counseling for breastfeeding; providing comment on their satisfaction with program providers; and serving alongside Title V staff on the Statewide Education Advisory Council.

CSHCN staff developed a contract with Families Together, Inc effective July 1, 1999. The contract helped ensure that families were involved with policy development and training of MCH staff. Families Together Inc staff regularly attend SHS staff meetings and are available to provide consultation as needed. SHS staff and Families Together, Inc staff have begun the process of developing a parent advisory group for SHS.

Infant-Toddler Services (Part C of IDEA) contracts with Families Together, Inc. To implement the child advocate system (identification of child advocates and training to assist them in understanding their partnership role in their child's early intervention program), to provide training about individual family service plans (IFSPs) for parents of infants and toddlers with disabilities,

and to coordinate a Parent to Parent program.

Families of children who are deaf or hard of hearing have participated on the task forces to develop newborn hearing screening guidelines and brochures, and to develop a resource guide for early intervention for families whose infants have been newly identified with hearing loss.

Contracts between Infant-Toddler Services and the 37 community based early intervention networks include the assurance that their Local Interagency Coordinating Councils have families of infants and toddlers with disabilities included in local training, the provision of technical assistance and as presenters at workshops and conferences.

1.5.2 State Agency Coordination

MCH collaborates with other programs in the State Health agency on a number of public health issues.

Office of Local and Rural Health

- Primary Care Cooperative Agreement
- District Nursing Consultants
- Community Health Assessment Coordination
- Farmworker Health
- Refugee Health

Bureau of Consumer Health

- Child Care Facilities Inspections &Licensing
- Childhood Lead Poisoning and Prevention.

Bureau of Health Promotion

- Breast & Cervical Cancer Screening Program
- Office of Injury/Disability Program
- Tobacco Use Prevention Program

Bureau of Health Facility Regulation

- Long Term Care Home Program Licensure and Certification Program
- Health Occupations Credentialing

Division of Health and Environmental Laboratories

- Inorganic Chemistry (Lead Screening)
- Neonatal Screening

Center for Health and Environmental Statistics, Vital Statistics

- Perinatal Outcome Data and Accuracy of Perinatal Utilization Index (APNU)

MCH coordinates with other State Agencies

- Kansas Department of Social & Rehabilitation Services (SRS)
  - Medical Services (Medicaid, HealthWave)
  - Employment Preparation Services
  - Substance Abuse, Mental Health and Developmental Disabilities
  - Children and Family Services (Foster Care)
  - Rehabilitation Services (Vocational Rehabilitation)
  - Disabilities Determination and Referral Services (SSI)
- Kansas State Department of Education (KSDE)
- Kansas Department of Insurance
- Kansas Department of Transportation
- Kansas Department of Human Resources
- Kansas Department of Corrections

University and other collaborations are as follows:

- University of Kansas
  - Bureau of Child Research/Center for Independent Living
  - Life Span Institute
  - University Affiliated Programs, Lawrence and Parson
  - Children's Development Unit/LEND Program
  - School of Medicine
  - School of Social Welfare
  - Preventive Medicine
- Wichita State University
- Kansas State University
- University of Kansas School of Medicine - Wichita, MPH Program
- Kansas Health Foundation (KHF) - sole mission to enhance public health in Kansas
- Kansas Health Institute - public health policy advisory body, KHF funded
- Kansas Public Health Association

MCH works with professional groups, private non-profit organizations and others.

- March of Dimes
- American Academy of Pediatrics - Kansas Chapter
- Kansas Children's Service League
- Children's Coalition
- Kansas Adolescent Health Alliance
- Dietetic Association of Kansas
- Kansas Action for Children
- Families Togther, Inc
- Kansas Hospital Association
- Assistive Technology Project of Kansas
- Kansas Medical Society
- Kansas Lung Association
- SAFE Kids Coalition
- Immunization Coalition

Description of Key Coordination Activities.

Federal Healthy Start Projects MCH participates in meetings at each of the two Kansas projects: Kansas City (Kansas & Missouri) and Wichita. The federal projects, which will be evaluated based on health outcomes such as reduction in infant mortality, include program components of community planning, coalition building, case management and outreach services, education and training activities, and consumer friendly services.

Federal CISS Project Healthy Child Care Kansas received a grant from MCHB and has developed a training manual for child care providers and an implementation plan to address the issue of children with special health care needs in child care. The manual includes the American with Disability Act, medication administration guidelines, childhood illnesses and resources for childcare providers related to CSHCN. Pilot training has been completed in Wyandotte County and a "train the trainer" sessions were completed with training offered to Kansas providers. A test has been developed and given to participants to measure effectiveness of the training.. A regional Healthy Child Care Summit brought together child care providers, pediatricians and government employees in May, 1998. The Summit was very successful in raising awareness about the need for

safe and healthy child care in Kansas. A technical assistance meeting was provided in June, 1999 which discussed the sustainability of the project.

Healthy Tomorrows The KU School of Medicine, Department of Family Practice, Wesley Medical Center, Wichita initiated the Healthy Tomorrows CISS grant project in Wichita. During its third year, the project continues through the United Methodist Health Clinic. This grant is co-funded by the American Academy of Pediatricians and provides health care services to approximately 2,000 school age children annually. Healthy Tomorrows, which began in 1996 is located at the Lincoln Elementary School, Wichita and is one of four school-linked clinics in the State funded by MCH Block funds.

Title V/Medicaid Interagency Agreement The Kansas Department of Health and Environment (KDHE) and the Kansas Department of Social and Rehabilitation Services (SRS) have a long history of working together to improve health services for mothers and children. An interagency agreement (on file with DHHS) provides a framework for interaction between MCH/CSHCN and Medicaid. The MCH/CSHCN staff and the Medicaid agency staff meet several times each year to discuss mutual concerns and to plan for identified service needs. The major focus of collaborative efforts during the past year continued to be reimbursement for Infant-Toddler services.

Other Medicaid Collaborative Efforts MCH/CSHCN staff have assisted Medicaid in: 1) inclusion of public health providers as partners at the table in discussion about managed care systems; 2) facilitation of medical information access to the SRS/Disability Determination and Referral Services as needed for determination of Supplemental Security Income eligibility through computerization and hard copy reports; and 3) developing plans for comprehensive school health services.

Infant Toddler Services and Medicaid MCH/Infant Toddler Services staff, in collaboration with Medicaid staff, have developed Medicaid reimbursement fee for service system for early intervention services (such as occupational therapy, physical therapy and speech-language therapy) through a specially designed Infant-Toddler early intervention Medicaid providership. Multiple training opportunities demonstrated to the Infant-Toddler Networks how to use their providership numbers to bill for these services. In February, 1999, the Infant-Toddler Services Medicaid providership was enhanced to include targeted case management (service coordination) as a reimbursable service for eligible infants and toddlers. Work began for the addition of developmental intervention services as a Medicaid reimbursable service.

Early and Periodic Screening, Screening, and Treatment (EPSDT) The Kansas EPSDT program, administered by the State social service agency is called Kan-Be-Healthy. MCH/CSHCN staff are members of the Advisory Committee of Kan-Be-Healthy which meets quarterly to provide input into policy and procedures. The interagency agreement provides a framework for collaboration to assure statewide availability of qualified nurse providers throughout the state. Medicaid provides funds to the Washburn University in Topeka School of Nursing to support this project. Title V initiated this project and developed a formal standard for nursing education. Title V also coordinated with Kansas schools of nursing to provide an outreach program of pediatric physical assessment coursework. More than 425 nurse providers have obtained appropriate coursework/ certification. Ongoing partnerships with the Kansas Medical Society and the Kansas Department of Education continue to enhance the effort of assuring provider availability. There has been a steady increase in EPSDT participation rates and child health assessments for all Kansas children including Medicaid eligible children. Title V continues to collaborate with departments of education and social services to implement and update a three-year state plan to increase participation by eligible children in EPSDT. Title V and Medicaid staff provide technical assistance to local Medicaid eligibility determination personnel and to local health department staff. Title V consults at least quarterly with Medicaid staff and Blue Cross/Blue Shield (BC/BS) regarding local health department questions. Title V and Medicaid staff talk regularly about strategies to maximize resources and to increase participation in this and related services. Health Start Home Visitors make active referrals for EPSDT services.

CSHCN/Medicaid /HealthWave In developing a system of care for children with special needs, CSHCN has built strong ties with Medicaid and others serving this population. The interagency agreement directs mutual referrals, cross program education, fiscal responsibilities and case management services for children participating in both programs. In addition, CSHCN has ongoing dialogue with Medicaid to develop the mechanism for CSHCN to access case management funds for the current and expanded activities of CSHCN staff. CSHCN has established a communication and referral process with the medicaid HMO's in the state. This established procedure helped to expand the referral process to the HealthWave HMO's.

Assistive Technology Project for Kansans This project helps persons with disabilities find ways to live and work as independently as possible through the use of assistive devices and services. The following components are included in the project: "Try before you buy" Interagency Equipment

Loan System; a policy and funding analysis with an effective grassroots coalition of consumers to respond to legislative and policy barriers; an annual statewide assistive technology conference; a contract to address barriers to acquisition and use of assistive technology; and five regional access sites. Coordination and collaboration is present between multiple state agencies for funding of the project and guidance through the Executive Advisory Board. The project is coordinated through the University Affiliated Program in Parsons, Kansas.

Medicaid Automated Information System (AIS) Title V implemented linkages with the Medicaid and Blue Cross/Blue Shield Automated Information System (AIS) so that CSHCN would have direct access to Medicaid information on children eligible for both Title V and Title XIX. This maximizes care coordination including EPSDT participation for persons eligible for CSHCN and Title XIX. By monitoring Medicaid and EPSDT participation, CSHCN helps in the effort to decrease duplication and promote quality service delivery to mutual program participants. CSHCN staff verify monthly the HMO status and primary care physician assigned to each child in order to request appropriate specialty referrals. CSHCN staff have the ability to prior approve and receive immediate approval or denial through AIS. The Wichita SHS office utilizes this system at "Seating Clinics."

Prenatal Health Promotion/Risk Reduction These services available for Medicaid eligible moms include, nursing case management, nutrition, social work and postpartum newborn home visits. Available maternal and child health related funds within the KDHE budget have been identified to utilize as match for federal Medicaid funds to support the implementation of this high risk nutrition and enhances social work services program for Medicaid eligible women. These services include enhanced nutrition, home visit and social work services for Medicaid eligible women enrolled in the Maternal & Infant program (M&I) and identified at nutritional and/or psycho/social risk. A collaborative effort between Title V and Medicaid assures reimbursement for non-public health agencies providing PNHP/RR Services for pregnant women and their infants enrolled in the M&I Program. M&I local projects (hospitals and other agencies in addition to local health departments) have expanded Medicaid reimbursement for enhanced prenatal care services including care coordination.

Nutrition & WIC Services The MCH Block Grant provides a portion of salaries for dieticians in the Nutrition and WIC Services section in order to obtain consultation, technical assistance, and development of Nutrition components of MCH/CSHCN programs. Nutrition consultation for

CSHCN includes identification and referral of children with nutrition disorders and development of community-based resources for nutrition services. Nutrition and WIC Services (NWS) staff collaborate with Maternal and Infant (M&I) staff on monitoring of local agencies, Kansas breastfeeding promotion activities, and the Kansas lead screening initiative. NWS staff collaborate with other MCH staff on school health and child care activities. This includes developing materials for local agencies that encourage EPSDT and immunization outreach during WIC clinics. NWS staff were participants in the Title V Strategic Planning session and the retreat to set MCH Year 2000 priority objectives. They reviewed and/or assisted in the review of key data areas and formulation of recommendations. NWS staff participates as a member of a joint USDA and HHS Work Group for Oral Health targeting Head Start and WIC program participants. This group has developed scientific white papers and are working on guidance materials for the Head Start and WIC programs. A mini-grant was awarded to McPherson Co. WIC program to evaluate the use of appropriate "tippy" cup use from age 6 months to weaning by 12 months.

Head Start Collaboration between Title V and Head Start occurs primarily at the local level. Under the leadership of Head Start, teams have been organized. At the local level, Title V agencies refer children to the comprehensive Head Start programs which encompass early childhood education, health, nutrition and social services. At the state level, Title V works closely with the Head Start representatives to promote school readiness of poor young children and a nurturing home environment to their families. The current focus of Head Start is to initiate Early Head Start programs to serve the 0 through 2 preschool population. Fourteen Early Head Starts are established the state. Early Head Start emphasizes pre-birth counseling and services, and focuses on educational programs for children and families These programs work closely with community-based Infant-Toddler Services (Part C of IDEA) to provide a natural environment for services for infants and toddlers with disabilities and their families.. Head Start for the 4 to 5 year-old age group emphasizes assistance to the entire family and works closely with the local communities.

Family Planning Title X funds (Public Health Service Act) are used to support family planning clinical services in 81 Kansas counties. Seventeen additional counties have formal referral arrangements with the clinic counties. The Title X program certifies match to the State Medicaid agency in order to enhance reimbursement to local providers, primarily local health departments. The interagency agreement with Medicaid specifies: outreach and referral systems, in-service education; joint bidding and contracting for Pap tests; state contract for contraceptive and other

medical supplies; and annual negotiation of annual provider fees. In addition, there is an annual update of women's health care standards, on-site administrative and clinical monitoring of local agencies. Many of the standards, forms and data systems used in Title V are an outgrowth of those which originated in Title X.

Migrant and Seasonal Farmworker Health The interagency agreement with Medicaid supports availability of medical and dental care to migrant and seasonal farmworkers and their families who would otherwise not have access to care because of their low income and transient lifestyle. Through seventy-five clinic sites, primary, preventive, acute and chronic care services are provided to children and families of migrant and seasonal farm workers in Kansas. Title V staff coordinate with Local and Rural Health staff to identify methods to maximize use of individual program funds to provide prenatal care, specialty care for CSHCN and follow-up. Title V provides orientation regarding the availability of M&I and medical specialty services in Kansas where there are significant problems in serving this population. In addition, Title V provides Farmworker Health with a medical services payment schedule for physician reimbursement to obtain comparability in reimbursement.

Refugee Health The Kansas Refugee Health Program, a component of the Kansas Refugee Resettlement Program under a cooperative agreement with the State social services agency (SRS), provides initial health screenings to new arrivals in all counties through the local county health departments. The components of the health screenings are: health history, laboratory tests, immunizations, physical examination, referrals for medical services related to health conditions, health education and follow-up. Children and women are referred for EPSDT (called in Kansas, Kan-Be-Healthy), immunizations, family planning and prenatal services. Appropriate translator services are provided or arranged by the local sponsoring resettlement agency.

School Health Ongoing efforts focus on expanding the role of the school nurse to include the provision of preventive and primary health care at school for children and youth who are at risk including underinsured and the uninsured school population. The federal legislation on inclusion has necessitated the reeducation of school nurses and training allied school personnel in the provision of care to medically complex children. Delegation of nursing tasks to unlicensed school personnel is an ongoing issue. Title V staff assist the State Education agency and Kansas Board of Nursing with this issue. Title V staff serves on the Statewide Education Advisory Council and attends the special education administration staff meetings. This collaboration has served to

strengthen the health services components for special health care needs students in local school districts.

"Guidelines for Serving Students with Special Needs Part II: Specialized Nursing Procedures," guidelines on local education agency responsibilities for services to CSHCN students, was a collaborative project between Title V and the State Department of Education. Standards for CSHCN are also underway for early childhood education programs and child care providers.

Title V representatives participate in the Head Start Collaboration Project which is housed in the social services State agency. This has resulted in Headstart students receiving free Hepatitis B series vaccines during the 1996-97 school year. MCH staff participate on the Regional Headstart Training Advisory Council organized to get appropriate health services training to Headstart providers.

Children's Advocacy Groups A number of groups routinely or periodically request Title V information, consultation or participation in some activity. These include: the Kansas Action for Children (KAC); Children's Coalition; and the Kansas Children's Service League.

Supplemental Security Income An interagency agreement delineates mutual responsibilities between Title V and SRS focusing on referral of SSI children and youth between the two agencies. A third party, the Children's Developmental Unit assists in design of materials to improve reporting of reliable information to make an accurate determination of eligibility for SSI benefits, and recruitment and expansion of the SSI provider pool for SSI consultative examinations. Another development is UAP training for providers who give consultative evaluations.

Child Care Facilities Inspections and Licensing Section This KDHE Section is responsible for licensing or registering child care facilities including day care, residential care, preschools, and child placement agencies. MCH funds infrastructure activities such as standards development, health and safety efforts.

Juvenile Justice A 1998 reorganization transferred responsibility for incarcerated youth from SRS to the Kansas Juvenile Justice Authority. This includes nursing services in the four State Youth Centers and two Screening Units. The consultation meetings resulted in the following: implementation of health and safety standards; efforts for follow-up by health department staff of youth who transition to the community; certification of nurse providers for child health services; coordination of education curricula for youth and staff. The Junction City school-linked project

provides educational programming to the Juvenile Justice Detention Center in Junction City.

The Department of Corrections Family Planning has established three special initiative projects in Barton, Crawford and Wyandotte Counties. These projects are the result of a successful joint application for funds made by Family Planning; SRS, Alcohol and Drug Abuse Services; and the Department of Corrections. The goal of these projects are to enhance family planning services in hard-to-reach populations (i.e., substance abuse treatment centers and/or correctional facilities, and Hispanic women). Some of the activities are weekly in-services on women's health issues at alcohol treatment centers and county jails; purchase of appropriate videos and written materials in Spanish; provision of translator services at clinics; and presentations to community organizations that provide services for women in hard-to-reach populations. Five counties were offered the opportunity to have these initiative projects based on the existent of homeless shelter serving women of reproductive age, women's correctional facilities and residential treatment centers serving woman and children in the county. Three counties made application and were funded.

Homeless Women and Children The Kansas Department of Commerce and Housing requested MCH participation in developing their state plan for continuity of services to homeless individuals. MCH provided an overview of services available through the public health system. In addition, MCH obtained WIC data. The data were sorted and organized by month, by population group (pregnant women, infants, children) and by county (for predicted high months only). Data tables and displays were provided to Kansas Department of Commerce and Housing for inclusion in their grant applications. Staff participated in the Kansas Department of Commerce and Housing's Statewide Continuum of Care Task Force. The Task force discussed regional planning meetings and strategies for linking the regional group structure with the state planning group, analyzed gaps in existing/available data, and suggested funding/application priorities. A data collection instrument was reviewed and planned for use in January/February 2000 point-in-time analysis together an accurate estimate of homeless persons and their needs.

SRS Resource Developmental Council This Council was established January, 2000, to bring together staff from the state agencies to look at available resources, budgeting issues and programmatic issues of the agencies. The agencies involved in this endeavor are SRS, KDHE, Department of Aging, Department of Human Resources, Department of Corrections, and the Juvenile Justice Authority. The mission is Maximize Resource Efficiency for the Benefit of Kansans. The Title V Director is a member of this Council which meets regularly to problem

solve, identify duplication , and identify coordination opportunities.

State Legislature Title V staff are responsive to legislative requests for information on Title V programs and/or issues affecting the maternal and child population. In addition, Title V provides both verbal and written testimonies to House and Senate Committees (standing, sub-, special, joint, and ad hoc) as delegated by the Division of Health and the KDHE Secretary. Upon request, Title V facilitates presentations by local service providers to legislative committees. Principal Senate (S) and House (H) Standing Committees include, but are not limited to: Appropriations (H), Education (H) (S), Federal and State Affairs (H) (S), Financial Institutions and Insurance (H) (S), Organization, Calendar and Rules (S), Public Health and Welfare (H) (S), Rules and Journal (H), and Ways and Means (S).

Governor's Office The Kansas Department of Health and Environment (KDHE) is a Cabinet level agency. The KDHE Secretary meets regularly with the Governor with the opportunity to apprise him of BCYF activities. The Governor reviews BCYF proposed initiatives for the Governor's budget. The KDHE Secretary acts as the KDHE liaison with the Governmental Affairs liaison relative to maternal and child health issues. The Director of BCYF has access to the Governmental Affairs liaison as appropriate to the situation.

In 1997, by Executive Order No. 97-1, the Governor established the Governor's Advisory Committee on Children, Youth and Families. The Advisory Committee serves in an advisory capacity to the Governor and shall:

- Assist the Governor in developing and implementing a coordinated, comprehensive service delivery system to serve the children and families of Kansas;
- Identify barriers to service and gaps in service due to strict definitions of boundaries between departments and agencies;
- Facilitate interagency and interdepartmental cooperation toward the common goal of serving children and families;
- Investigate and identify methodologies for combining of funds across departmental boundaries to better serve children and families;
- Propose actions needed to achieve coordination of funding and services across departmental lines; and
- Encourage and facilitate joint planning and coordination between the public and private sectors to better serve the needs of children and families.

The KDHE Secretary serves as a member of the Committee by official appointment from the Governor. The BCYF Director has staffed Committee meetings on behalf of the KDHE Secretary.

- HB 2558 was passed by the 1999 legislature (KSA 38-1808). This bill deals with the disposition of the tobacco litigation settlement. As part of this legislation the Committee on Children and Families was abolished and a Kansas Children's Cabinet was created. See pp. 5-7 for the details of this legislation.

Section II REQUIREMENTS FOR THE ANNUAL REPORT

2.1 Annual Expenditures

Annual expenditures information is provided for fiscal years FY 97 - FY 99 on Forms 3, 4 and 5. These are located in Section V, Supporting Documents. Kansas has had no carryover funds for the years reported. Total federal allocations for each of these years is expended.

2.2 Annual Number of Individuals Served

Kansas MCH spent two years developing a data system for collection of maternal and child health services provided by about 100 local agencies, automated and nonautomated. The federal requirements for reporting data changed during this process. Given continuing changing needs at both the federal and state levels, data system development will continue to be an evolutionary process. In addition, various commercial integrated public health data systems are being reviewed for implementation throughout the state.

During 1999, the most current year for our data, 9,661 pregnant women received M&I prenatal care and coordination services through local agencies. This is about one in four of all women delivering live births. During the same time period 32,239 infants and children received well child and sick child care, immunizations, developmental screens and related care. CSHCN provided case management or medical specialty services for 13,159 children. Parent education, support and referral services were provided to 15,832 families through Healthy Start home visitor program. See Forms 6, 7, 8, 9 in Section V, Supporting Documents

2.3 State Summary Profile

Form 10 in Section V, the Supporting Documents section provides an overview of state initiatives and partnerships. These are listed by levels of the pyramid: direct medical care and enabling services; population-based services; and infrastructure building services. The reader is also referred to Section 1.5.2 - State Agency Coordination and Section 4.1 - Program Activities related to Performance Measures.

2.4 Progress on Annual Performance Measures

Refer to Forms 11 in Section V, Supporting Documents. Refer also to commentary in Section 3.1, Needs Assessment of the Maternal and Child Health Population. The annual plan for FY 1999 emerged from the five-year state MCH needs assessment, goal setting by the state MCH Coalition and subsequent annual objectives and action steps. With a well-defined appraisal from the state MCH advisory coalition, Health Advisory Coalition for Children, Youth and Families (HACCYF), Kansas recognized that the improvement of the health and well being of all women and children in an ambivalent social environment was a formidable and perpetual mission. The state Title V program gave main consideration to intra- and interagency/operational linkages and coordination efforts, taking into account available Kansas resources, managed care initiatives and delivery system capabilities. Emphasis was placed on determining how best to distribute limited funds while supporting community-based solutions tailored to the specific needs of the three population groups: mothers, pregnant women and infants; children and adolescents; and children with special health care needs.

This narrative examines Kansas' progress toward the eighteen required National Performance Measures (NPM) and the seven state negotiated Performance Measures (SPM). Kansas selected the seven state negotiated Performance Measures (SPM) to address eight of the ten Kansas Priority Needs predetermined by nominal group process by Kansas BCYF staff (refer to Form 14). Notations in italics are provided to indicate the relevant Priority Need number(s) for the corresponding state negotiated Performance Measure. Of the eighteen National Performance Measures detailed in the Title V Block Grant Performance Measurement System, twelve measures correspond to eleven objectives reported in the "Kansas Maternal and Child Health Year 2000 Objectives: Midcourse Review & 1996 revisions." Notations in brackets are provided to indicate the Kansas Objective for the corresponding Performance Measure.

Note that referenced priority needs and state-negotiated performance measures are those from the previous cycle. Priority needs identified in 1998 are listed on the following page and referenced by number in this section.

1. Improve access to health care for mothers and children
2. Promote community health assessment to address priority needs
3. Ensure healthy births through pre- and postnatal interventions
4. Improve nutritional status of mothers and children
5. Initiate strategies to reduce substance abuse
6. Reduce unintentional injuries to children
7. Reduce intentional injury through family supports and interventions
8. Address the reproductive health needs of men and women
9. Promote quality standards of health care
10. Assure quality care through provider education

Direct Medical Care Services / Capacity

NPM 1 The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

MCH population group: CSHCN

[no corresponding 1997 Kansas objective]

Kansas provides case management services to SSI beneficiaries up to the age 21. All children receiving SSI are automatically eligible for Medicaid and SHS staff work with families to ensure they make the formal application for Medicaid. SHS staff also help ensure that SSI beneficiaries obtain maximum benefits from Medicaid through such services as Kan-Be-Healthy (i.e., EPSDT). In FY1996, 1,329 out of 8,430 SSI beneficiaries up to the age 21 (15.8%; baseline data) received rehabilitative services from the Kansas CSHCN Program. In FY 1999, 1,697 out of 6,030 SSI beneficiaries received rehabilitative services. Special Health Services (SHS) Section, KDHE and Disability Determination Services (DDS) Section, SRS are the data sources for this measure. The application process has been revised to make it less difficult for families to apply for case management services..

NPM 2 The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.

MCH population group: CSHCN

[no corresponding 1997 Kansas objective]

Kansas continues to provide all nine speciality services and is able to attain the full degree of this performance measure. All nine are applicable under the policies and procedures of the Kansas CSHCN Program [FY1996 baseline data]. Diagnostic services are available, without regard to family income, to Kansas youth under the age of 21 years who are suspected to have a severe disability, or chronic disease. Each application is individually reviewed, and a decision is made according to guidelines for financial and medical eligibility. Treatment services include medical specialists, outpatient care, hospitalization, surgery, durable medical equipment, and reimbursement for medical specialty care. Special services include counseling and planning for health care needs, developing an individual plan of health care, and follow-along for each person accepted for services. OT and PT are provided on a limited basis for rehabilitative therapy only. Home health care is provided as nursing services related to intravenous (IV) therapy. Respiratory, nutrition and home health care services are provided for a limited number of medical conditions. Early intervention services include screening, diagnostic and treatment services and are provided in collaboration with the Part C, Infant-Toddler Program.

Direct Medical Care Services / Risk Factor

SPM 1 Percent of deliveries (live births and fetal deaths) with reported history of alcohol use.

MCH population group: pregnant women, mothers, infants

[no corresponding 1997 Kansas objective] Kansas Priority Needs: 3 & 5 (previous)

Poor pregnancy outcomes due to maternal alcohol use are well documented. Alcohol consumption is associated with fetal alcohol syndrome which is characterized by growth retardation, facial malformations, and central nervous system dysfunctions including mental retardation. Ideally, abstention from alcohol use by pregnant women will become the established behavior. Preventive interventions to reduce maternal use of alcohol include health education to increase awareness of the hazards of alcohol use and identification of alcohol abuse or addiction prior to conception or in early pregnancy. Kansas FY1996 baseline data for this new measure is 0.84%, data source: KDHE Vital Statistics, Perinatal Casualty Report. FY1998 data shows deliveries with reported alcohol use at 0.68%. The provisional FY99 data

shows the percent of deliveries with a mother's history of alcohol use is 0.6%.

Title V and Medicaid staff participate on committees related to perinatal substance abuse initiatives/services. Agency initiatives and plans regarding substance abuse initiatives are shared. Additionally, the interagency agreement specifies methods for program information and services sharing, consultation and continuing education, treatment services, and fees and reimbursement. Both Title V and Medicaid work with Alcohol and Substance Abuse Services (ADAS) to address: perinatal provider education regarding substance abuse prevention and risk identification; availability of substance abuse counseling; referral procedures and follow-up; and, utilization of a toll-free line for information and referral.

Title V is represented on the Kansas Substance Abuse Prevention Team along with SRS, local health departments, public and private perinatal providers. The team meets semi-annually to share information.

Enabling Services / Capacity

NPM 3 The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home."

MCH population group: CSHCN

[no corresponding 1997 Kansas objective]

Special Health Services (SHS), KDHE does not currently have the capacity to collect data for all children with special health care needs in the state. Information regarding a "medical home" was obtained during the case management process for only those receiving assistance through SHS. In FY1997, 1,006 children out of 1,145 children on the SHS caseload (87.8%; baseline data) had identified in their individual plan of health care a physician "known to the child and family and . . . able to develop a relationship of mutual responsibility and trust with them."[1] Data Source: Kansas SHS case management files. In FY 1999, 1,183 children out of 1,217 children on the SHS caseload (97.2%) identified a primary care physician. Kansas will continue to obtain information for this measure on those children when case management is performed. A plan will be developed to expand the process to cover all CSHCN in Kansas. SHS staff will begin this process following completion of the National Survey.

[1] *The Medical Home Concept*, p. 5, The Medical Home and Early Intervention: Linking Services for Children With Special Health Care Needs, American Academy of Pediatrics, 1995.

SPM 2 The percent of children served in Title V local agencies who are insured through private or public (Medicaid, CHIP, other) insurance.

MCH population group: children and adolescents

[no corresponding 1997 Kansas objective] Kansas Priority Need: 1 (previous)

A primary and often cited barrier to the utilization of clinical preventive services is financial. Financial barriers can be reduced for the uninsured children in Kansas through their participation in the Kansas CHIP program entitled, Health Wave (refer to NPM 12). There was no significant change from the FY1996 baseline for this measure to the FY 1997 indicator. In FY 1997, the percent of children in Title V local agencies who are insured through private or public (Medicaid, CHIP, other) insurance is 56.1%. The FY99 data indicates 64.6 % of those served have public or private insurance coverage. Data source: MCH Data Planning System, Children & Families Section, KDHE.

MCH addresses this state performance measure through assessment, policy development and assurance activities. Kansas MCH conducts periodic surveys of providers relating to accessibility of services. Both MCH and CSHCN collect information on insurance status of clients. Uninsured clients who are eligible for public insurance (Medicaid or CHIP) are referred and/or assisted in enrollment. Local MCH agencies conduct outreach activities through schools, child care centers, health departments, private non profits, and hospitals. Outreach and enrollment by local agencies are priority activities through contracts, in-service education, and technical assistance. Since 1997, MCH and Family Planning have collected information on the insurance status of clients. The state and county-level data is examined to determine trends. MCH/CSHCN participate in a number of state-level interagency policy making groups relating to insurance coverage for mothers and children in Kansas. SRS routinely invites MCH/CSHCN participation in Medicaid and CHIP workgroups around specific issues. In turn, MCH/CSHCN invites SRS participation in various policy making activities.

Enabling Services / Risk Factor

SPM 3 Rate of spina bifida and other neural tube defects.

MCH population group: pregnant women, mothers

[no corresponding 1997 Kansas objective] Kansas Priority Needs: 3, 4 & 10 (previous)

Spina bifida and anencephaly are common and serious birth defects. In 1996 the rate was 8.2 with drops in 1997 to 5.1 and in 1998 to 4.4. The 1999 rate of 8.3 is comparable to the rate of 1996. Available evidence indicates that 0.4 mg (400 : g) per day of folic acid, one of the B vitamins, will reduce the number

of cases of neural tube defects (NTDs). All women of childbearing age who are capable of being pregnant should consume the recommended dose of folic acid daily to reduce risk of having a pregnancy affected with spina bifida or other NTDs. Title V, Family Planning and NWS staff met with the March of Dimes to develop strategies to increase awareness of the benefits of folic acid consumption for women in childbearing years. Materials in English and Spanish are available. Data sources: Congenital Malformation Reporting System and Center for Health and Environmental Statistics, Vital Statistics

Population-Based Services / Risk Factor

NPM 4 Percent of newborns in the State with at least one screening for each PKU, hypothyroidism, galactosemia, hemoglobinopathies [(e.g., the sickle cell disease) (combined)]

MCH population group: pregnant women, mothers, infants

[Kansas Objective: Screen all newborns[1] for phenylketonuria (PKU), congenital hypothyroidism (CH), galactosemia (GAL), and hemoglobinopathies (HGB). Track number of newborns screened annually. All newborns who have been screened presumptive positive for PKU, CH, GAL or sickle cell disease will receive appropriate treatment.]

In Kansas, newborn screening is mandated, collection is required prior to hospital discharge, program criteria for a valid screen have been established and abnormal screens are retested. Kansas has a protocol for tracking infants, high-risk infants are identified within 30 days after birth and placed on supportive therapy to prevent mental retardation and other adverse health effects. Early diagnosis and treatment has been found to reduce morbidity and mortality associated with PKU, CH, GAL or sickle cell disease and other hemoglobinopathies (HGB). Since 1993, this objective has moved in the right direction. The process for matching birth certificate data with newborn screening information to identify a percentage of infants screened was implemented in February 1997. In FY1997, there were 36,138 first time screenings; 99.8% of the infants were screened. In FY 1998, there were 37,434 first time screening; 99.96% of the infants were screened. In 1999 there 38,124 first time screening; 99.7% of the infants were screened. Data source: KDHE Vital Statistics and Neonatal Screening Lab.

[1] All newborns except those whose parents refuse the testing as a violation of a religious tenet or practice.

NPM 5 Percent of children through age two who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.

MCH population group: children and adolescents

[Kansas Objective: Increase to at least 90 percent the proportion of children ≤ 24 months who complete the basic 4:3:1 immunization series (diphtheria, tetanus, pertussis; oral polio; measles, mumps, rubella inoculation.)]

Kansas has three data sources for this measure: Kansas Certificate of Immunization, a 2-year retrospective, population-based survey; CDC National Immunization Survey, a random household telephone survey matched to health care provider records; and Kansas WIC Program records. The KDHE Immunization Director recommends use of the Kansas Certificate of Immunization data.

Progress on this measure has been favorable. Responses from Kansas schools to the retrospective immunization coverage survey show a significant increase in completion of the basic immunizations. Over the last three years, the percent of Kansas children immunized has gone from 70.2% to 75.1%. If this trend continues, coverage rates of Kansas two year olds can be expected to reach the 90% objective within five years.

Operation Immunize is a statewide campaign, implemented by KDHE, that offers free vaccinations against measles, mumps, rubella, pertussis, diphtheria, polio, tetanus, varicella (chicken pox), haemophilus influenza B, and hepatitis B to children ages 35 months and under. This campaign attains tremendous support from businesses, volunteer organizations, schools, hospitals, health professionals and the media throughout Kansas. Operation Immunize strategies involve promotional, educational, community awareness and outreach efforts. MCH/CSHCN staff participate in the Kansas Immunization Coalition. This group has decided to expand the target population from children under age two to immunizations across the lifespan. A special emphasis is planned for immunizing school children for Hepatitis B.

NPM 6 The rate of births (per 1,000) for teenagers aged 15 through 17 years.

MCH population group: children and adolescents

[Kansas Objective: Reduce rate of births to females aged 15 through 17 years to no more than 27 per 1,000 adolescents.]

From 1990 to 1997 despite a slight increase in the number of births to female adolescents (age 15-

17), due to a steady increase in the number of females in the 15-17 population group, there has been a steady decrease in the rate of births to Kansas adolescents. In 1998 there was a significant decrease in the number of births to this population, although there was population growth, although the rate was reduced to 24.7 and in 1999 (provisional data) to 24.1.

Year	Number	Population	Rate*
1990	1,440	47,831	30.1
1991	1,425	48,814	29.2
1992	1,528	50,741	30.1
1993	1,594	52,102	30.6
1994	1,641	54,120	30.3
1995	1,692	56,196	30.1
1996	1,615	58,237	27.7
1997	1,651	60,173	27.4
1998	1,524	62,717	24.7
1999	1,495**	61,829	24.1**

*Rate per 1,000 female 15-17 population. Population estimates were compiled by the U.S. Census Bureau as of July 1, 1990-1998 and released on July 21, 1998 estimates released on March 9, 2000.

** Provisional data

Comparing today's rate of adolescent live births with those of the 1950's, the decline has been dramatic – a 31.7 percent reduction. The rate of live births to Kansas females ages 15-19 has declined from 76.3 live births per 1,000 age-group population in 1950 to 52.1 in 1995. The percent of out-of-wedlock adolescent (15-19) live births, on the other hand, has increased dramatically from 7.4 percent in 1950 to 72.4 percent in 1995. Federal welfare reform legislation attempts to address the rising number of out-of-wedlock births.

Kansas MCH has identified counties with consistently high adolescent pregnancy rates and funded community organizations within those counties to implement specific interventions. It is challenging to develop outcome and performance measures for these projects and to evaluate relative effectiveness of various strategies (e.g., curricula adopted, peer education/professional education, abstinence-based/abstinence-only, and so forth). There has been considerable legislative and other pressure to continue to refine and improve on program evaluation efforts. Assessment capacity is the major ongoing concern. In the 1999 Legislative session, TANF funds were allocated to expand program evaluation of teen

pregnancy prevention programs in Kansas and to enhance existing projects.

NPM 7 Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

MCH population group: children and adolescents

[Kansas Objective: Obtain baseline data or a scientifically-based estimate on the proportion of children who have received protective sealants on the occlusal surfaces of permanent molar teeth]

Dental caries, a unique microbial infection, remain among the most prevalent and preventable diseases of adults and children. Once established, it is progressive, does not heal without treatment, and leaves visible evidence of past infection. Because early diagnosis and prompt treatment of caries can halt tooth destruction and prevent tooth destruction and prevent tooth loss, low prevalence of untreated caries should be attainable. National studies have shown application of dental sealants reduce by two-thirds the incidence of dental caries. For FY 1996-1997 provisional baseline date on this measure was provided by the KDHE Bureau for Disease Prevention and Health Promotion (BDPHP), with the Behavioral Risk Factor Survey (BRFS) as the data source. About forty percent of parents sampled reported that a youth (7 to 17 years of age) in the household had received sealants on at least one permanent molar tooth. The 1998 BRFS data identifies 697 respondents had children aged 7-17 years, 298 (42.15%) of these children had received dental sealants. Generalized to the population of Kansas children 7-17 years of age it is estimated that 188,442 children had dental sealants.

NPM 8 The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.

MCH population group: children and adolescents

[Kansas Objective: Reduce by 15% unintentional (including motor vehicle crashes, motorcyclists, bicyclists, and pedestrians: drowning deaths; and residential fire deaths) and intentional (homicide and suicide) deaths among children, adolescents and young adults ages 0 to 24. Track number annually.]

In 1996, motor vehicle accidents (MVAs) were the leading cause of the unintentional injury death to all Kansas youth 0-24 (22.8%) and in each of the following age groups: 1-4 years (31.8%, n=7), 5-14 years(65.1%, n=28) and 15-24 years (80.9%). The number of MVA deaths among Kansas youth has not maintained a steady direction from 1990 through 1996. This disparate trend applies to the rate of deaths to children aged 1-14 per 100,000 caused by MV crashes during the same time span as well: 1990 (rate=5.9),

1991 (rate=5.1), 1992 (rate=5.2), 1993 (rate=4.5), 1994 (rate=5.7), 1995 (rate=5.2) 1996 (rate=6.6), 1997 (rate 4.3), 1998 (rate 7.4) and 1999 (rate 6.2). The goal Kansas has adopted for this new measure is the Healthy People 2000 Objective to reduce deaths to children (aged 1 -14) caused by motor vehicle crashes to no more than 3.5 per 100,000 age group population. The data shows erratic movement in the rate.

"Please Be Seated" is an educational, voluntary program of the Kansas SAFE KIDS Coalition which is currently "on hold" as funding mechanisms and support have not been developed for the continuation of the program. The Kansas highway patrol has increased their efforts at enforcement of the seat belt law by issuing tickets to noncompliant motorists stopped for other reasons.

NPM 9 Percentage of mothers who breastfeed their infants at hospital discharge.

MCH population group: pregnant women, mothers, infants

[Kansas Objective: Increase to at least 75% the proportion of women who exclusively or partially breastfeed their babies in the early postpartum period and to at least 50% the proportion who continue breastfeeding until their babies are 5 to 6 months old.]

In 1996, Kansas WIC received a grant to develop a breastfeeding Peer Counselor Program. A breastfeeding Peer Counselor is a mother who has breastfed one or more infants, successfully completed a training program and is competent to provide breastfeeding advice and information. From 1990 through 1996, the initiation and duration of breastfeeding rates among WIC participating mothers, have demonstrated a remarkable progress toward reaching the Year 2000 Goal (Data Source: Pediatric Nutrition Surveillance System, CDC). The 1990 baseline data, according to PedNSS-WIC/CDC, for breastfeeding mothers in the early postpartum period was 49.8%. This percentage has raised to 66.1% in 1998.

This positive trend is comparable to the Mothers' Survey, Ross Products Division, Abbott Laboratories during the same years. Using data from the Ross Laboratories Mothers' Survey, for both WIC infants and All Infants, Kansas has surpassed the national percentages for each year from 1988 through 1998. For WIC Infants in 1998, the comparison for Breastfeeding Rates In-Hospital were 59.9% at hospital discharge and 19.9% at six months. Nationally it is 52.6% and 18.9% According to the Mothers' Survey for All Infants in Kansas, 69.8% mothers had initiated breastfeeding prior to hospital discharge in 1998 and 26.4 at six months. Nationally it is 64..3% and 28.6% respectively. PedNSS data was used to track performance measures on Form 11.

NPM 10 Percentage of newborns who have been screened for hearing impairment before hospital

discharge.

MCH population group: pregnant women, mothers, infants

[Kansas Objective: Assure hearing screening for 90% of infants and toddlers birth through age 2 by State-sponsored early identification programs]

Baseline data for newborn hearing screening was 5% in FY98. On April 14, 1999, the Governor signed the newborn infant hearing screening act, requiring the screening of hearing of all newborn infants, effective July 1, 1999. Task forces were convened to develop guidelines for newborn hearing screening, audiologic assessment, medical assessment and amplification, as well as, a resource guide for families of infants with confirmed hearing loss. Regulations, yet to be approved, will provide specific information for program implementation by birthing hospitals. Because of computer issues revolving around Y2K, developing a data transmission system using the electronic birth certificate (EBC) system, available in 97% of the Kansas birthing facilities, was postponed to SFY01. In 1999, 58% of the infants born in Kansas were screened with a hearing test for hearing impairment.

SPM 4 Rate of residential fire deaths among children (ages 0-4)

MCH population group: children and adolescents

[Kansas Objective: Reduce by 15% unintentional (including motor vehicle crashes, motorcyclists, bicyclists, and pedestrians: drowning deaths; and residential fire deaths) and intentional (homicide and suicide) deaths among children, adolescents and young adults ages 0 to 24. Track number annually.]
Kansas Priority Need: 6 (previous)

The number of fire deaths among Kansas youth between 0 to 24 years of age have shown an overall decline yet has not maintained a steady direction from 1990 through 1996. Fire and burns are the leading cause of fatal injury in the home.

The FY1996 baseline data for this measure is 4.1/100,000 children 0-4 years; the data source is the KDHE Injury Prevention Program. Fire is the second leading cause of unintentional injury death for Kansas children 1-4 years old. The 1999 rate of .5 indicates a sharp reduction from the 2.8 in 1996, 5.0 in 1997 and 3.9 in 1998. Kansas implemented a smoke detector law effective July 1998 which mandates smoke detectors in all Kansas homes, but there is no enforcement provision. Healthy Start home visitors distribute and arrange for installation in homes of low-income families with young children with assistance of local fire departments, boy scout troups, etc. Other home safety information is provided during the visit. To implement activities at the state and community levels, there is close collaboration with SAFE Kids,

Kansas Fire Prevention Program, State Fire Marshall's Office, local fire officials and hospitals.

Infrastructure Building Services / Capacity

NPM 11 Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.

MCH population group: CSHCN

[no corresponding 1997 Kansas objective]

As part of the application process, SHS has been able to gather information regarding insurance coverage on those families receiving case management. For this measure, the FY1997 denominator data included children attending clinics sponsored by SHS and in which there was no data collected regarding their insurance coverage. Consequently, there was a drop in the percentage of children showing insurance coverage from FY1996. Using FY1997 as the baseline year, 34.9% CSHCN had a source of insurance; the Data Source is SHS Case Management files. A new form has been used to capture more client information for those children attending SHS sponsored clinics. The new reporting form includes such information as patient name, insurance information and SSI status. The percent of CSHCN children with health insurance remains between 43.8% and 34.9% with FY99 being 41%. All of these are well below the target percent.

NPM 12 Percent of children without health insurance.

MCH population group: children and adolescents

[no corresponding 1997 Kansas objective]

Barriers to health care service utilization can be reduced for the uninsured children in Kansas through their participation in the Kansas CHIP program entitled, Health Wave. This program covers children through age 18 with income up to 200 percent of poverty. Benefits are at least equal to Early, Periodic Screening, Diagnosis and Treatment (EPSDT) services. Enrollment is simplified and Kansas offers presumptive eligibility where applicable (in unspecified circumstances). Baseline data obtained was the three-year average for uninsured low income children under 19 years of age in Kansas for years 1993 through 1995. In FY1996, the three year average was 8.1% (n=60,000) according to the U.S. Census Bureau: Health Insurance Statistics: Low Income Uninsured Children by State. This decreased to 6.9% in FY1997 for years 1994-1996. U.S. Census data for 1998 showed a slight increase to 7.0% while the 1999 data shows a decrease to 5.5.

SPM 5 Percent of school nurses trained in use of quality standards including CSHCN students.

MCH population group: CSHCN

[no corresponding 1997 Kansas objective] KS Priority Needs: 9 & 10 (previous)

More children with complex health problems are entering Kansas schools. This requires high levels of skilled interventions. Standards and training of school nurses will lead to improved health status and prevention of further complications. Kansas MCH/CSHCN developed guidelines for school children with complex health needs. Statewide training commenced in FY 1999. This school nurse training is expected to benefit children with and without special health care needs. Baseline data is available for the denominator only. The number of school nurses on the KDHE state school nurse roster is approximately 680. No unduplicated count exists on the number of school nurses nor the number trained in the current data systems.

SPM 6 Percent of child care centers that have staff trained through Healthy Child Care Kansas.

MCH population group: CSHCN

[no corresponding 1997 Kansas objective] KS Priority Needs: 9 & 10 (previous)

Families of CSHCN have difficulty finding safe, appropriate, affordable child care for their children. More training and technical assistance must be available to ensure that children with special health care needs are being cared for properly. Training and support affirm that quality child care settings will meet their potentially complex medical needs. Heart of America Family Services is the training contractor for this objective. Baseline data has been obtained from both Heart of America Family Services (numerator) and the KDHE Child Care Facilities & Licensing Section (denominator). At this time, the Healthy Child Care Kansas task force is looking at sustaining the project, some issues include the method to track the training and certification of child care providers. Using FY 1997 as the Baseline year, 9% of Kansas child care providers had received the training. In FY1998, 12% of Kansas child care providers had received training and in 1999 14%.

Infrastructure Building Services / Process

NPM 13 Percent of potentially Medicaid eligible children who received a service paid by the Medicaid Program

MCH population group: children and adolescents

[Kansas Objective: Increase to at least 95% the proportion of EPSDT eligible children who participate in the full complement of EPSDT services, including physical health, mental health, oral health, vision and hearing, all periodic screening as recommended by the American Academy of Pediatrics, any interperiodic screening, and all needed diagnosis and treatment.]

The protections Medicaid provides eligible children and the services covered, including EPSDT, are essential to the nation's health. States should ensure that all eligible children are enrolled in Medicaid and benefit from the optimal amount of services available. KAN-Be-Healthy (i.e., EPSDT), is a preventive program for children from low-income families covered under the federal/state health insurance program, Medicaid. Under the program, children receive regular scheduled health screenings. Screenings are done on a periodic schedule by the American Association of Pediatrics and are done by a physician or a KAN-Be-Healthy certified nurse. Screenings include a health and developmental history, a physical exam, immunizations, laboratory tests including blood tests for lead poisoning, and health education. In addition, a child is entitled to vision, hearing and dental screening services. The KAN-Be-Healthy program, administered by the Kansas Department of Rehabilitation Services, is available to all children under age 21 in the Medicaid program. Over the last several years, the number of low children whose families qualify for Medicaid because of low income who have received Kan-Be-Healthy screenings increased substantially, up from 14% of eligible children in 1990 (baseline year) to 68% (n=55,249) in 1997. Data Source: Kansas Social and Rehabilitation Services (http//www.state.ks.us/public/srs). In FY97 there was 83.4% of children who received EPSDT screenings, 83.9% in.FY98, 84.6% in FY99.

NPM 14 The degree to which the State assures family participation in program and policy activities in the State CSHCN program.

MCH population group: CSHCN

[no corresponding 1997 Kansas objective]

In FY97, the baseline score of 3/18 was derived from subjective self-evaluation for this measure. The Kansas CSHCN program currently utilizes parents on the Special Bequest Advisory Commission and also works in cooperation with Families Together (parent-to-parent network) regarding policy issues. SHS created a task force which developed qualitative measures for each of the six characteristics. The SHS program has a formal agreement in place with Families Together, Inc, the state parent-to-parent organization. The contract provides more formal involvement form families.

SPM 7 The percent of Kansas counties that assess maternal and child health needs.

MCH population group: pregnant women, mothers, infants; children and adolescents; CSHCN

[no corresponding 1997 Kansas objective] Kansas Priority Need: 2 (previous)

Completion of a community health assessment is a requirement for local agencies in Kansas that receive MCH grants. The needs assessment helps communities to: analyze the health status of the MCH population; identify problems; educate the community; evaluate health resources, services and existing systems of care; and, establish health priorities. Title V staff are available to help plan appropriate interventions for the maternal and child health population in participating communities. As mentioned above, 101 of the 105 Kansas counties currently provide at least one of the listed Title V services. The four counties that are not among the others are in western Kansas, comprising Cheyenne, Greeley, Haskell and Wichita counties. In 1996, 18% (baseline data) or 19 of 105 Kansas counties were participating CHAP communities. In 1999, 47 (45%) of Kansas communities have completed the community health assessment process. Data sources for this measure are CHAP Communities Status File; Aid to Local Grants Process. To date, MCH-related problems that have been identified include teen pregnancy; alcohol, tobacco and drug use; abuse and neglect; crime and violence; child care; and access to primary care.

Infrastructure Building Services / Risk Factor

NPM 15 Percent of very low birth weight live births.

MCH population group: pregnant women, mothers, infants

[Kansas Objective: Reduce low birth weight to an incidence of no more than 5 percent of live births and very low birth weight to no more than 1 percent of live births.]

In 1989, the Kansas very low birth weight baseline was 1.1%. Of the 434 VLBW live births, 78.1% were White infants and 19.6% were Black infants. In 1996, the Kansas very low birth weight baseline was 1.4%. Of the 509 VLBW live births that year, 78.4% (n=399) were White infants and 18.9% (n=96) were Black infants. There has been little noticeable change in LBW and VLBW incidence during the past 16 years. Also in 1996, the disparity (ratio) for Black VLBW (3.5%) was nearly three times that of White VLBW (1.2%). Kansas VLBW is notably higher among women less than 18 years (2.8% n=47) and in the 15-19 age

group (2.0% n=93). All other age groups between 20 and 34 years have a similar percentage at 1.3%. Women 35 years and over are slightly higher at 1.5%. The 1997, 1998 and 1999 data are not significantly different from the 1996 baseline of 1.4% at 1.2%, 1.4%, and 1.3% respectively.

In 1974, Maternal and Infant (M&I) services, were established in Kansas through the support of Maternal and Child Health (MCH) funding. In 1982, M&I services were expanded to include women with identified risks of poor pregnancy outcomes (e.g., premature labor/delivery, low birth weight and infant death). Services include, but are not limited to: outreach to identify high-risk pregnant women; pregnancy testing; and case management for enrolled clients. Integration with other public health services such as family planning, nutrition counseling (WIC), genetic and substance abuse counseling, Healthy Start home visits and prenatal education services is emphasized. By 1997, women in 77 Kansas counties had access to M&I services. Significant decreases in the incidence of low birth weight have been documented in the M&I population when compared to similar at-risk populations not receiving these comprehensive services. Four projects were funded in the Pregnancy Maintenance Program, projected to serve 4,550 pregnant woman. No data is available as the reports are not due until July 15, 2000.

NPM 16 The rate (per 100,000) of suicide deaths among youths aged 15-19.

MCH population group: children and adolescents

[Kansas Objective: Reduce suicides and the incidence of injurious suicide attempts among youth aged 15 through 19 to no more than 8.2 per 100,000 youth.]

Suicide is the second highest cause of death for Kansans 15-24 years of age. While the suicide rate for all groups has remained stable both nationally and in Kansas for the last fifteen years, there appears to be an epidemic increase in suicides among youth. Kansas still lacks a statistically representative measurement for adolescent suicide attempts. The “1997 Kids Count Data Book” published by the Annie E. Casey Foundation notes that Kansas ranks 36th out of 50 states in the rate of teen deaths by accident, homicide and suicide (deaths per 100,000 teens ages 15-19). In 1990, baseline data for Kansas showed a suicide rate of 11 per 100,000 youth 15-19. Since 1991, adolescent suicides in Kansas have sustained an overall increase with slight fluctuations since the baseline year. In 1996, the suicide rate for youths 15-19 was 16.3 per 100,000 youth. This declined slightly to a rate of 11.9 in 1997 and then returned to 16.3 1998. The 1999 data shows a sharp decline to a rate of 8.

To date, Crawford County, one of the thirty-seven Kansas Community Health Assessment Process (CHAP) counties, has identified adolescent suicide as an MCH-related priority problem to be addressed.

All three Kansas school-linked clinics: Junction City, Sedgwick County, and Wyandotte County, provide mental health referral. Kansas is developing a state plan to address suicide and are planning a conference in the fall of 2000.

NPM 17 Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

MCH population group: pregnant women, mothers, infants

[no corresponding 1997 Kansas objective]

Level III, or subspecialty, facilities, as classified by the American College of Obstetricians and Gynecologists (ACOG) and American Academy of Pediatrics (AAP), provide all the staff with appropriate competencies and the medical technology/ equipment required to deliver high-risk deliveries and neonates. Kansas has five hospitals located in the northeastern (Wyandotte, Johnson, and Shawnee counties) and south-central (Sedgwick county) parts of the state (KUMC, Overland Park Medical Center, Stormont Vail, Via Christi - St Francis Campus, and Wesley). In FY1996, 73% (baseline data) very low birth weight infants (n=325) were delivered in Kansas Level III facilities. This increased to 75.7% in 1997 and 77.2% in 1998. There was a drop to 76.8% in 1999. Data sources: Kansas Vital Statistics and hospital discharge records.

NPM 18 Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

MCH population group: pregnant women, mothers, infants

[Kansas Objective: Increase to at least 90 percent the proportion of all pregnant women who receive prenatal care in the first trimester.]

With a 1996 percentage of 85.4% there has been moderate progress in the percentage of Kansas women delivering liveborn infants who entered prenatal care in the first trimester since the 1990 baseline of 80.5%.

In 1997, 1998, and 1999 the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester remained relatively unchanged at 85.6% , 85.7% and 85.8%respectively. There are differences between age groups and race/ethnicity related to the beginning of prenatal care.

2.5 Progress on Outcome Measures

This narrative examines Kansas' progress toward the six required National Outcome Measures and explores the association between the National and State performance measures with the Outcome Measures. By using the core public health functions as a framework for this narrative, KDHE recognizes the vital purpose these services provide in maintaining the general health and well-being of the MCH/CSHCN population in Kansas.

Of the six National Performance Measures detailed in the Title V Block Grant Performance Measurement System, three measures correspond to one objective, two subobjectives and one related subobjective reported in the **Kansas Maternal and Child Health Year 2000 Objectives: Midcourse Review & 1996 revisions**. Notations in parentheses are provided to indicate the Kansas Objective for the corresponding Performance Measure. The data source for all six National Performance Measures is the KDHE Office of Vital Statistics; data trend analysis by KDHE Office of Health Care Information and State Systems Development Initiative.

OUTCOME MEASURE 1 — The infant mortality rate per 1,000 live births

[**Kansas Objective**: Reduce the infant mortality rate to no more than 7 per 1,000 live births.]

In Kansas, the infant mortality rate (IMR) was improving continually during the five-year span from 1991 through 1995. With a 1990 baseline of 8.9 per 1,000, Kansas gradually reduced the IMR to a record low of 6.9 in 1995. However, the IMR took a sudden upswing in 1996 with a total of 299 infant deaths or 8.2 per 1,000 live births. The 1997 IMR improved over that for 1996 at 7.9 and 8.2. The 1998 IMR showed further improvement to 6.9 per 1,000 live births. The 1999 IMR increased to 7.3 which is an increase over 1998.

OUTCOME MEASURE 2 — The ratio of the black mortality rate to the white mortality rate

[**related Kansas Subobjective**: Reduce the infant mortality rate among Blacks to no more than 11 per 1,000 live births.]

In Kansas, the white infant mortality rate declined continually during the five-year span from 1991 (IMR= 8.1) through 1995 (IMR=6.1). The white infant death rate was 7.1 deaths per 1,000 live births in 1996, a decrease of 64.9 percent from the IMR of 20.2 in 1966. The white IMR in 1976 was 12.8, in 1986 it was 8.1.

The black infant mortality rate increased annually during the four-year span from 1990 (IMR=

17.1) through 1993 (IMR=23.5). The black IMR dropped to a record low 15.6 in 1994 and began climbing again in 1995 (IMR=17.8). The black infant death rate was 22.9 deaths per 1,000 live births in 1996, a decrease of 40.5 percent from the IMR of 38.5 in 1966.

The goal Kansas has adopted for this measure is to reduce disparity (ratio) between the Black and White infant mortality rates to no more than 1.6/1,000 black IMR to 1.0/1,000 white IMR. To determine the goal for this measure, the following method was followed. Using the Kansas Objective for the infant mortality rate (total population) with a goal of 7.0/1,000 as a proxy for a white infant mortality rate and the Kansas Objective for the black infant mortality rate with a goal of 11.0/1,000, the contrived Kansas Objective for the black IMR to the white IMR ratio equaled 1.6 (rounded: 11:7 ratio). The Kansas black IMR to the white IMR ratio trend follows a similar inconsistency as the black infant mortality rate, increasing annually from 1990 (ratio = 2.3; baseline data) through 1993 (IMR=23.5). The ratio dropped to a record 2.2 in 1994 and began climbing again in 1995 (ratio=2.9).

The black infant mortality ratio for Kansas has shown steady improvement from 1996 and 1998 from 3.2 to 2.5, and then to 1.4 for the three year tracking period. In 1999, there was an increase to 2.2 IMR for black infants.

OUTCOME The neonatal mortality rate per 1,000 live births

MEASURE 3 [**Kansas Subobjective**: Reduce the neonatal mortality rate to no more than 4.5 per 1,000 live births.]

In Kansas, the neonatal mortality rate (NMR) was improving continually during the five-year span from 1991 through 1995. With a 1990 baseline of 5.0 per 1,000, Kansas' NMR increased slightly to 5.1 in 1991, then began a steady reduction to a low of 4.5 in 1995. However, the NMR took a sharp rise in 1996 with a total of 199 neonatal deaths or 5.4 per 1,000 live births. This was an increase of 20% percent from the 1995 NMR.

From the 1996 baseline of 5.4, NMR declined to 4.7 in 1997 and to 4.5 in 1998. In 1999 the NMR increased to 4.9 which is a slight elevation..

OUTCOME The postneonatal mortality rate per 1,000 live births

MEASURE 4 [**Kansas Subobjective**: Reduce the postneonatal mortality rate to no more than 2.5 per 1,000 live births.]

In Kansas, the postneonatal mortality rate (PNMR) was improving continually during the five-year

span from 1991 through 1995. With a 1990 baseline of 3.3 per 1,000, Kansas' PNMR increased considerably to 3.9 in 1991, then began a steady reduction to 2.4 in 1995. However, the NMR took a moderate rise in 1996 with a total of 100 postneonatal deaths or 2.7 per 1,000 live births. This was an increase of 12.5 percent from the 1995 NMR.

Kansas PNMR has remained relatively unchanged over the four year reporting period, 1996 through 1999. The baseline for 1996 of 2.7 held for 1997 with a slight decline to 2.4 postneonatal deaths per 1,000 live births in both 1998 and 1999.

OUTCOME The perinatal mortality rate per 1,000 live births

MEASURE 5 [no corresponding 1997 **Kansas objective**]

Kansas reports the perinatal mortality rate using a Perinatal Period III breakdown: the aggregate total of fetal deaths (fetus weighs over 350 grams) and hebdomadal deaths (deaths that occur prior to the 7th day of life).

The goal Kansas has adopted for this measure is to reduce the Perinatal Period III rate to 9.5 per 1,000. In order to determine this goal, the following method was followed. Starting with the Kansas Subobjective for the neonatal mortality rate with a goal of 4.5/1,000 and adding the Healthy People 2000 Kansas Objective for the fetal death rate with a goal of 5.0/1,000, the contrived Kansas Objective for the Perinatal Period III death rate (i.e., perinatal mortality rate) equaled 9.5 per 1,000 live births. The Perinatal Period III death rate baseline in Kansas was 9.7/1,000 live births in 1990. Overall, the Perinatal Period III death rate remained consistent during the five-year span from 1991 through 1994. 1995 was an exceptional year when the rate dropped to 8.5. For comparison, the 1996 rate represents a 52.6 percent decrease from the 1966 death rate of 26.7 (n=977). In 1976, the rate was 18.9 (n=674) and in 1986, the rate was 10.0 (n=395). Of the 336 total Perinatal Period III deaths in 1996, 179 were fetal deaths and 157 hebdomadal deaths. In 1996, 46.6 of the reported fetal deaths occurred to mothers in the 20-29 age group, with a fetal death rate of 49.1 deaths per 1,000 total live births. Also, in 1996, 73.6 percent of all fetal deaths weighed less than 2,500 grams. The fetal death rates by race were comparable: white = 4.9, black = 5.1.

The 1996 perinatal mortality rate baseline of 9.2/1,000 live births increased slightly to 9.6 in 1997 and then dropped to 8.6 in both1998 and 1999.

OUTCOME The child death rate per 100,000 children aged 1-14

MEASURE 6 [no corresponding 1997 **Kansas objective**]

Kansas annually tracks the child death rate in two age breakdowns: children under 5 and children aged 5-14. Kansas, the child death rate for children under 5 and children aged 5-14. The 1986 baseline for children under 5 was 2.2 per 1,000 age-group population. The mid-course (1991) rate was also 2.2. In 1996, the rate decreased to 2.0. The 1986 baseline for children aged 5-14 was 0.3 per 1,000 age-group population. The mid-course (1991) rate was also 0.3. In 1996, the rate remained at 0.3.

The goal Kansas has adopted for this measure is the Healthy People 2000 age-related goal to reduce the death rate for children by 15% to no more than 28 per 100,000 children aged 1-14. In 1996, the rate remained at 0.3. Using 1990 for determining the baseline data for this measure, the child death rate for children aged 1-14 years was 29.7 per 100,000. Like the two rates shown above, this rate also shows little movement. In 1991 the rate increased to 32.9 but remained stable from 1992 through 1995 with a four-year rate of 27.7. In 1996, there were 164 child deaths with the rate increasing to 30.86.

The 1996 baseline for child deaths (age 1-14) per 100,000 age group population of 30.9 declined to 24.6 in 1997. This rose to 28.4 in 1998, still below the baseline year. In 1999 the rate of 26.2 is a decrease.

Overview

In addressing the eighteen required National Performance Measures (NPM) and the seven state negotiated Performance Measures (SPM), Kansas Title V has identified the direction of change between the baseline and the most recent data point.

In FY99, only one performance measures went in the wrong direction: SPM 3 Rate of Spina Bifida and other Neural Tube Defects increased to 8.3 relative to a FY98 rate of 4.4. The cause of the increase is unknown, although the rates are based on relatively small numbers and are erratic from year to year. Thus, we need to monitor this trend to see if it is a true increase or simply a random fluctuation. Nine measures had little or no change. NPM 4 (percent newborns screened) and NPM 15 (percent of LBW live births) have remained stable for 3 years and may have reached their maximum.

Six of these measures (SPM 1, NPM 6, NPM 17 and NPM 18) contribute to a favorable infant mortality rate, neonatal rate, post-neonatal rate and perinatal rate (outcome measures 1, 3, 4 and 5). In addition, six measures (SPM 1, NPM 6, SPM 7, NPM 15, NPM 17 and NPM 18) contribute favorably to the ratio of black infant mortality to white infant mortality (Outcome Measure 2). SPM 3 contributes unfavorably to Outcome Measures 1, 2, 3, 4. NPM 2, NPM3, NPM 5, NPM 8, SPM 4, SPM 6 and SPM

7 contribute favorably to Outcome Measure 6.

Performance Measure	FY 99 PERFORMANCE MEASURE STATUS				
	Baseline Data (Available*, Not Available)	Comparison Data (Available*, Not Available)	Movement in Right Direction	Little or No Change	Movement in Wrong Direction
NPM 1	available	available	**U**	-	-
NPM 2	available	available	-	**U**	-
SPM 1	available	available	**U**	-	-
NPM 3	available	available	**U**	-	-
SPM 2	available	available	**U**	-	-
SPM 3	available	available	-	-	**U**
NPM 4	available	available	**U**	**U**	-
NPM 5	available	available	**U**	-	-
NPM 6	available	available	**U**	-	-
NPM 7	available	available	-	**U**	-
NPM 8	available	available	**U**	-	-
NPM 9	available	available	**U**		-
NPM 10	available	available	**U**	-	-
SPM 4	available	available	**U**	-	-
NPM 11	available	available	-	**U**	-
NPM 12	available	available	**U**	-	-
SPM 5	available	not available	-	**U**	-

Performance Measure	FY 99 PERFORMANCE MEASURE STATUS				
	Baseline Data (Available*, Not Available)	Comparison Data (Available*, Not Available)	Movement in Right Direction	Little or No Change	Movement in Wrong Direction
SPM 6	available	available	**U**	-	-
NPM 13	available	available	-	**U**	-
NPM 14	available	available	**U**	-	-
SPM 7	available	available	**U**	-	-
NPM 15	available	available	-	**U**	-
NPM 16	available	available	**U**	-	-
NPM 17	available	available	-	**U**	-
NPM 18	available	available	-	**U**	-

* Estimates for all are available but quality data which matches the required definition is not available in all instances.

Section III. REQUIREMENTS FOR APPLICATION [Section 505]

3.1. Needs Assessment of the Maternal and Child Health Population

During FY 2000, a statewide MCH needs assessment was conducted as part of the Joint State Needs Assessment to determine the need for

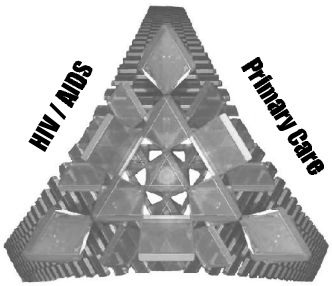
- primary and preventive services for pregnant women, mothers and infants;
- preventive and primary care services for children; and,
- services for CSHCN.

Context. The Kansas Joint State Needs Assessment (JSNA) has been a joint effort between three HRSA-funded programs: Primary Care, HIV/AIDS, and Maternal and Child Health. (Details of the joint nature of this needs assessment are discussed in section 3.1.1.) The JSNA Mission statement is given below.

JSNA Mission: "Improve the health of Kansans through an assessment of needs and the system of services for Primary Care, HIV/AIDS, and Maternal and Child Health".

Adopted by JSNA Steering Committee, October 1999

Joint State Needs Assessment



Maternal and Child Health

Based on "Three Intersecting Planes" by Sasha Ledinsky © 1998

Overview of Needs Assessment in Grant Document. A detailed overview of the JSNA is presented in this document, with a focus on the Maternal and Child Health population. Although final conclusions have been reached (e.g., selection of priority needs), assessment is an ongoing process. We are continuing to assess the health of Kansans and to draw conclusions and implement program activities as a result of our recent data analysis. The information presented here is a snapshot of our progress as of July 1, 2000. More detailed results and complete information on our progress to date will be presented in a final Joint State Needs Assessment report to be released later this year.

A listing of acronyms used throughout the JSNA discussion is given on the following page. Also in this document:

- Section 3.1.1 explains the JSNA process.
- Section 3.1.2 presents an overview of the resulting analyses and results.
- Section 3.1.2.1 provides detail for selected JSNA indicators as well as the JSNA Indexes, tools for program planning and identifying disparities across the state.

T Sections 3.1.2.2 through 3.1.2.5 summarize results by level of service.

Joint State Needs Assessment Acronyms

AIDS: acquired immune deficiency syndrome
ADAP: AIDS Drug Assistance Program
APNCU: Adequacy of Prenatal Care Utilization
BCYF: Bureau for Children, Youth, and Families
BEDP: Bureau of Epidemiology and Disease Prevention
BRFSS: Behavioral Risk Factor Surveillance System
CDC: Centers for Disease Control and Prevention
CHAP: Community Health Assessment Process
CHIP: Child Health Insurance Program
CHSI: Core Health Status Indicator
CSHCN: Children with Special Health Care Needs
DHSI: Developmental Health Status Indicator
DRG: Diagnostic Related Group
D.S.-Rural: Densely-Settled Rural
EPSDT: Early and Periodic Screening, Diagnostic and Treatment
ERP: Electronic Reporting Package
FQHC: Federally Qualified Health Centers
FP: Family Planning
FTE: full-time equivalent
HCFA: Health Care Financing Administration
HEDIS: Health Plan Employer Data and Information Set
HP: Healthy People
HPSA: Health Professional Shortage Area
HRSA: Health Resources and Services Administration
HSI: Health Status Indicator
IDS: Indicator Detail Sheet
JSNA: Joint State Needs Assessment
KAMU: Kansas Association for the Medically Underserved
KBH: Kan Be Healthy
KDHE: Kansas Department of Health and Environment
KHA: Kansas Hospital Association
LHD: local health department
MCH: Maternal Child Health
NPM: National Performance Measure
OB/Gyn: Obstetrics/Gynecology
OHCI: Office of Health Care Information
OLRH: Office of Local and Rural Health
OM: Outcome Measure
PC: Primary Care
PDG: Population Density (Peer) Group
PRE: Population density group by Race/Ethnicity
SIDS**:** Sudden Infant Death Syndrome
SPM: State Performance Measure
SSDI: State Systems Development Initiative
SSI: Supplemental Security Income

Reader Hint: *Needs assessment sections will reference first the Title V section, then the JSNA section in parentheses. For example, JSNA Background is described in Section 3.1.1(A.1).*

WIC: Women, Infants, and Children
YPLL: Years Productive Life Lost (or Years Potential Life Lost)

3.1.1 Needs Assessment Process

3.1.1 (A) Process Overview. This section gives the background of the JSNA as well as an overview of the JSNA needs assessment cycle and a timeline of JSNA events.

3.1.1 (A.1) JSNA Background. The conclusion of this cycle of the Joint State Needs Assessment culminates efforts started in 1995 when the Kansas MCH program began planning the next cycle of their five-year needs assessment. In 1995, the HRSA-funded Primary Care program (Primary Care Office Grant) accepted an invitation by the Director of the Bureau for Children, Youth and Families (BCYF) to partner on needs assessment efforts. A series of collaborative sessions during 1995 and 1996 involving staff within and outside of KDHE resulted in a comprehensive list of indicators, a JSNA process structure, and a detailed indicator and analysis framework. The SSDI Coordinator served as JSNA Project Coordinator and staffed these efforts, extensively researching indicator, project structure, and analysis options. Working collaboratively with the Primary Care program in the Office of Local and Rural Health, JSNA indicators and portions of the project structure were influenced by the previous statewide Primary Care assessment. In 1998, HIV/AIDS officially joined as a JSNA partner at the invitation of the BCYF Bureau Director. KDHE's Office of Health Care Information (OHCI) has served as a key resource related to data and analysis efforts.

The JSNA is a partnership of three HRSA-funded programs.

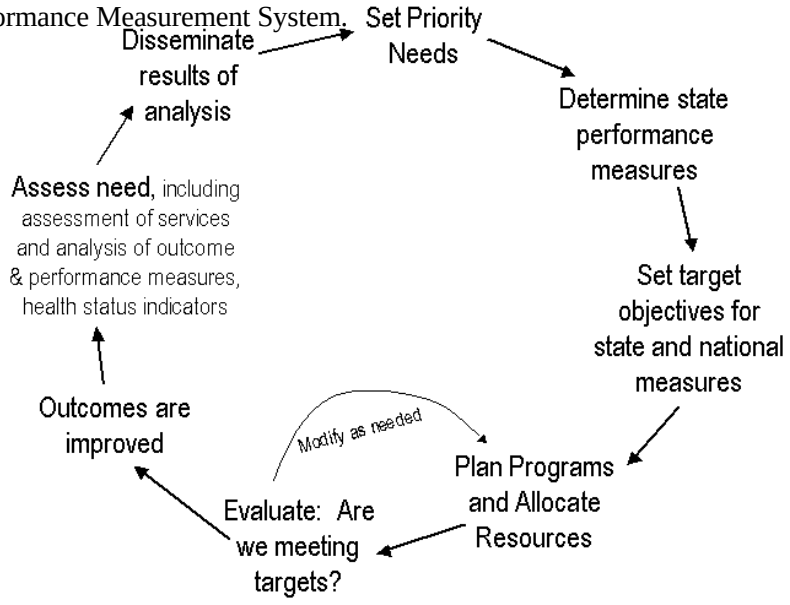
Program	Location in KDHE	Grant
HIV/AIDS	Bureau of Epidemiology and Disease Prevention (BEDP)	Ryan White Title II
Primary Care (PC)	Office of Local and Rural Health (OLRH)	Primary Care Office Grant
Maternal and Child Health (MCH)	Bureau for Children, Youth, and Families (BCYF)	MCH Title V Block Grant

Although the original JSNA framework has evolved to accommodate the Title V MCH Block Grant requirements and state program needs, the project design provided the foundation for the intensive analysis performed this year. Furthermore, the original JSNA indicators have been incorporated in the process along with required Title V Block Grant indicators.

During the past year, there has been an intensive collaborative assessment. A contractor was utilized to assist with the MCH, Primary Care, and joint data collection and analysis portions of the assessment. A separate contractor was secured by the AIDS program to fulfill assessment

needs specific to the HIV/AIDS program.

3.1.1 (A.2) Needs Assessment Cycle. The needs assessment cycle model used for the JSNA (see diagram on following page) is based on the CDC surveillance cycle and incorporates the Title V Block Grant Performance Measurement System.



JSNA Needs Assessment Cycle

During this past year, we have assessed need, disseminated results, determined priorities, and set performance measures and targets. Currently, we are at the "Plan Programs and Allocate Resources" stage of the JSNA Needs Assessment Cycle. Although an initial evaluation of MCH programs and resource allocation has been performed for this grant application, in-depth program planning related to the identified priorities will be performed as part of the JSNA follow-up activities.

3.1.1 (A.3) JSNA Timeline. A timeline is presented to give an overview of JSNA efforts with a focus on assessment activities during the past year.

Date	JSNA Event
1995	Joint State Needs Assessment partnership is formed between MCH and Primary Care.
1995-1996	JSNA indicator set, project design, analysis plan, and final report outline are drafted as a result of collaborative meetings.

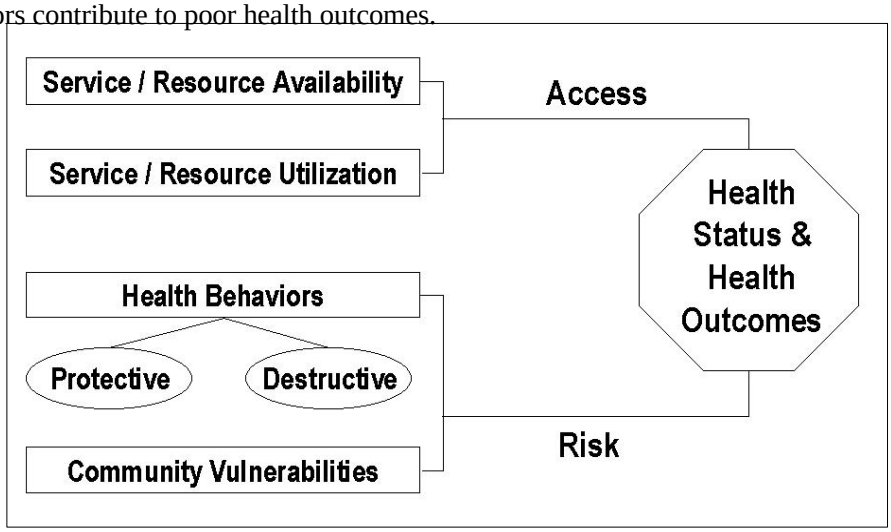
Date	JSNA Event
1996-1998	SSDI Project Coordinator continues to research and update JSNA indicators and project design, seeking collaborative input as needed.
1998	HIV/AIDS program accepts invitation to officially join JSNA partnership. Plans are made for intensive assessment efforts in 1999-2000.
Feb. 1999	JSNA contractor is secured.
May 1999	Kick-off steering committee meeting: Program perspectives, roles, responsibilities, time line.
June 1999	Steering committee meeting: Technical review of assessment process.
Oct. 1999	Steering committee meeting: Mission statement adopted. HIV/AIDS progress report. Review of demographic, socioeconomic, and perinatal analysis results, related program activities, and emerging priorities.
Jan. 2000	Steering committee meeting: HIV/AIDS assessment results. Review of morbidity and mortality results and emerging priorities. Review of CSHCN preliminary results, data challenges, and related program activities, and services.
Jan. 2000	Meeting of MCH, PC, and HIV/AIDS program staff: Discussion of combined MCH, PC, and HIV/AIDS annual Medicaid data request to meet program needs. Discussion of JSNA summary analysis options. Consensus: Population and program-based county indexes for PC and MCH.
Mar. 2000	JSNA Family Planning Index submitted with Title X Grant.
April 2000	Steering committee meeting: Review of draft PC and MCH indexes and emerging priorities.
May 2000	Prioritization Retreat JSNA results presented to Resource Committee. Priority needs drafted.
May 2000	Video Conference Public input received on draft priority needs.

Date	JSNA Event
June 2000	Steering committee meeting: Priority needs approved. Dialog on performance measures, program activities, and ongoing assessment efforts.
June 2000	State-negotiated performance measures determined based on input from steering committee, program managers, and data resources.
June 2000	Target objectives set based on input from program managers.
July 2000	Abridged JSNA results presented with MCH Title V Block Grant.
July - Sept 2000	Final JSNA report released. JSNA follow-up assessment activities
2001-2005	Ongoing assessment, monitoring, and evaluation.

3.1.1 (B) Methodology

3.1.1 (B.1) Foundational Efforts

3.1.1 (B.1.a) **Original Project Design**. The project design drafted in 1995-1996, although not fully incorporated into the Title V Block Grant needs assessment description, has been used throughout this process to help identify the types of information to analyze. Three types of information have been reviewed in this assessment: access, risk, and health status. This original JSNA indicator structure is based on the assumption that low access and/or high risk factors contribute to poor health outcomes.



JSNA Original Indicator Structure

Although the previous structure has been used extensively in JSNA planning, in this document, JSNA indicators are presented in the following simplified categories:

- Demographic
- Socioeconomic
- Health Risk / Health Status
- Access / Resources

3.1.1 (B.1.b) **Technical Review**. During the spring of 1999, there was an extensive technical review of JSNA indicators, project design, and analysis procedures in light of current literature, program activities, and data availability. This built on earlier extensive research for the JSNA during 1995-1999 by the SSDI Project Coordinator. Some of the tasks performed were as follows:

- Reviewed **goal and mission statements** of Healthy People 2000, Healthy People 2010, HRSA, HRSA Maternal and Child Health Bureau, HRSA Bureau of Primary Health Care, HRSA HIV/AIDS Bureau, and other related efforts.
- Reviewed **current literature related to health assessment**. Selected assessment tools, including some from the Office of Local and Rural Health's Kansas Community Health Assessment Process (CHAP), were incorporated into the JSNA process.
- Extensively reviewed and compared **standard sets of objectives and indicators** including Healthy People 2000, Healthy Kansans 2000, *draft* Healthy People 2010, HEDIS, Title V Block Grant, previous Primary Care assessments, required HIV/AIDS indicators, and others.
- Reviewed **regularly available information from standard data resources** including vital records, Census, WIC, KDHE Children and Families Data System, Medicaid, Department of Education, BRFSS, hospital discharge data set, provider licensure surveys, Kansas Cancer Registry, and many others.
- Reviewed **literature related to quantitative analysis tools** including various indexes, matrices, use of charts and maps, statistical analysis procedures, and other methodologies such a systems dynamics.
- Reviewed **target-setting methodologies** including those used by Healthy People 2000 and 2010.

3.1.1 (B.2) Collaboration Process. There were several opportunities for collaboration built into the JSNA process:

1. Joint Nature of Assessment
2. Steering Committee
3. Prioritization Retreat
4. Video Conference
5. Other Collaborative Efforts

3.1.1 (B.2.a) Joint Nature of Assessment. The joint nature of the needs assessment (MCH, PC, and HIV/AIDS) has resulted in diverse input from a wide range of programs, data resources, and constituencies. Some of the benefits and logistical challenges identified in the joint assessment are identified below.

Benefits of Joint Assessment:

- The JSNA has allowed MCH, PC, and HIV/AIDS to **share needs assessment data, tasks, and resources**.
- All three programs have benefitted from a **greater depth and breadth of assessment** than would have been possible had the assessments been performed separately.
- The JSNA increased awareness of the overlap in **target population groups**.
- The JSNA **increased awareness of the efforts of other programs**, resulting in ideas for future support and collaboration between programs to reach target constituencies more effectively.
- The JSNA has resulted in **greater standardization of indicators, terminology, definitions, priorities, and program planning efforts**.
- **Cross-cutting and infrastructure priorities** were identified and can be simultaneously addressed by all three programs.

Logistical Challenges of Joint Assessment:

- The JSNA has attempted to **resolve the differences in program and grant requirements to allow the assessment to proceed jointly** whenever possible. For example, there were differences in required indicators, regions, target population groups, quantitative versus qualitative assessment methods, and indicator and service classification systems (e.g., pyramid).
- At the same time, **each program within the JSNA has individualized their assessment process**, as needed, to insure the assessment results would meet their unique needs. The flexibility of the Primary Care Office Grant and the natural similarities between the MCH and PC target populations and overall program goals have allowed MCH and PC to assess their needs and set priorities almost entirely in tandem. On the other hand, the HIV/AIDS data collection and analysis portion of the JSNA has been performed mostly separate from MCH and PC to meet the unique needs and requirements of the AIDS program.

3.1.1 (B.2.b) **JSNA Steering Committee**. The current JSNA Steering Committee was formed in 1998 and consisted of some of the original members of the advisory group that met during 1995 and 1996 and provided consultation as needed to the SSDI Project Coordinator as needed during 1997. The Steering Committee consisted of approximately 15 key decision makers including Bureau directors representing each program, Director of KDHE's Office of Health Care Information, a parent of a special needs child, a local health department representative, and members representing private and not-for-profit organizations and the academic community. The Steering Committee met quarterly beginning in May of 1999. See the JSNA timeline in Section 3.1.1 (A.3) for Steering Committee meeting topics. The MCH, PC, and HIV/AIDS program staff regularly participated in the Steering Committee meetings as presenters.

As the needs assessment progressed, an attempt was made to broaden input opportunities as priorities emerged. For example, later meetings involved a mental health professional (related to the behavioral health priority need) and representatives from Kansas Social and Rehabilitation Services Medicaid program (related to the coordinated systems of care priority need).

3.1.1 (B.2.c) **Prioritization Retreat**. In May 2000, approximately 35 representatives of a diverse group of programs, organizations, and interests met to draft priority needs. HIV/AIDS had already selected program-specific priorities and presented the results of their assessment and draft priorities. Program staff from MCH and PC had extensively reviewed JSNA assessment results along with current literature and suggested several draft priority needs related to each program / population group: Primary Care; Pregnant Women, Mothers, and Infants; Children and Adolescents; and CSHCN. Participants were given an opportunity to modify the suggested priorities and to propose additions to or deletions from the priority list. Participants then selected the top nine overall priority needs relating to PC, MCH, cross-cutting, and infrastructure issues.

Representatives from the following programs, groups, and organizations provided direct feedback in the JSNA.

Adolescent Health Program (KDHE)
Adult & Medical Services (Medicaid, HealthWave) (SRS)
AIDS Program (KDHE)
BRFSS Program (KDHE)
Breast and Cervical Cancer Program (KDHE)
Bureau for Children, Youth, and Families (KDHE)
Bureau of Epidemiology & Disease Prevention (KDHE)
Bureau of Health Promotion (KDHE)
Child Health Program (KDHE)
Children and Family Services (SRS)
CSHCN parent
CSHCN Program (KDHE)
Family Planning Program (Title X) (KDHE)
Family Services and Guidance Center
Farmworker Program (Migrant program) (KDHE)
Immunization Program (KDHE)
Infant/Toddler Program (KDHE)
Kan Be Healthy (EPSDT) Program (BC/BS)
Kansas Association for the Medically Underserved
Kansas Health Institute
Kansas Hospital Association
Kansas Public Health Association
Kansas State Department of Education
Lead Poisoning Prevention Program (KDHE)
Local Health Departments
March of Dimes
Maternal and Infant Program (KDHE)
Newborn Screening Program (KDHE)
Office of Injury/Disability Program (KDHE)
Office of Local and Rural Health (KDHE)
Perinatal Association of Kansas
Primary Care Program (KDHE)
School Health Program (KDHE)
SSDI Project (KDHE)
Teen Pregnancy Prevention Program (KDHE)
University of Kansas School of Medicine
University of Kansas School of Medicine - MPH Program
WIC Program (KDHE)

3.1.1 (B.2.d) **Video Conference**. One week after the prioritization retreat, feedback on JSNA results and drafted priority needs was solicited from the public at six video conferencing sites around the state. The event was well-publicized through the *Kansas Register*, press releases, and the monthly local health department mailing. Twenty local health departments were represented. One priority need related to coordinated systems of care was added to the list as a direct result of feedback from the local level.

3.1.1 (B.2.e) **Other Collaborative Efforts**. Key results were distributed by e-mail to known stakeholders, soliciting feedback. Input from many other individuals, programs and resources was solicited as needed throughout the process.

3.1.1 (B.3) HIV/AIDS Methodology. The HIV/AIDS program conducted an extensive analysis of the need for services in the HIV/AIDS population. There were three primary analysis tools:

- **Epidemiological Profile**: Analysis of quantitative HIV/AIDS data.
- **Focus Groups**: Four focus groups were conducted, including a focus group of HIV-positive women.
- **Written Survey**: The written survey was mailed through case managers and physicians offices to 519 HIV-positive persons; 182 responded by the deadline.

Of the JSNA partners, HIV/AIDS utilized primary data from focus groups and a written survey to meet many of their unique assessment needs while PC and MCH relied more

A separate researcher was contracted by KDHE to conduct the HIV/AIDS portion of the JSNA to fulfill specific program needs and Ryan White/Title II needs assessment grant requirements. There were opportunities for informal collaboration between HIV/AIDS and PC and MCH relating to selected demographic, socioeconomic, risk, and health status indicators. Also, there was opportunity for collaboration when assessing the needs of and services provided to overlapping target population groups.

3.1.1 (B.4) Primary Care Methodology. The Primary Care (PC) program has now been involved with MCH in the JSNA for five years. Portions of the original JSNA project design were based on previous PC assessment efforts. This, coupled with the flexibility and needs of the Primary Care program, have allowed the PC and MCH portions of the assessment to be conducted almost entirely in tandem, including shared indicators and priority needs. PC has simply had a broader approach to assessing the need for services in their target populations.

3.1.1 (B.5) **Indicator and Data Resources Used**. In addition to the Title V Block Grant required indicators, other indicator and data sets were utilized in the JSNA. The needs assessment portion of the Title V Block grant does not contain all analysis results; only selected indicator results have been included.

3.1.1 (B.5.a) **JSNA Indicator Set**. The JSNA indicator set drafted in 1996 has been, for the most part, incorporated into current assessment efforts. Many of the original JSNA indicators were already required by the Title V Block grant as performance or health status indicators.

3.1.1 (B.5.b) **Primary Care / County Health Profiles**. During the JSNA analysis, Primary Care coordinated the development of an updated version of the Kansas County Health Profiles (CHP), community-based assessment tools. The CHPs included indicators from previous PC assessment efforts as well as others expected to meet local assessment needs. A large portion of this analyzed data was utilized by the JSNA as well as the CHPs.

3.1.1 (B.5.c) **MCH Title V Block Grant**. The Title V Block Grant indicators provided a cornerstone for the MCH data analysis portion of the JSNA:

- Outcome Measures
- Core Performance Measures
- State Negotiated Performance Measures
- Core Health Status Indicators
- Developmental Health Status Indicators

Where quantitative data did not accurately describe the need for services, interviews and input from JSNA participants were helpful.

3.1.1 (B.5.d) **Other Data Resources**. Other indicators have been incorporated into the JSNA as needed. For example, as indexes were developed to summarize need (see Section 3.1.1. [B.7]), certain new indicators were developed. Where quantitative data did not accurately describe the need for services, interviews and input from JSNA participants was helpful.

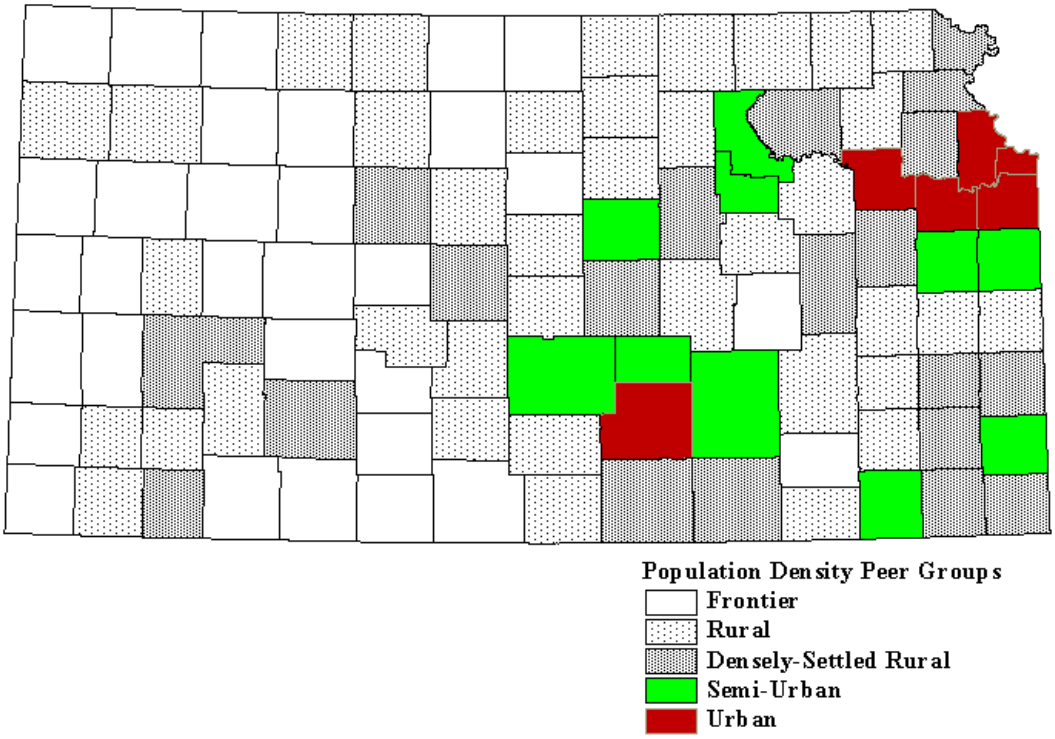
3.1.1 (B.6) **Indicator Stratifications**. In an effort to compensate for small numbers, assess recent trends, and assess geographic and demographic disparities, indicators have been collected and analyzed in a variety of ways.

3.1.1 (B.6.a) **Five Years, 1994-1998:** When possible, five years of data (preferably 1994 through 1998) has been analyzed annually on the state level and combined on the county level to account for small numbers.

3.1.1 (B.6.b) **Geographic**. Geographic disparities have been analyzed by county and by Population Density Peer Group, a rural/urban grouping used by the Primary Care program in the Office of Local and Rural Health.

3.1.1 (B.6.b.1) **Population Density (Peer) Groups (PDG)**. To enhance rural/urban comparisons, most indicators have been summarized by Population Density Peer Group. The peer groups are comprised of counties with similar population densities in persons per square mile.

Population Density Peer Group	1998 Pop. Density (persons per sq. mi.)	Number of Counties	Percent of Kansas Population
Frontier	Less than 6.0	31	4%
Rural	6.0 - 19.9	38	11%
Densely-Settled Rural	20.0 - 39.9	20	17%
Semi-Urban	40.0 - 149.9	10	16%
Urban	150.0	6	51%



The Population Density Peer Groups have been developed to meet the needs of Kansas. Other than "frontier", the groups do not conform to a national standard or the Census definitions of "rural" and "urban".

3.1.1 (B.6.b.2) **County**. Data availability by county was an original JSNA indicator requirement to promote improved planning and resource allocation, as well as to insure that needs assessment results could be directly applied at the local level. Thus, most indicators have been collected and analyzed on the county level.

3.1.1 (B.6.c) **Demographic**. To highlight demographic disparities, indicators have been stratified by the following demographic characteristics whenever possible:

- **Age Group**
- **Race/Ethnicity**
- **Gender**
- **Other**: Characteristics such as educational attainment income, Medicaid status, and marital status were used when possible. Unfortunately, Kansas has relatively few data sets which allow for comparison by income, poverty level or Medicaid status.

Indicator or Index?
Throughout the Kansas JSNA discussion, the terms ***indicator*** *and* ***index*** *are frequently used.*

- ***Indicator*** *is used generically to describe any data or measure used in the assessment, including required Title V Block Grant performance measures, health status indicators, and other data specific to the JSNA.*

- ***Index*** *is used to describe the composite summary of selected key indicators. There are five JSNA indexes, each made up of nine to nineteen indicators.*

3.1.1 (B.7) JSNA Indexes. Throughout the five-year history of the JSNA, a number of quantitative analysis tools have been explored. Based on the input of program staff, it was determined that county-based indexes evaluating the needs of target population groups would be most useful. Thus, four MCH and one PC index have been developed as a central part of the assessment analysis.

3.1.1 (B.7.a) **General Description of Indexes**

3.1.1 (B.7.a.1) **Purpose**. The indexes serve three purposes.

(1) **Improve ease of data interpretation**. *Many* indicators were used in the JSNA. The indexes allow program planners to assimilate data analysis results by summarizing selected "key" indicators.

(2) **Highlight disparities**. The indexes highlight disparities geographically (by county and population density group) and by race and ethnicity, where data is available.

(3) **Intervention planning**. Once an area has been designated high need, the indexes can assist with planning appropriate interventions.

3.1.1 (B.7.a.2) Index Structures. The JSNA indexes may be structured and reported three ways:

(1) **By County**: Each of the 105 counties has an index score to highlight counties most in need of services.

(2) **By Population Density peer Group (PDG Index)**: Each of the five population density peer groups is scored to highlight need for services across the rural/urban continuum.

The abbreviations **PDG** and **PRE** are used throughout the JSNA discussion. Both refer to JSNA ways of grouping data to highlight disparities.

Acronym	Description	Highlights disparities...
PDG	**P**opulation **D**ensity (Peer) **G**roup	*Geographically, a*cross rural/urban continuum

(3) **By Population density group by Race/Ethnicity (PRE Index)**: The purpose of PRE Indexes is to highlight disparities *both* across the rural/urban continuum *and* across race and ethnicity. Four race/ethnicity groups are reported:

- White
- Black
- Other Non-White (includes Native American, Asian, and Pacific Islander)
- Hispanic Ethnicity (any race)

Twenty groups are scored (4 race/ethnicity groups x 5 population density groups). To date, only two PRE indexes have been developed (Family Planning PRE and Perinatal PRE).

3.1.1 (B.7.a.3) Indicators Selected for Indexes. Many indicators have been analyzed and reviewed during the JSNA, including all of the Title V MCH Performance Measurement System indicator and measurement sets. The indexes include selected "key" indicators to assess the needs of a particular population group. Criteria used to select JSNA indicators included

- Standardization with Title V indicators (and other standard sets) whenever possible
- Data availability and data quality
- Small number concerns
- Ability of the MCH or PC program to meet the need for services represented by the indicator
- Magnitude of need represented by indicator

For each index, indicators are listed by the following categories

- Demographic
- Socioeconomic
- Health Status / Health Risk
- Access / Resources

3.1.1 (B.7.a.4) General Index Calculations.

(1) **Rank**. All index tables rank the indicators from highest value to lowest value. Counties are ranked from "1" to "105"; population density groups are ranked from "1" to "5"; and PRE groups are ranked from "1" to "20". Note that a rank of "1" does not consistently indicate a high need for services; it only indicates a high indicator value. For example, a county ranked "3" for 18-19 pregnancy rate and "102" for adequacy of prenatal care would have one of the highest 18-19 pregnancy rates in the state (greater need) and one of the lowest proportions of mothers receiving adequate prenatal care (also greater need).

(2) **Z-Score (Standardized Score)**. To calculate the index score, it is necessary to standardize the indicator values; z-scores were used. Using z-scores to standardize each indicator allows for direct comparison across geographic areas *and* across indicators. For an individual group (e.g., county), the general calculation for a z-score is as follows:

$$Z-score = \frac{County\ Mean - Indicator\ Value}{County\ Standard\ Deviation}$$

Z-scores *provide for easy identification of relative need by allowing data to be directly compared across geographic areas and across indicators.*

The terms ***z-score*** *and* ***standardized score*** *are used interchangeably.*

High standardized scores

Z-scores are always calculated such that ***high*** **standardized scores represent** ***high*** **need** and ***low*** **standardized scores represent** ***low*** **need**.

(3) **Index Score**. For the index score, the z-scores are multiplied by a weight. All indicators began with a weight of "1" and were adjusted based on data quality concerns, ability to measure need for services, magnitude of need represented, and preventability of need represented. The z-scores for each indicator were then multiplied by the

appropriate weight and summed for the final index. See Index tables in Section 3.1.2.1(B) for relative weights used for each indicator.

A *high* final index score represents *high* comparative need for services; a *low* final index score represents a *low* need for services compared to the other groups.

3.1.1 (B.7.b) **Primary Care Index**. The JSNA Primary Care (PC) Index is the third iteration of the PC Index. The first PC Index was released in 1994 as part of a statewide primary care assessment (Primary Care Access Plan). An updated PC Index was released in 1996. The PC Index reports index scores by county and by PDG with plans to eventually report a PRE PC index. Primary Care Index results are summarized in Section 3.1.2.(A.2.b). Refer to Section 3.1.2.1 (B.2) for complete results.

The following key indicators were selected for inclusion in the PC Index.

Demographic Indicators

(1) Percent Minority Population

(2) Percent of Population Aged 65 and Older

Socio-Economic Indicator

(3) Percent of Population in Poverty

Health Status / Health Risk Indicators

(4) Percent Low Birth Weight Births

(5) Crude Birth Rate: Total Live Births per 1,000 Population

(6) Crude Death Rate: Total Deaths per 1,000 Population

(7) Violent Crime Rate

(8) Unintentional Injury Death Rate

(9) Unintentional Injury Years Productive Life Lost (Before Age 65) Rate

(10) "Preventable" Inpatient Hospitalizations per 1,000 Population

Summary of JSNA Indexes

1. **Primary Care Index**
   County Index
   PDG Index

Pregnant Women, Mothers, & Infants

2. **Family Planning Index**
   County Index
   PDG Index
   PRE Index

3. **Perinatal Index**
   County Index
   PDG Index
   PRE Index

Children and Adolescents

4. **Child Health Index**
   County Index
   PDG Index

5. **Adolescent Health Index**
   County Index
   PDG Index

CSHCN

6. **CSHCN Index (under development)**
   PDG Index

PDG: Population Density peer Group
PRE: Population density group, Race and Ethnicity

(11) Percent Preventable Cancers Detected Early

Access / Resource Indicators

(12) Percent Immunized by Age Two

(13) Percent Adequate Prenatal Care

(14) Population per Primary Care Physician FTE

(15) Percent Linguistically Isolated

3.1.1 (B.7.c) **Family Planning Index** . The Family Planning (FP) Index was reported in March with the Title X Family Planning Grant. Index scores are reported by county, PDG, and PRE groups. Family Planning Index results are summarized in Section 3.1.2. (A.3.b.[1]). Refer to Section 3.1.2.1(B.3) for complete results.

The following key indicators were selected for inclusion in the FP Index; they are based on Missouri's Family Planning Index:

Socioeconomic Indicators

(1) Live Births to Mothers with Less than 12 Years Education

(2) Per Capita Income

(3) Unemployment Rate

Health Risk / Health Outcome Indicators

(4) Pregnancy Rate, Ages 15-17

(5) Pregnancy Rate, Ages 18-19

(6) Pregnancy Rate, Ages 20-34

(7) Pregnancy Rate, Ages 35-44

(8) Percent Teen Mothers (< Age 20) with Repeat Birth

(9) Percent with Short Interbirth Spacing (< 18 months)

PDG: Population Density (Peer) Group
PRE: Population density peer group, Race and Ethnicity

3.1.1 (B.7.d) **Perinatal Index**. The Perinatal Index reports scores by county, PDG, and PRE groups. Perinatal Index results are summarized in Section 3.1.2. (A.3.b[2]). Refer to Section 3.1.2(B.4) for complete results.

The following key indicators have been selected for inclusion in the Perinatal Index:

Demographic Indicator

(1) Percent Female Population Age 15-44

Socioeconomic Indicators

(2) Percent of Children Aged 0 to 17 in Poverty

(3) Percent Mothers with Live Birth with Low Education (< 12 years)

(4) Medicaid Deliveries per 100 Live Births

Health Risk/Health Status Indicators

(5) Percent Low Birth Weight Singleton Births

(6) Infant Mortality Rate

(7) Percent of WIC Mothers Breastfeeding at Postpartum Visit

(8) Total Births (Live Births and Fetal Deaths) per 1,000 Females Aged 15-17

Access / Resources

(9) Percent Adequate Prenatal Care

3.1.1 (B.7.e) **Child Health Index (Developmental)**. The Child Health Index reports scores by county and PDG. The Title V Block Grant defines a child as a person "from 1st birthday through the 21st year". However, the JSNA has divided children into two groups: children and adolescents. Children aged 1 through 9 are the target population of the Child Health Index. Age groups used for indicators may vary, however, due to data availability and other considerations. The Child Health Index is still considered developmental; data describing certain key child health issues is not yet available. Child Health Index results are summarized in Section 3.1.2. (A.4.b[1]). Refer to Section 3.1.2 (B.5) for complete results.

Demographic Indicator

(1) Percent of Population Aged 0 to 9

Socioeconomic Indicators

(2) Percent Children (Age 0-17) in Poverty

Health Status / Health Risk Indicators

(3) Percent Overweight WIC Children (i.e., High Weight for Height)

(4) Percent Motor Vehicle Crash Victims (Age 0-15) Not Using Proper Safety Equipment

(5) Reported Child Abuse Cases per 1,000 Children Age 0-17

(6) Child Death Rate: Deaths per 100,000 Age 1-14

(7) Respiratory Inpatient Hospitalizations per 10,000 Children Aged 0-17

(8) Inpatient Hospitalizations for Mental Health Problems per 100,000 Children Aged 0-14

(–) Nonfatal Injuries (to be included as county-level hospital discharge data becomes available)

Access / Resource Indicators

(9) Percent KBH Medical Participation: Percent Age 0 to 9 with at least one Medical Screen

(10) Percent KBH Dental Participation: Percent Age 0 to 9 with at least one Dental Screen

(11) Percent Immunized by Age 2 with 4:3:1 Combo

(12) Child Care Availability per 100 Children Aged 0 to 12

(13) Head Start Slots Available per 100 Preschoolers Aged 3 to 5 in Poverty

3.1.1 (B.7.f) **Adolescent Health Index (Developmental)**. The Adolescent Health Index reports scores by county and PDG. Adolescents aged 10 through 24 are the target population group. Age groups used for indicators may vary, however, due to data availability and other considerations. The Adolescent Health Index is still considered developmental; quality data describing certain key adolescent health issues is not yet available. Adolescent Health Index results are summarized in Section 3.1.2. (A.4.b[2]). Refer to Section 3.1.2 (B.6) for complete results.

Demographic Indicator

(1) Percent Population Aged 10 to 24

Socioeconomic Indicators

(2) Percent Aged 5 to 17 in Poverty

(3) Percent Enrolled in Medicaid (Age 10-24)

(4) Juvenile Court Filings per 1,000 (Age 0-17)

(5) Graduation Rate: Percent Enrolled Receiving High School Diploma

(6) Percent High School Graduates Pursuing Post-Secondary Education

Health Status / Health Risk Indicators

(7) Suicide Deaths per 100,000 (Age 15-24)

(8) Homicide Deaths per 100,000 (Age 15-24)

(9) Motor Vehicle Deaths per 100,000 (Age 15-24)

(10) Alcohol-Related Motor Vehicle Accident Victims per 10,000 (Age 15-24)

(11) Chlamydia and Gonorrhea cases per 10,000 (1995-98) (Ages 15-19)

(12) Percent Smoked Cigarettes within past 30 days

(13) Percent Consumed Alcohol within past 30 days

(14) Percent Used Marijuana within past 30 days

(15) Percent Used Inhalants within past 30 days

(16) Hospitalizations for Mental Health Problems per 10,000 Aged 15-24

(17) Hospitalizations for Drugs & Alcohol per 100,000 Aged 15-24

Access / Resource Indicators

(18) Percent Eligible (Age 10-21) with at least one KBH Medical Screen

(19) Percent Eligible (Age 10-21) with at least one KBH Dental Screen

3.1.1 (B.7.g) **CSHCN Index (Under Development)**. A CHSCN Index is under development. Population-based data for the CSHCN population is limited. A preliminary CSHCN Index was developed by PDG for the following indicators. However, the results are not reported in this needs assessment due to questionable data quality and small numbers for some indicators.

Demographic Indicators

(1) Percent of Students aged 3 to 22 in Special Education Programs

Health Status / Health Risk Indicators

(2) Number of Birth Defects

(3) Birth Defect Rate

(4) Respiratory Inpatient Hospitalizations per 10,000 Children Aged 0 to 17

(5) Percent Very Low Birth Weight Births

Access / Resource Indicators

(6) Special Education Student to Special Education Provider FTE Ratio

(7) Estimated Children with Cleft Lip/Palate or Hearing Impairment per Audiologist

(8) Estimated Children with Cleft Lip/Palate or Hearing Impairment per Speech Pathologist

(9) Estimated Unmet Need: Estimated Percent of *All* Kansas CSHCN Served by the CSHCN Program

(10) Estimated Unmet Need, Neural Tube Defects

(11) Estimated Unmet Need, Cerebral Palsy

(12) Estimated Unmet Need, Cardiac Conditions

(13) Estimated Unmet Need, Cleft Lip / Cleft Palate

(14) Percent of Primary Care Physician FTEs Enrolled as CSHCN Providers

(15) Care Coordination, Primary Care: Percent of CSHCN Primary Care Physicians who

regularly communicate with others on their patients' care teams.

(16) Care Coordination, Specialist: Percent of CSHCN Specialist Physicians who regularly communicate with others on their patients' care teams.

(17) Percent of CSHCN Primary Care Physicians who have patients who travel over 100 miles

(18) Percent of CSHCN Dentists who have patients who travel over 100 miles

(19) Percent of CSCHN Specialists who have patients who travel over 100 miles

Other indicators under development related to dental care, medical home, and newborn screening follow-up.

3.1.1 (B.8) Priority Needs.

3.1.1 (B.8.a) **Selection Process**. Kansas' current priority needs and state negotiated performance were chosen in 1998 without the benefit of a current, comprehensive needs assessment. Although this list of priorities was made available to all JSNA participants at several times throughout the year, the new priorities were chosen from a "clean slate" as a direct result of the JSNA.

Preliminary HIV/AIDS, PC, and MCH assessment results were presented throughout the year at JSNA Steering Committee meetings. Certain needs began emerging through this process. In April and May of 2000, program staff drafted possible priority needs for each population group based on needs assessment results, current literature, and program efforts. These possible needs with accompanying data and justifications were presented to the Resource Committee at the Prioritization Retreat. Participants were given an opportunity to modify or add to the list of suggested priorities, then select the top priority needs. The top nine priority needs drafted as a result of the Retreat were presented for public input at the Video Conference. Based on the input received, ten priority needs were selected.

3.1.1 (B.8.b) **Selection Criteria**. Suggested priority needs met these minimum criteria:

- Meeting the need should have an ultimate positive **impact on health outcomes.**
- The need should be **trackable and measurable**.
- The need should have a relatively **few number of identifiable risk factors** (if applicable).
- We should be able to address the need with a **finite, manageable set of program activities**, services, or interventions.

Prioritization Retreat participants were encouraged to rate suggested priority needs using

CDC's basic priority rating system.

3.1.1 (B.9) State-Negotiated Performance Measures

3.1.1 (B.9.a) **Selection Process**. The JSNA Steering Committee met on June 8, 2000 and adopted the draft priority needs. Possible performance measures for each priority need were presented to the Steering Committee and discussed. MCH Program Staff chose the final list of state-negotiated performance measures based on input from the Steering Committee and others.

3.1.1 (B.9.b) **Selection Criteria**. The following questions were used to help select state-negotiated performance measures:

- Which priorities are already adequately addressed by national performance measures?
- Does a Core or Developmental Health Status Indicator address this priority?
- Do other indicators already developed for the JSNA address this priority?
- What does Healthy People 2010 use to measure this priority?
- Is data available which can be reported with the FY 2001 Title V Grant? Is the data available annually on a state and county level?
- Are there clearly planned program activities which are directly related to the draft state-negotiated performance measures?

3.1.1 (B.10) **Target Objectives**. Various target-setting methodologies were researched and presented early in the JSNA process. Past progress on national performance and outcome measures has been reviewed by MCH program staff. Target objectives have been set consistent with expected improvement based on recent trends and current program activities.

3.1.1 (B.11) **Program Activities and Resource Allocation**. Kansas is in the process of reviewing program plans and resource allocation based on the new priorities. Current program activities related to priority needs are described in Section 4.1. Intensive JSNA follow-up activities will continue through September 2000 and will result in a more detailed plan for program activities and collaborative JSNA efforts aimed at meeting the priority needs.

Basic Priority Rating System

Total Score = (A + 2B) x C

A: Size

B: Severity

C: Preventability

3.1.1 (B.12) **Strengths and Weaknesses of the JSNA**. Although the JSNA is an on-going effort, strengths and weaknesses to-date are identified on the following page from the perspective of Title V requirements.

Strengths of JSNA Process	
[Joint nature of the assessment yielded excellent opportunities for current and future collaboration. [Assessment of health status was detailed and in-depth. [Use of indexes enhanced the focus on geographic and race/ethnicity disparities. [Many quantitative resources were developed to aid state- and community-based problem-solving. [In-depth review of data led to specific opportunities to improve data infrastructure and coordination with data resources.	
Weaknesses of JSNA Process	**Attempts to Resolve**
— Limited data for child and CSHCN populations hindered our ability to assess and quantify the needs of these populations as much as we would have liked.	T Building data, epidemiological, and analysis capacity has been identified as a priority need.
— The vacancy in the full-time SSDI Project Coordinator position resulted in diminished manpower. This resulted in the inclusion of less qualitative data in the needs assessment (e.g., focus groups had been planned).	T The Prioritization Retreat and Video Conference allowed for face-to-face input from a group representing diverse interests.
— Fragmented data systems and various other issues contributed to a less-than complete analysis of the service system than was originally planned.	T Follow-up activities related to "Coordinated Systems of Care" and "CSHCN Acces" priority needs will enhance information on the system of services.
— JSNA results should be used to more comprehensively identify interventions and services and plan program activities to meet the newly identified priority needs.	T Intensive JSNA follow-up analysis and planning will continue through September.

3.1.1 (B.13) On-Going JSNA Efforts. Assessment is an on-going process. The JSNA is continuing intensive analysis, interpretation, dissemination, and planning efforts related to this cycle of data collection and analysis. The JSNA Steering Committee is expected to continue to meet. Intensive follow-up efforts are scheduled for July through September:

- Complete the development of "products" presenting JSNA data and results for program staff, public, and communities (e.g., community report cards, data CDs).
- Based on the results of the JSNA, develop a plan for continued coordination between the three HRSA programs: MCH, Primary Care, and HIV/AIDS.
- Develop a plan for program staff to use outcome, performance, and health status measures to monitor and evaluate their programs and the MCH population during the next five years.
- Research and identify proven state and community interventions to help meet priority needs. Develop a plan for incorporating these interventions into MCH programs.

3.1.2. Needs Assessment Content

Note: Some of the information required for Sections 3.1.2.1., 3.1.2.2., 3.1.2.3, 3.1.2.4, and 3.1.2.5 is embedded within this section.

3.1.2. (A) Assessment

3.1.2. (A.1) HIV/AIDS. The HIV/AIDS Program is a JSNA partner. An overview of the results of their portion of the needs assessment is given here.

3.1.2. (A.1.a) Target Population Groups. The HIV/AIDS target populations include groups engaging in risky behaviors (e.g., men who have sex with men, intravenous drug users) and HIV-positive populations including men who have sex with men, heterosexual men, and women. **Perinatal exposure from HIV-positive women is a concern.** The number of women with AIDS and rate of AIDS among women has remained low in Kansas. However, "**there has been an overall gradual increase in the proportion of women who have developed AIDS relative to men.**" (*HIV/AIDS Epi Profile 1999: Impact of HIV/AIDS on Kansas Residents*, KDHE BEDP)

*Note the **bolded** HIV/AIDS target populations, conclusions and priorities.*

These directly relate to the MCH population and/or were identified as a cross-cutting priority by all three JSNA partners.

3.1.2 (A.1.b) **Overview of Results Related to MCH**. Of the four focus groups in the HIV/AIDS assessment, one was a **focus group of nine HIV-positive women**, resulting in the following information:

- Needs
  - More Physicians
  - Continuation of Medical Insurance
  - AIDS Drug Assistance Program (ADAP)
  - Mental Health Support
  - Family Resources and Support
  - Help with Child Care
- Enhancements Needed
  - Transportation
  - More Pediatricians
  - Return to Work Program
- They felt discrimination for having a family and *not* being gay. They wanted more family-oriented events.

3.1.2 (A.1.c) Conclusions. Here are the conclusions of the HIV/AIDS portion of the JSNA:

- The **demographics of the Kansas HIV/AIDS community is changing**, but many of the needs remain the same.
- The most important and needed care services are **primary care**, ADAP, case management, and **dental care**.
- More physicians are needed in the opinion of the patients.
- More HIV/AIDS knowledge is needed by the case managers, in the opinion of the clients.
- **More non-gay oriented activities and services are needed for the women, families**, and non-gay men.
- Case managers are not seeing over one-third of their clients often enough to meet the new standards of care.
- To a large extent, the *medical* standard of care is being met.
- Many of the trends and assumptions being made in the care system were validated.
- Kansas testing sites are doing a good job at risk reduction counseling, but need

improvement on information of the care system to newly diagnosed clients.

- More funding is needed to meet the growing needs of the HIV/AIDS population.
- More well-informed providers are needed in all aspects of care.

3.1.2 (A.1.d) **Priorities**. Half of the HIV/AIDS priorities specifically relate to the MCH population or MCH priority needs:

- Insure medication availability.
- **Insure all clients have access to care**.
- **Increase access to maternal child programs**.
- **Assess access for prenatal testing**.
- Increase professional providers of all care services.
- Continue assessment annually for the next 3-5 years.

3.1.2 (A.2) **Primary Care**. Just as all aspects of the assessment have closely paralleled for MCH and PC, the results have also been integrated. Many of the conclusions presented in the MCH portion of the assessment also apply to PC, although the focus of the PC program may be a bit broader. For example, one MCH priority need is to "reduce reproductive health geographic and demographic disparities." PC shares this priority and is interested in reducing disparities across all aspects of health status in all vulnerable populations related to all facets of primary care access.

Although each program has a unique focus and unique tasks, many commonalities in the overall goals, target populations, and emerging priorities of the MCH and PC programs became evident throughout the JSNA process.

Only an overview of the PC section of the JSNA is given here. Additional information will be provided in the final JSNA report.

3.1.2 (A.2.a) **Target Population Groups**. Primary Care's target population groups are underserved and vulnerable populations including those who experience financial, geographic, cultural, linguistic, and physical barriers to care. Target populations include, but are not limited to, the following groups:

- Low income, uninsured and under-insured, and others needing "safety net" providers
- Limited English proficiency
- Geographically isolated, particularly those living in rural and frontier areas

- Those with transportation problems
- Migrant and farmworker populations
- Refugees, new immigrants, and undocumented
- Elderly poor and those dually eligible for Medicare and Medicaid
- Racial and ethnic minorities
- "Special" populations, including HIV/AIDS, CSHCN, and those with complex chronic conditions

3.1.2 (A.2.b) **Overview of Results**. The geographic disparities highlighted by the Primary Care (PC) Index parallel those found by the Family Planning and Perinatal Indexes.

A recurring theme throughout the JSNA, Densely-Settled Rural Southwest counties, Geary and Wyandotte scored highest in need on the county Primary Care Index. Chase and Elk, the only two frontier counties in the eastern portion of the state, also scored high. On the PDG Index, Densely-Settled Rural counties scored highest in need while Urban counties scored lowest in need.

Wyandotte and Geary each have unique issues and can not be classified with another group of counties. Seward, Finney, and Ford are all Densely-Settled Rural (D.S.-Rural) counties in the Southwest portion of the state with relatively high proportions Spanish-speaking immigrants.

Johnson County (Kansas City suburbs) is a wealthy county and performs well on the Primary Care Index and many other JSNA indicators. Interestingly, Johnson County is attracting increasing numbers of Spanish-speaking immigrants, although they do not make up a large proportion of the county's total population.

The map on the following page displays the Primary Care Index county results.

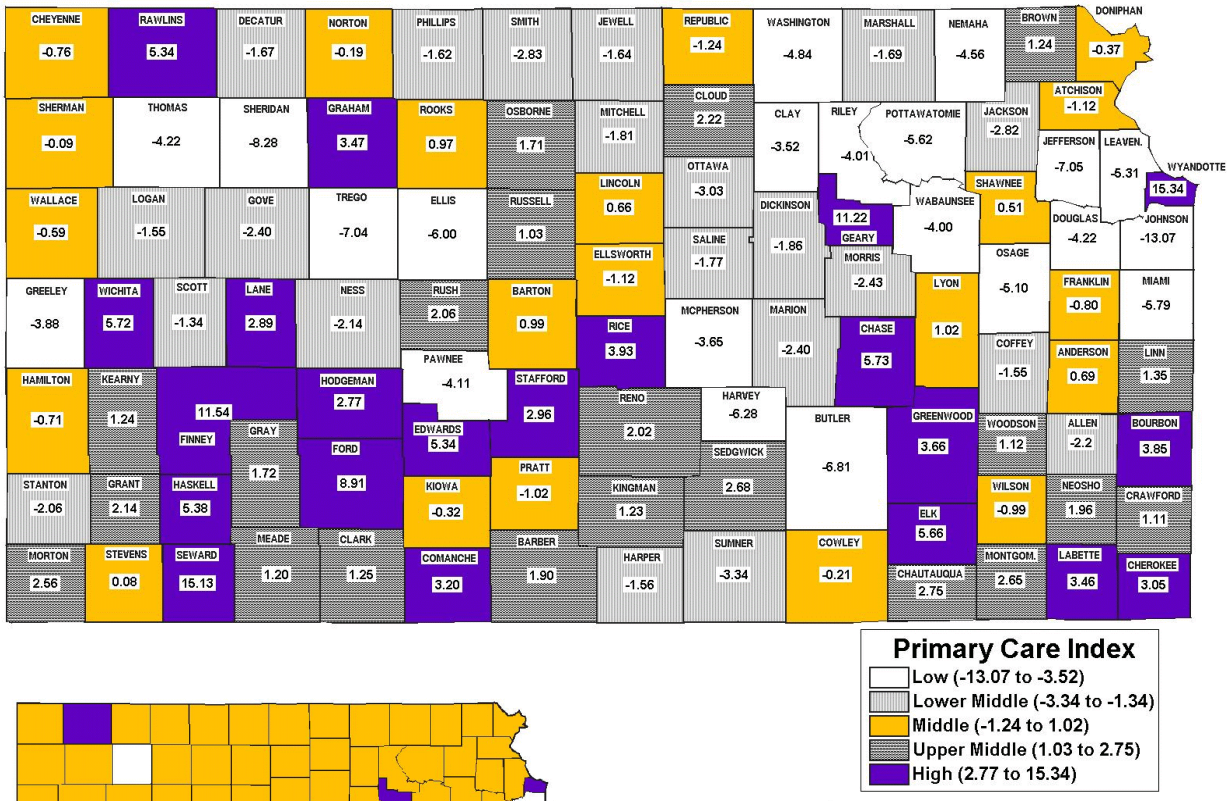
High-Need Counties for Multiple JSNA Indicators

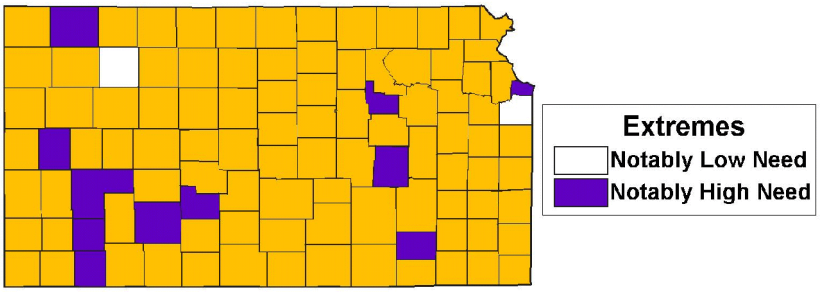
***Wyandotte**: Inner-city Kansas City, KS.*

***Geary**: Junction City, KS. Home of Fort Riley Army Base.*

***Finney**, **Ford**, and **Seward** are Densely-Settled Rural (D.S. - Rural) Counties in Southwest Kansas. A primary industry is the beef/meat-packing industry. These counties have relatively high proportions of Hispanic and limited English proficiency populations. Each has a central city of 15,000 to 25,000 in population.*

Complete index results for all counties and population density peer groups are given in Section3.1.2.1 (B.2).





The following table shows a side-by-side comparison of index results for the five most in-need counties. Kansas' performance on each of the Primary Care Indicators is thoroughly presented in the Indicator Detail Sheets (IDS) in Section 3.1.2.1 (A). IDS numbers are listed in the table.

Primary Care Index: Five Most-in-Need Counties

			SW KS D.S.-Rural Counties		
County	**Wyandotte**	**Geary**	**Seward**	**Finney**	**Ford**
PC Index Rank	**1**	**4**	**2**	**3**	**5**
Demographic Indicators					
Percent Minority (IDS 05)	3.8	3.4	3.1	3.6	2.0
Percent Age 65 and Over (IDS 04)	-1.2	-1.6	-1.8	-2.0	-1.3
Socioeconomic Indicators					
Percent Below Poverty (IDS 07)	2.6	1.4	1.3	0.0	0.3
Health Status / Health Risk Indicators					
% Low Birth Wt. Births (IDS 24)	1.6	1.6	-0.3	-0.1	0.5
Crude Birth Rate	1.5	4.1	3.2	3.6	2.5
Crude Death Rate (IDS 42)	-0.5	-1.5	-1.7	-2.0	-1.1
Violent Crime Rate (IDS 31)	5.0	3.8	2.3	1.4	1.5
Unintentional Injury Death Rate (IDS 43)	-0.9	-0.6	0.2	-0.4	-0.6
Unintentional Injury YPLL Rate (IDS 44)	-0.4	0.3	0.9	0.5	-0.2
"Preventable" Hosp. Rate (IDS 39)	0.1	-1.5	-0.7	-1.0	-0.6
Percent Early Cancer Detection (IDS 40)	-0.4	-0.8	-0.6	-0.5	-0.4
Access / Resources Indicators					
Percent Immunized by Age 2 (IDS 45)	3.3	1.2	2.1	0.9	0.2
Population per PC Phys. FTE (IDS 46)	-0.6	-0.1	-0.1	0.0	-0.3
Percent Adequate Prenatal Care (IDS 49)	0.4	0.9	2.4	2.7	2.5
Percent Linguistically Isolated (IDS 50)	0.4	0.3	5.4	5.0	3.5
Primary Care Index Score	**15.3**	**11.2**	**15.1**	**11.5**	**8.9**

In general, high standardized scores represent counties with high need for Primary Care services. Low z-scores represent low need. Counties with z-scores greater than 1.5 are notably worse than other areas of the state and may require special interventions related to that need. Z-scores do not necessarily add to totals due to weighting; all indicators are not weighted equally.
IDS: Indicator Detail Sheet. See Section 3.1.2.1 (A)

Note that each of the top five counties have very high proportions of minorities, relative to other counties in the state. All counties have relatively high birth rates, low crude death rates and low proportions of elderly. Wyandotte and Geary perform poorly on percent low weight births. The D.S.-Rural group of counties performs within an average range for low birth weight, but poorly on adequate prenatal care.

Complete Primary Care analysis results and conclusions will be presented in the final JSNA report.

3.1.2 (A.2.c) Priorities. Primary Care priorities overlap MCH priorities. Those priorities of particular interest to PC are listed below:

MCH Priority #	Priority Need
1	**Access**: Improve access to all aspects of primary care for vulnerable populations.
3	**Disparities**: Reduce demographic and geographic health disparities.
4	**Data, Epidemiological, and Analysis Resources**: Increase data infrastructure, epidemiological capacity, and products of analyses for improved state and community problem-solving.
8	**Oral Health**: Develop oral health capacity.
9	**Behavioral Health Capacity**: Develop behavioral health infrastructure.
10	**Coordinated Systems of Care**: Improve systems coordination and remove barriers caused by categorical programs and funding.

Access was the top priority related to PC. Identified PC access issues included:

- Access for the limited English proficiency population
- Culturally competent providers and service systems
- Translation services
- Medical home issues
- Need for expanded provider hours
- Geographic access disparities
- Telemedicine needs
- Availability of Medicaid providers in all parts of the state
- Safety-net providers to insure access to uninsured and under-insured
- Provider education and provider proficiency
- Access to *all* components of primary care, including dental, vision, hearing, and mental health screening and services
- Transportation to services

3.1.2 (A.3) MCH Population Group: Pregnant Women, Mothers, and Infants

3.1.2 (A.3.a) Target Populations. The target population for Family Planning is women of reproductive age.

The target Perinatal population groups are

- Pregnant Women
- Mothers through Postpartum
- Infants (0-12 months; in particular, infants 0-28 days)

The infant population group may overlap with the Child Health target population group.

3.1.2 (A.3.b) **Overview of Results**. The results of key demographic, socioeconomic, and health status, and access/resource indicators are presented here through the results of the Family Planning and Perinatal Indexes.

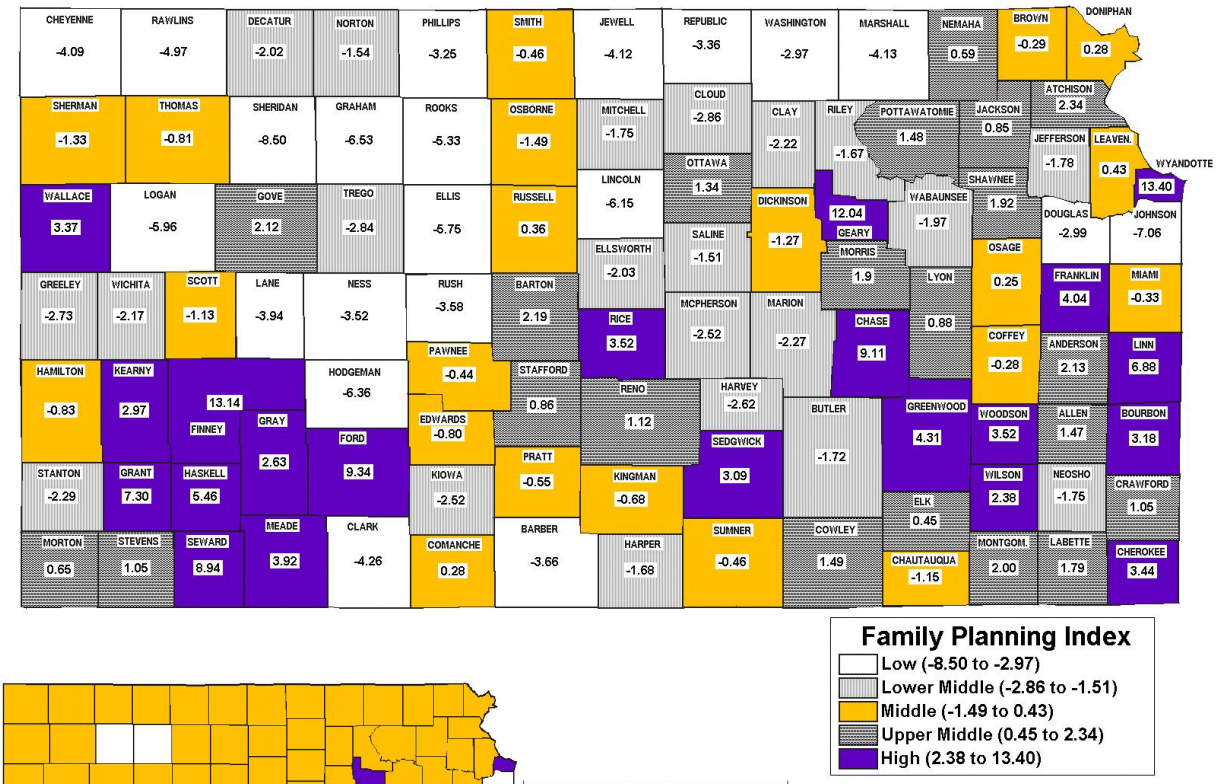
For each JSNA Index, refer to Section 3.1.2.1(B) for complete results.

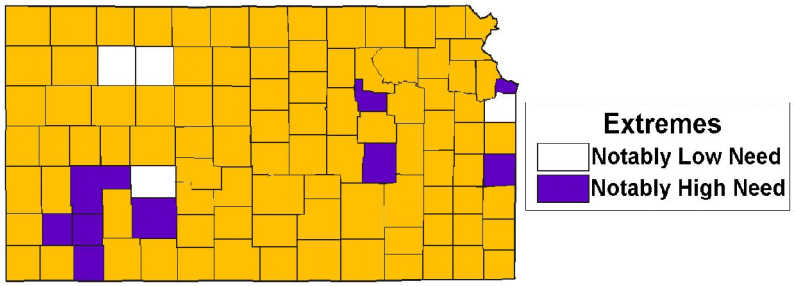
3.1.2 (A.3.b.1) **Family Planning Index**. The Family Planning Index is reported by all three groupings: County, PDG, and PRE. See Section 3.1.2.1 (B.3) for complete results of all indexes.

The geographic disparities highlighted by the Family Planning Index closely parallel Perinatal and Primary Care Index results. Again, Wyandotte, Geary and Southwest D.S.-Rural, and Chase Counties are in the top ten high need. Johnson County, along with three Frontier Counties, has the lowest need. (See map on the following page.) Over the rural/urban continuum, the D.S-Rural PDG scored highest in need.

Population Density Peer Group	Rank	Index Score
Densely-Settled Rural	1	2.84
Urban	2	0.79
Semi-Urban	3	0.39
Rural	4	0.12
Frontier	5	-1.57

On the PRE Index, of the twenty groups, the top three are Hispanic (D.S.-Rural Hispanic, Rural Hispanic, and Frontier Hispanic). (See Section 3.1.2.1[B.3] for more detail.)





The table on the following page gives a side-by-side comparison of needs for the top scoring counties. Kansas' performance on each of the Family Planning Indicators is thoroughly presented in the Indicator Detail Sheets (IDS) in Section 3.1.2.1(A). IDS numbers are listed in the table.

Note that the top four counties have high adolescent pregnancy rates. All except Wyandotte have notably high pregnancy rates for women ages 20 to 34. Finney and Ford have high pregnancy rates for ages 35 to 44; Hispanic women in these counties with extended child-bearing years appear to contribute to this high rate. The Hispanic D.S.-Rural pregnancy rate for women aged 35 to 44 is well over twice the rate for White females in D.S.-Rural counties.

Family Planning Index: Five Most-in-Need Counties

		SW KS D.S.-Rural			
County	**Wyandotte**	**Finney**	**Ford**	**Geary**	**Chase**
Family Planning Index Rank	**1**	**2**	**4**	**3**	**5**
Socioeconomic Indicators					
Per Capita Income (IDS 14)	0.9	0.2	-0.1	1.0	0.1
Unemployment Rate (IDS 15)	2.8	-0.5	-0.8	2.3	0.7
Percent Mothers with Low Ed. (IDS 08)	1.4	3.2	2.9	-0.4	0.1
Health Status / Health Risk Indicators					
Pregnancy Rate: Age 15-17 (IDS 16)	3.2	2.7	2.3	3.4	2.3
Pregnancy Rate: Age 18-19 (IDS 17)	1.9	1.5	1.0	1.8	-0.1
Pregnancy Rate: Age 20-34 (IDS 20)	0.8	2.3	2.3	2.6	3.1
Pregnancy Rate: Age 35-44 (IDS 21)	0.5	2.8	1.3	0.5	0.9
Percent Teen Mothers with Repeat Birth (IDS 19)	1.6	1.2	0.7	1.3	1.2
Percent with Short Interbirth Spacing (IDS 22)	2.1	1.2	1.0	1.4	1.3
Family Planning Index Score	**13.4**	**13.1**	**9.3**	**12.0**	**9.1**

In general, high standardized scores represent counties with high need for Family Planning services. Low z-scores represent low need. Counties with z-scores greater than 1.5 are notably worse than other areas of the state and may require special interventions related to that need. Z-scores do not necessarily add to totals due to weighting; all indicators are not weighted equally.
IDS: Indicator Detail Sheet. See Section 3.1.2.1 (A)

All of the top five counties had comparatively higher percentage of teens with a repeat birth. Wyandotte County, in particular, had a high percentage of mothers with short interbirth spacing. The D.S.-Rural Counties were significantly higher than average for percent of mothers with less than 12 years of education. Again, Hispanic populations appear to contribute to the high percentage in these counties. The percentage of Hispanic women giving birth in Densely-Settled Rural Counties with less than twelve years of education is nearly four times greater than the state average (65.1% versus 17.7%)!

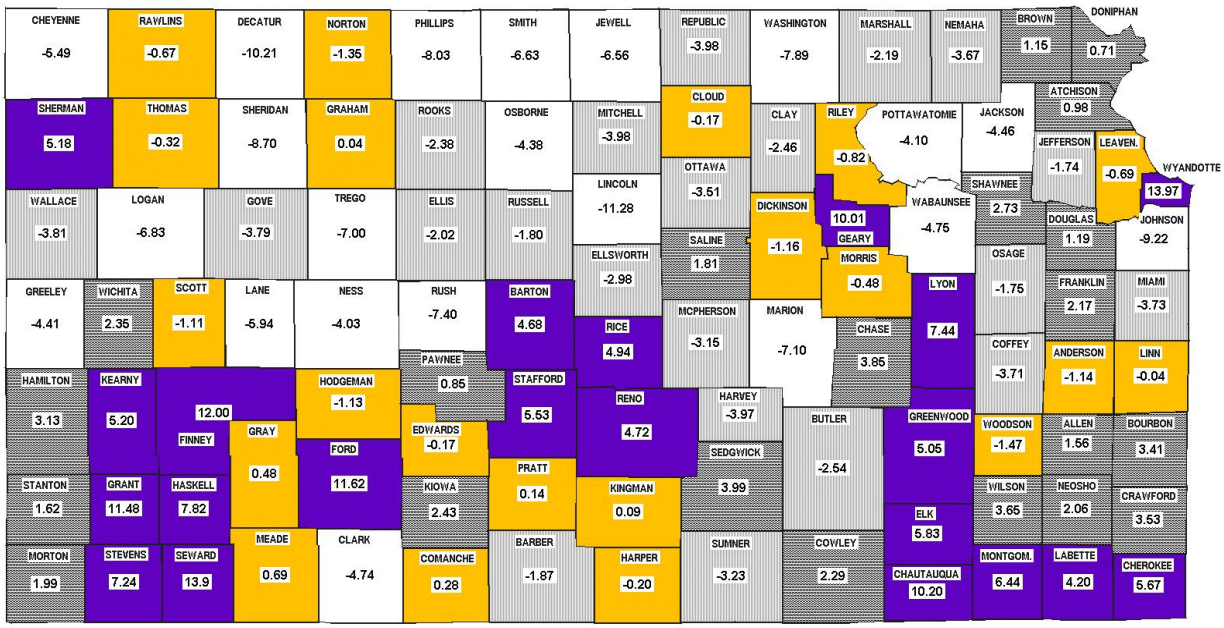
3.1.2 (A.3.b.2) Perinatal Index. The Perinatal Index is reported by all three groupings: County, PDG, and PRE. See Section 3.1.2.1 (B.4) for complete results of all indexes.

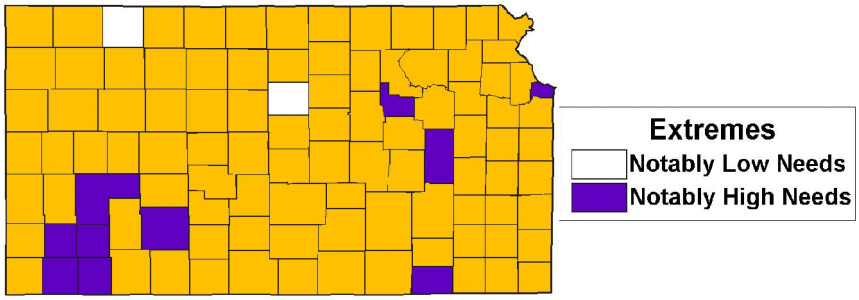
The geographic disparities highlighted by the Perinatal Index closely parallel Family Planning and Primary Care Index results. Again, Wyandotte, Geary, and Southwest D.S.-Rural are in the top ten. Three SW Kansas Rural Counties (Grant, Haskell, and Stevens) also show up in the top ten.

Over the rural/urban continuum, the D.S-Rural PDG scored highest in need.

Population Density Peer Group	Rank	Index Score
Densely-Settled Rural	1	7.11
Semi-Urban	2	2.34
Urban	3	-1.00
Rural	4	-1.54
Frontier	5	-6.91

On the PRE Index, of the twenty groups, three of the top five are Black population groups (D.S.-Rural Black, Urban Black, and Rural Black) and two are Hispanic (D.S.-Rural Hispanic and Rural Hispanic). (See Section 3.1.2.1[B.4] for more detail.)





Perinatal Index: Five Most-in-Need Counties

		SW KS D.S.-Rural			
County	**Wyandotte**	**Seward**	**Finney**	**Ford**	**Grant**
Perinatal Index Rank	**1**	**2**	**3**	**4**	**5**
Demographic Indicators					
Percent Females Age 15-44 (IDS 03)	1.2	1.4	1.7	1.1	1.1
Socioeconomic Indicators					
% Age 0-17 Below Poverty (IDS 06)	3.3	1.3	-0.2	0.3	-0.1
% Mothers with Low Education (IDS 08)	1.4	3.2	3.2	2.9	3.1
Medicaid Delivery Rate (IDS 09)	1.4	1.9	0.0	0.8	0.9
Health Status / Health Risk Indicators					
% Low Birth Wt. Singleton Births (IDS 25)	1.9	-0.1	0.0	0.5	0.7
Infant Mortality Rate (IDS 28)	0.3	-0.5	-0.1	0.2	0.5
Percent Breastfeeding (WIC) (IDS 26)	1.1	-0.6	-0.1	-0.3	0.4
Total Birth Rate Ages 15-17	2.9	3.4	3.3	2.1	3.4
Access / Resources					
Percent Adequate Prenatal Care (IDS 49)	0.4	2.4	2.7	2.5	1.0
Perinatal Index Score	**14.0**	**13.9**	**12.0**	**11.6**	**11.5**

In general, high standardized scores represent counties with high need for Perinatal services. Low z-scores represent low need. Counties with z-scores greater than 1.5 are notably worse than other areas of the state and may require special interventions related to that need. Z-scores do not necessarily add to totals due to weighting; all indicators are not weighted equally.
IDS: Indicator Detail Sheet. See Section 3.1.2.1 (A)

An overview of needs for the top five high-need counties is given here. Kansas' performance on each of the Perinatal Indicators is thoroughly presented in the Indicator Detail Sheets (IDS) in Section 3.1.2.1(A). IDS numbers are listed in the above table.

Note that Grant, a SW Rural county performs similarly to the SW D.S.-Rural counties. Wyandotte, while scoring the highest, clearly has different needs than the SW counties. For example, Wyandotte performs poorly on percent low birth weight singleton births while the SW counties perform within an average range. Adequate Prenatal Care is not a significant problem in Wyandotte County, but the SW D.S. Rural counties perform significantly worse than the rest of the state. All of the top five have notably high adolescent total birth (live births plus fetal deaths) rates.

3.1.2 (A.3.b.3) Other Results. Selected results not covered by indicator detail sheets are discussed here.

Women in need of contraceptive services. In 1995, an estimated 588,130 women were in need of contraceptive services (Alan Guttmacher Institute). This is based on the estimated numbers of women aged 13 to 19 and women aged 20 and older whose family incomes are below 250% poverty.

Abortion. Of the 11,624 abortions performed in Kansas (1998), 44.6% were to out-of-state residents. Five percent (586) were performed after 21 weeks gestation. The number of abortions per 1,000 live births remains well below the national average (186 versus 314 in 1996) and has declined approximately 10% from 1996.

Alcohol and Tobacco Use During Pregnancy. Although alcohol and tobacco risk factors are collected on the birth certificates, the data is presumed to be significantly underreported, particularly for alcohol. Reported alcohol among women with live births has declined slightly in the last five years, while reported tobacco use has varied little. In 1998, 0.4% of live births identified alcohol use as a risk factor, and 12.5% identified tobacco use.

Due to more thorough data collection methods, WIC data is expected to be less underreported than birth certificate data, especially for tobacco use. During FY 1998, 1.3% of pregnant women in WIC reported alcohol use at their first visit. Regarding tobacco, 22% reported cigarette use during the last three months of their pregnancy.

Neonatal Deaths. Infant mortality is described in IDS 28. Furthermore, neonatal deaths are described in Section 2.5. Progress on Outcome Measures 01 through 05.

Child Death Review Board: In its 1997 annual report, the Child Review Board found that just over half of childhood deaths in 1997 were due to natural causes. Premature births contributed to 134 of the 263 natural causes deaths. Of deaths among children less than one year old, 12 mothers used alcohol, 11 used drugs, and 38 smoked tobacco products during their pregnancies. The Board concluded that while little can be done to prevent natural deaths from occurring, one of the best precautions is for a pregnant women to take care of her body, for her own sake and for the sake of her unborn child.

Outcomes for Medicaid Population. The matching of birth records and Medicaid claims files is in-process at the time of grant submission. A match of approximately 70% of the estimated Medicaid deliveries has been completed to-date. Evaluation of Core HSI 06 indicated disparate outcomes by Medicaid and non-Medicaid populations. (See Section 5.4 for exact results.)

Other. For other results related to Pregnant Women, Mothers, and Infants, refer to

- Section 2.4. Progress on Annual Performance Measures. Specifically, see NPM 04, 09, and 10 as well as SPM 02, 03, and 01.
- Section 5.4. Refer to Core HSI 06, 07A, 07C and Development HSI 06, 07, and 08.

3.1.2 (A.3.c) **Key Conclusions**. Family Planning identified needs related to the JSNA and submitted with the Title X grant are as follows:

- Allocate resources targeting those counties with highest need based on the FP Index.
- Educate program staff and young women regarding the health benefits of longer inter-birth intervals.
- Renew efforts to reduce disparities with special emphasis needed to reach women of Hispanic ethnicity in Southwest Kansas and Black women in urban counties.
- Increase linkages with the Statewide Farmworker Health Program (Office of Local and Rural Health) to increase public and professional awareness of services available through both programs.
- Share data and information with counties to encourage community-based problem-solving.

*The **Statewide Farmworker Health Program** is located in the Primary Care Section of the Office of Local and Rural Health. The program administers a coordinated statewide system for migrant and seasonal farmworkers to obtain primary health care services.*

The majority of the program's clients are Spanish-speaking immigrants, a high-need population

For the most part, these FP conclusions have been incorporated into one or more MCH priority needs.

Based on the Perinatal Index and other JSNA results, the following perinatal needs were identified:

- Initiate new and/or expanded public and provider perinatal systems targeting those counties with highest need to facilitate access to risk-appropriate perinatal services.
- Reduce perinatal outcomes and care utilization disparities with special emphasis on childbearing women of Hispanic ethnicity and Black women in targeted population density groups.
- Initiate outreach systems to promote entry into and utilization of prenatal and infant/child health services.

Perinatal conclusions have also been incorporated into one or more priority needs.

3.1.2 (A.3.d) **Priority and Related Performance Measures**. Several priorities relate to aspects of family planning or perinatal health, but one priority in particular addresses the needs of Pregnant Women, Mothers, and Infants: #3 Reduce reproductive health demographic and geographic disparities.

Although "reproductive health" is the targeted area for disparity reduction, the JSNA is interested in reducing disparities in all aspects of health and health service systems. Reproductive health has been targeted because (1) significant disparities have been identified in JSNA reproductive health indicators and (2) reproductive health data is readily available by age group, race/ethnicity, geographic area, and other stratifications through vital statistics records. Efforts will be made to improve data capacity to allow for disparity analysis in the child, adolescent and CSHCN populations.

#3 Reduce <u>reproductive health</u> <u>demographic</u> and <u>geographic</u> disparities.

Reproductive Health: Includes family planning and perinatal. Although the focus is on the pregnant women, mothers and infants population group, we wish to reduce disparities in all populations.

Demographic: Focus is on racial and ethnic groups, but also interested in disparities by age group, gender, income, educational attainment, etc.

Geographic: Particularly by Population Density Peer Groups: Frontier, Rural, Densely-settled Rural, Semi-urban, and Urban. JSNA analysis showed D.S.-Rural Counties with high needs in reproductive health.

Disparities: We will seek to reduce disparities by improving the reproductive health outcomes of the high-need demographic and geographic populations.

Related Performance Measures. Although other indicators related to this need will be regularly reviewed, the following key performance measures will be used to track progress:

OM 01	Ratio of black infant mortality rate to white infant mortality rate.
CHSI 06	Medicaid and Non-Medicaid comparison for (a) low birth weight, (b) infant mortality, (c) first trimester prenatal care, and (d) APNCU prenatal care.
SPM 08	Ratio of Kansas APNCU Index to Densely-Settled Rural Hispanic APNCU. ***Rationale for State Performance Measure****: The proportion of Hispanic women in Densely-Settled Rural counties (particularly SW Kansas counties) receiving care is strikingly below the state average and that for other population groups. For 1999, 79.5% of Kansas women received adequate or better prenatal care compared to only 51.9% of Hispanic women in Densely-Settled Rural counties.*

3.1.2 (A.4) MCH Population Group: Children and Adolescents. For the purposes of JSNA analysis, the MCH Children population group has been broken into two groups: Children and Adolescents.

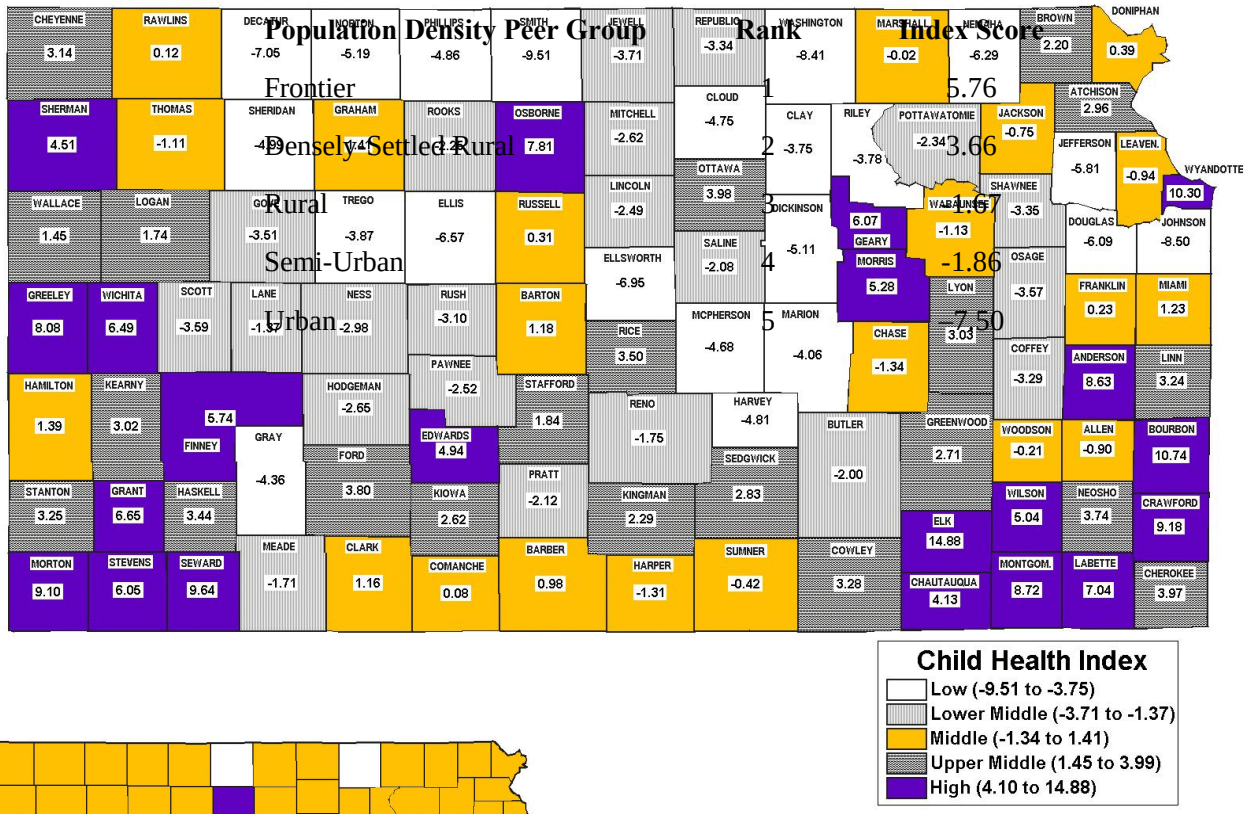
3.1.2 (A.4.a) Target Populations. The target population for children is age 0 through 9, with a focus on ages 1 through 9. For some issues and indicators, it may be desirable to include children through age 14 or older due to data availability, consistency of reporting, and target age groups for interventions.

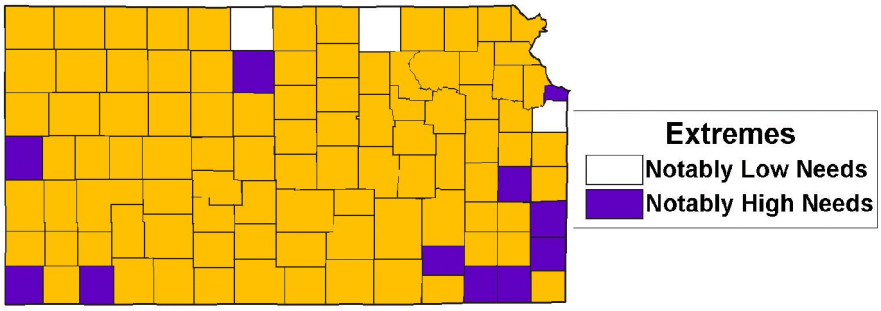
The target population for adolescents is age 10 through 21. Again, the age group may vary depending on data availability and other considerations. Several of the adolescent health indicators report ages 15 to 24.

3.1.2 (A.4.b) Overview of Results. The results of key demographic, socioeconomic, health status, and access/resource indicators are presented through the results of the Child and Adolescent Health Indexes.

3.1.2 (A.4.b.1) Child Health Index. The Child Health Index is reported on two levels: by County and by PDG. See Section 3.1.2.1(B.5) for complete results. Population-based data for children is limited. Preliminary Index results are reported even though the Child Health Index is considered developmental.

Across the rural/urban continuum, Frontier counties scored highest in-need due to poor performance on access and resource-related indicators. Urban counties fared the best.


Population Density Peer Group
Rank
Index Score
Frontier
1
5.76
Densely Settled Rural
2
3.66
Rural
3
1.67
Semi-Urban
4
-1.86
Urban
5
-7.50
Child Health Index
Low (-9.51 to -3.75)
Lower Middle (-3.71 to -1.37)
Middle (-1.34 to 1.41)
Upper Middle (1.45 to 3.99)
High (4.10 to 14.88)


Extremes
Notably Low Needs
Notably High Needs

Wyandotte, a group of Southeast Kansas Counties, and a group of Southwest Kansas Counties perform poorly on the Child Health Index.

An overview of needs for the top five high-need counties is given on the following page. Kansas' performance on most of the Child Health indicators is thoroughly presented in the Indicator Detail Sheets (IDS) in Section 3.1.2.1(A). IDS numbers are listed in the following table.

Child Health Index: Five Most-in-Need Counties

	Southeast KS Counties				
County	**Elk**	**Bourbon**	**Crawford**	**Wyandotte**	**Seward**
Child Health Index Rank	**1**	**2**	**5**	**3**	**4**
Demographic Indicators					
Percent Age 0-9 (IDS 01)	-1.1	-0.1	-0.8	0.9	2.7
Socioeconomic Indicators					
Percent Age 0-17 Below Poverty (IDS 06)	2.4	2.0	1.7	3.3	1.3
Health Status / Health Risk Indicators					
Percent Overweight WIC Children (IDS 27)	0.2	1.8	0.7	-0.4	1.9
Safety Equipment Non-Use Age 1-15 (IDS 33)	-0.2	0.2	-0.4	-0.8	0.4
Reported Child Abuse Cases (IDS 30)	2.9	1.6	1.3	0.6	0.2
Child Death Rate Age 1-14 (IDS 29)	0.1	0.5	-0.2	0.2	-0.6
Respiratory Inpatient Hospitalizations (IDS 41)	-1.0	0.1	4.2	1.1	0.1
Inpatient Hosp. for Mental Health Problems	4.8	3.6	2.5	1.7	-0.5
Access / Resources Indicators					
KBH Medical Participation Age 0-9 (IDS 52)	1.8	-0.7	0.0	0.3	0.8
KBH Dental Participation Age 5-9 (IDS 52)	0.7	-0.5	-1.3	-0.3	-0.5

Percent Immunized by Age 2 (IDS 45)	0.1	0.7	0.9	3.3	2.1
Child Care Availability (IDS 51)	2.4	0.7	0.0	0.1	1.0
Head Start Participation (IDS 51)	1.9	0.8	0.7	0.3	1.1
Child Health Index Score	**14.9**	**10.7**	**9.2**	**10.3**	**9.6**

In general, high standardized scores represent counties with high need for Child Health services. Low z-scores represent low need. Counties with z-scores greater than 1.5 are notably worse than other areas of the state and may require special interventions related to that need. Z-scores do not necessarily add to totals due to weighting; all indicators are not weighted equally.
IDS: Indicator Detail Sheet. See Section 3.1.2.1 (A)

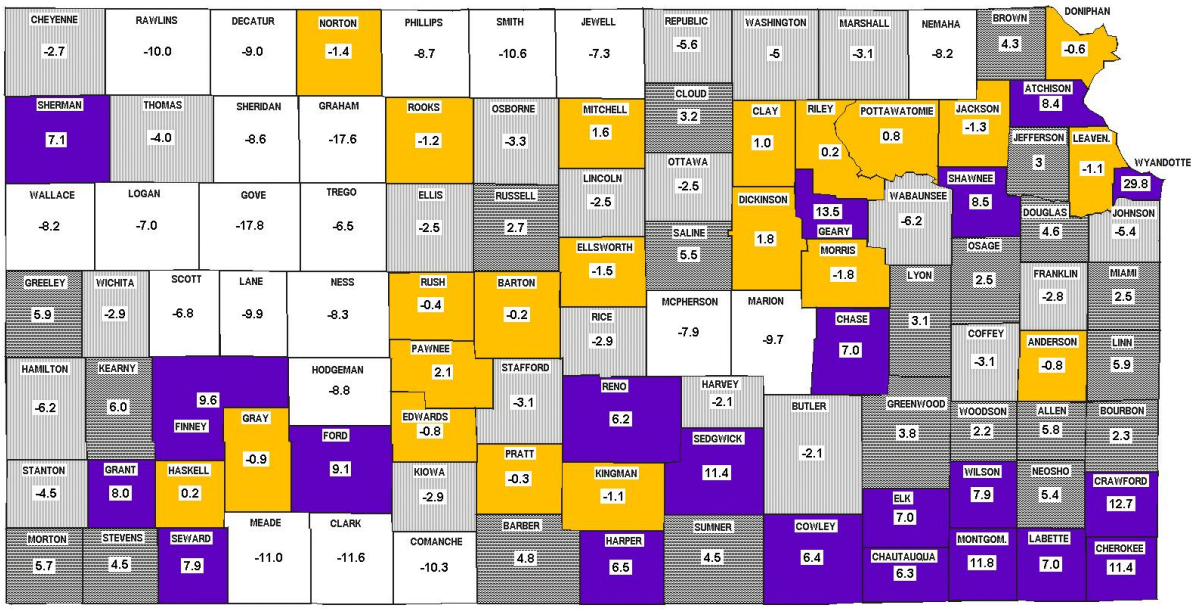
The five most-in-need counties identified by the Child Health Index are Elk, Bourbon, and Crawford (Southeast Kansas counties), Wyandotte, and Seward (a SW D.S.-Rural county). The three Southeast Kansas counties span three PDGs (Frontier, Densely-Settled Rural, and Semi-Urban). All have a high rate of inpatient hospitalizations for mental health problems, although this is a questionable indicator as it only includes community hospitals. They also show a high rate of reported child abuse cases. All five counties have a relatively high rate of children in poverty, but perform average or above average on reported child safety equipment usage in motor vehicles crashes.

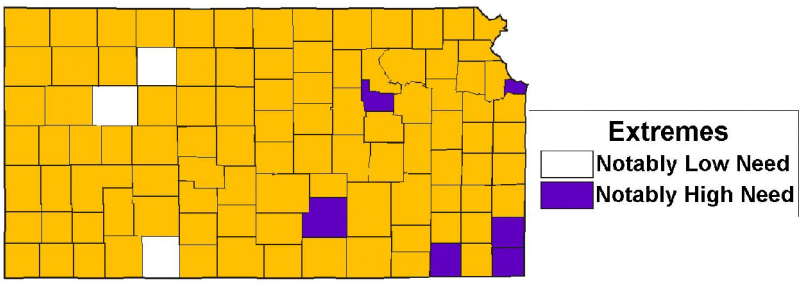
3.1.2 (A.4.b.2) Adolescent Health Index. The Adolescent Health Index is reported on two levels: by County and by PDG. See Section 3.1.2.1(B.6) for complete results. Behavioral risk data (apart from drug and alcohol use) for adolescents is limited. Preliminary results are reported even though the Adolescent Health Index is considered developmental.

Across the rural/urban continuum, the Adolescent Health Index results are nearly opposite those of the Child Health Index. Urban counties have the highest need while Frontier counties score lowest in-need.

Population Density Peer Group	Rank	Index Score
Urban	1	8.74
Densely-Settled Rural	2	5.78
Semi-Urban	3	-0.29
Rural	4	-2.71
Frontier	5	-11.52

An overview of needs for the top five high-need counties is shown below. Kansas' performance on most of the Adolescent





Health Indicators is thoroughly presented in the

Indicator Detail Sheets (IDS) in Section 3.1.2.1(A).

Adolescent Index: Five Most-in-Need Counties

	Urban Counties		*Southeast KS Semi-Urban*		
County	**Wyandotte**	**Sedgwick**	**Crawford**	**Montgomery**	**Geary**
Adolescent Index Rank	**1**	**5**	**3**	**4**	**2**
Demographic Indicators					
Percent Age 10-24 (IDS 02)	0.6	0.4	1.3	0.1	1.9
Socioeconomic Indicators					
% Age 5-17 Below Poverty (IDS 06)	3.3	0.4	1.6	1.5	1.4
% Medicaid Enroll. Age 10-21 (IDS 10)	1.9	0.1	0.6	1.2	0.4
Juvenile Court Filing Rate (IDS 11)	1.5	-0.6	0.3	0.9	2.2
Graduation Rate (IDS 12)	2.4	2.2	0.9	1.4	2.3
Percent Post-Secondary Ed (IDS 13)	0.6	0.5	0.5	1.0	1.0
Health Status / Health Risk Indicators					
Suicide Rate Age 15-24 (IDS 32)	0.1	0.1	-0.1	-0.4	0.1
Homicide Rate Age 15-24 (IDS 32)	6.7	1.4	-0.2	0.8	1.9
Motor Veh. Death Rate Age 15-24 (IDS 32)	-0.7	-0.7	-0.8	-0.3	-0.3
Alcohol-Related Accident Rate (IDS 34)	0.6	0.1	0.5	-0.5	-0.9
Reported STD Rate Age 15-19 (IDS 35)	5.5	1.8	0.3	0.7	6.2
Self-Reported Tobacco Use (IDS 36)	0.1	0.5	1.3	0.8	-1.3
Self-Reported Alcohol Use (IDS 37)	0.0	0.0	0.9	0.0	-1.8
Self-Reported Marijuana Use (IDS 38)	2.4	1.0	1.9	1.0	-0.6
Self-Reported Inhalant Use (IDS 38)	0.4	0.7	0.1	0.3	1.4
Alcohol & Drug-Related Inpt. Hosp.	3.7	2.8	3.6	0.6	-0.8
Inpatient Hosp. for Mental Health Problems Age 15-24	1.2	1.7	2.0	2.3	-0.1
Access / Resources Indicators					
KBH Medical Part. Age 10-21 (IDS 52)	0.5	0.4	-0.2	0.0	0.5
KBH Dental Part. Age 10-21 (IDS 52)	0.0	-0.4	-1.2	0.8	0.8
Adolescent Index Score	**29.8**	**11.4**	**12.7**	**11.8**	**13.5**

In general, high standardized scores represent counties with high need for Adolescent Health services. Low z-scores represent low need. Counties with z-scores greater than 1.5 are notably worse than other areas of the state and may require special interventions related to that need. Z-scores do not necessarily add to totals due to weighting; all indicators are not weighted equally.
IDS: Indicator Detail Sheet. See Section 3.1.2.1 (A)

The five most-in-need counties identified by the Adolescent Health Index are Wyandotte and Sedgwick (Urban counties), Crawford and Montgomery (Semi-Urban Southeast counties), and Geary.

Notable Index results include the adolescent homicide rate for Wyandotte County and the reported STD rate for Wyandotte and Geary counties, which are *significantly* higher than the rest of the state. Geary displays the largest contrast in type of need to the other four counties. Geary performs average to good on several indicators, but performs poorly on juvenile court filing rate, graduation rate, homicide rate, and STD rate.

3.1.2 (A.4.b.3) Other Results.

Child Death Review Board Results. Kansas' Child Death Review Board included the following disturbing findings for 1997: 31 motor vehicle deaths to Kansas children without safety equipment, 25 deaths due to unintentional suffocation or strangulation (including 12 drowning deaths), 21 deaths each due to homicide and suicide, 12 fire-related deaths, and 7 deaths due to child abuse. There were also 46 deaths attributed to SIDS. Based on these findings, the Board outlined prevention points, most related to the prevention of intentional and unintentional injuries:

- Enforce child safety restraint laws.
- Keep firearms from unsupervised children.
- Perform autopsies in childhood deaths which result from causes other than natural disease processes.
- Parents and other caretakers should be educated on proper sleeping arrangements for infants and small children.
- Public education efforts aimed at parents and other caretakers should focus on proper supervision of infants, children, and adolescents.
- Parents, teachers, and all persons who work with adolescents and children should be educated about the risk factors for suicide.
- There should be public education efforts aimed at parents and other caretakers about fire safety.

Childhood Lead Poisoning. In 1998, 892 cases of pediatric lead poisoning were reported in Kansas. After a 33% decrease from 1996 to 1997, the 15% increase from 1997 to 1998 may represent an increase in screening, screening a greater proportion of high risk

children, or an actual increase in the incidence of pediatric lead poisoning.

WIC Nutritional Risk Factors. Of the four child nutritional risk factors regularly tracked by the WIC Pediatric Nutrition Surveillance System, short stature, underweight, overweight, and low hemoglobin/hematocrit, only overweight has shown a slightly increasing trend over the past ten years. The rest have consistently decreased.

Youth Risk Behavior Survey (YRBS). Although the YRBS is conducted in Kansas, the sample sizes are too small to produce results useful for decision making.

Communities that Care (CTC). The CTC survey is conducted in most counties and samples the 6th, 8th, 10th and 12th grades. It is similar to the YRBS, but the questions are limited to drug, alcohol, and tobacco use. See Indicator Detail Sheets 39 through 42 for selected results.

Oral Health. Although children are a target population for dental services, oral health is considered a cross-cutting issue and is discussed in the following sections:

- Section 2.4. Progress on NPM 7.
- Section 3.1.2 (A.6.c.): Oral health priorities
- Section 3.1.2.2 (B.1.c): Dental provider availability
- Section 3.1.2.2 (C.3): Access to Medicaid dental services
- Section 5.4. Developmental HSI 04.

Other. For other results related to Children and Adolescents, refer to

- Section 2.4. Progress on Annual Performance Measures. Specifically, refer to NPM 05, 06, 08 12, 13, and 16 as well as SPM 2 and 4.
- Section 2.5. Progress on Outcome Measure 05.
- Sections 5.4 and 5.6. Refer to Core HSI 01, 02, and 07B and Development HSI 01, 02, 03A, 05, 06, 07, 09, 10, and 12.

3.1.2 (A.4.c) **Key Conclusions**. Based on the Child Health Index, other JSNA results, and current national trends, the following child health needs were identified:

(1) Reduce unintentional injuries in children.

(2) Reduce mental and emotional illness in children.

(3) Reduce childhood morbidity and mortality due to asthma.

(4) Increase childhood immunization rates.

(5) Reduce the incidence of child abuse and neglect.

(6) Increase lead screening and reduce morbidity due to childhood lead poisoning.

(7) Improve childhood nutrition.

(8) Improve access to oral health services for children.

All identified child health needs *except* (3) asthma, (4) immunizations, and (6) lead screening have been directly incorporated into JSNA priorities. These three needs are addressed indirectly by the access (#1) and coordinated systems of care (#10) JSNA priorities.

Based on the Adolescent Health Index, other JSNA results, and current national trends, the following adolescent health needs were identified:

(1) Reduce adolescent injuries, homicide, and suicide.

(2) Reduce mental and emotional illness in adolescents.

(3) Reduce adolescent morbidity and mortality due to asthma.

(4) Improve adolescent nutrition.

(5) Reduce abuse and neglect among adolescents.

(6) Reduce adolescent illegal use of substances.

Of the identified adolescent health needs, (1), (2), (4), and (5) have been directly incorporated into JSNA priorites. Asthma (3) is addressed indirectly by the access (#1) and coordinated systems of care (#10) priorities. Illegal substance use (6) is addressed indirectly by priority need #9 related to behavioral health.

3.1.2 (A.4.d) **Priorities and Related Performance Measures**. Three JSNA priorities have been selected directly relating to child and adolescent health. The cross-cutting priorities, introduced in Section 3.1.2(A.6), also relate to child and adolescent health.

#5 Reduce unintentional injuries.

#6 Reduce intentional injuries.

#7 Increase proper nutrition and physical activity, particularly among children and adolescents.

#5 Reduce unintentional injuries.

Unintentional Injuries: Motor vehicle accidents, drownings, residential fires, and firearms were singled out during JSNA discussions, but JSNA program activities will not necessarily be limited to a particular cause(s) of unintentional injury. Children and adolescents are the target population for MCH, but PC is interested in all age groups.

#5 Reduce unintentional injuries, continued

Related Performance Measures . Although other indicators related to this need will be reviewed, the following key MCH performance measures will be used to track progress:

OM 06: Child death rate per 100,000 children aged 1-14.

NPM 08: Rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.

DHSI 01A: Death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

DHSI 01B: Death rate per 100,000 from unintentional injuries due to motor vehicle crashes among children aged 14 years and younger.

DHSI 01C: Death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15-24 years.

DHSI 02A: The rate per 100,000 of unintentional injuries among children aged 14 years and younger.

DHSI 02B: The rate per 100,000 of all nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.

DHSI 02C: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15-24 years.

DHSI 03A: The rate per 1,000 women aged 15-19 years with a reported case of chlamydia.

SPM 10: Percent of children under age 4 in motor vehicle crashes using proper child safety equipment.

Rationale for State Performance Measure: *Although there are several Title V indicators already related to unintentional injuries among children and adolescents, quality hospital discharge data has not been fully developed to study nonfatal injuries. Furthermore, although Kansas statute requires children under age 4 to be restrained in a child safety seat, Kansas traffic accident data shows that only 69.7% (1995-1998) of children aged 0 to 3 were using a child safety seat properly in motor vehicle crashes. Wyandotte County as well as several Frontier, Rural, and Western KS D.S.-Rural exhibit percentages well below 60%.*

#6 Reduce intentional injuries.

Intentional Injuries: Suicide, youth violence, school violence, domestic violence, and child abuse were identified during JSNA discussions. Although children and adolescents (including CSHCN) are the primary focus, there is also a desire to reduce unintentional injuries among women in general. Furthermore, PC is interested in reducing violence in all age groups.

Related Performance Measures. Although other indicators related to this need will be reviewed, the following key MCH performance measures will be used to track progress:

NPM 16: Rate per 100,000 of suicide deaths among youths aged 15-19.

DHSI 09: Juvenile crime arrests.

SPM 11: Violent acts per 100 enrolled students, 6th through 9th grades.

Rationale for State Performance Measure: *Among the possible intentional injury state performance measures reviewed, the measure representing school violence among younger adolescents was thought to be most amenable to change by Title V involvement.*

#7 Increase proper nutrition and physical activity, particularly among children and adolescents.

Nutrition and physical activity: Child and adolescent obesity was specifically discussed during JSNA. Although the focus is children and adolescents, this JSNA priority includes pregnant women and, from a primary care perspective, all population groups.

Related Performance Measures. Although other indicators related to this need will be reviewed, the following key MCH performance measures will be used to track progress:

NPM 09: Percent of mothers who breastfeed their infants at hospital discharge.

Rationale for State Performance Measure: *Kansas does not have reliable population-based data for all children and adolescents related to physical activity and nutrition. Thus, percent overweight 36-59 month olds from the WIC data system is used.*

3.1.2 (A.5) MCH Population Group: CSHCN

3.1.2 (A.5.a) Target Populations. For planning and analysis the JSNA has adopted the Title V definition:

> Children with special health care needs are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. Newacheck, et. al., *Pediatrics* (1998)

3.1.2 (A.5.b) Overview of Results. Population-based data for CSHCN is limited which hindered the assessment of the CSHCN population group. As stated earlier, a CSHCN Index is under development. Although the complete Index results have not been reported at this time, selected indicators are included. 4,378 in KS?

Birth defects. During 1995-1998, there were 4,378 congenital anomalies. The number of selected birth defects is given in the below table: What could I check these #'s with?

Congenital Anomaly	1995	1996	1997	1998	1995-1998
Other Musculoskeletal/Integumental Anomalies	131	88	103	109	431
Heart Malformation, except PDA	99	81	97	87	364
PDA	75	51	50	52	228
Other Circulatory/Respiratory Anomalies	94	60	55	45	254
Cleft Lip/Palate	44	44	34	39	161
Spina Bifida/Meningocele	24	23	14	11	72
Total Congenital Anomalies	**4,183**	**3,913**	**3,899**	**4,105**	**8,113**

Respiratory inpatient hospitalizations. ICD-9 level data was not readily available during the time of this assessment. Instead, DRG data for bronchitis and asthma inpatient hospitalizations for 0-17 year olds had been used. See Indicator Detail Sheet 41 in Section 3.1.2.1(A).

Very low birth weight births. See Indicator Detail Sheet 23 in Section 3.1.2.1(A).

Estimated unmet needs. The number of CSHCN children who could potentially receive care coordination, information, or other services from the CSHCN program have been estimated based on the proportion of children meeting the national definition for CSHCN. Applying 18% (Newacheck, et. al. 1998) to the population of Kansas children, there are an estimated 154,156 Kansas children meeting the definition of CSHCN (1998). During 1998, 10,972 Kansas children were served by the CSHCN program.

> *Applying the 18% estimate, there are an estimated 154,156 Kansas children age 0 through 21 meeting the definition of CSHCN.*

In 1999, this number increased to 13,139. We believe the increase is primarily due to our increased ability to capture children served by the program.

Through the JSNA, we attempted to determine the level of unmet need by comparing the estimated number of CSHCN children in the state to the number currently served through the Title V CSHCN program. However, the CSHCN data system does not capture everyone touched by the program. Furthermore, the estimates are based on a percentage of the population aged 0 to 21. Not all estimated CSHCN children have need of assistance or would meet income requirements or diagnostic requirements for continued care coordination. Additionally, some may contact the program once for educational or informational materials and would not require assistance every year. However, our attempt to quantify unmet needs have given us a place to start in

(1) Estimating the number of CSHCN children in Kansas.
(2) Recognizing that there is likely unmet need based on the adopted Newacheck CSHCN definition.
(3) Identifying the need to insure our data collection system can better capture any child to whom we provide any type of assistance.

Medical Home. Kansas has struggled with the ability to measure medical home. Now, the percentage of Title V CSHCN children with a "medical home" is applied to statewide estimates. Kansas is anticipating the national survey will help obtain information on CSHCN statewide.

Meanwhile, the "Your Voice Counts!" state-specific survey conducted by Brandeis University in cooperation with Family Voices provided some information for Kansas. Of those surveyed, 85% responded that the child had a primary care provider (PCP). Of the remaining responses, 3% said the child did not have a PCP, 7% did not know; and 5% did not respond.

Provider Availability: Primary Care. The CSHCN data system maintains a list of enrolled providers. However, the program is not regularly notified when the providers move or retire. A match was performed between CSHCN primary care physicians and the physician licensure database. Although the nature of the data from both systems created complications and potential problems, preliminary results are reported. An estimated 15% of primary care physicians (1998) are enrolled as a CSHCN provider. Results by PDG are on the following page.

Population Density Peer Group	Percent of Licensed PC Physicians Enrolled as CSHCN Provider
Frontier	28%
Rural	28%
Densely-Settled Rural	25%
Semi-Urban	18%
Urban	8%

Although the urban areas have lower participation rates, a high primary care physician participation rate is not necessarily needed to provide services to CSHCN children who make up a relatively small proportion of the urban child population.

Provider Availability: Specialty. Geographically, specialty providers are located in urban areas, limiting access. According to the CSHCN provider database, there are eight Pediatric Cardiologists enrolled in the CSHCN program: two in Wichita, five in the Kansas City area, and one in Topeka. There are eleven Pediatric Neurologists, all in urban areas.

Provider Team Communication. In a 1998 survey, CSHCN providers were asked "Do you routinely communicate CSHCN patient information to other members of the CSHCN patient/family's health team?" Of responding specialists, 69% indicated they "always" or "usually" routinely communicate compared to only 41% of responding primary care physicians.

According to a 1998 survey of Kansas CSHCN providers, Specialists are more likely to routinely communicate CSHCN patient information to other members of the CSHCN patient/family's health team than Primary Care physicians.

Excessive Travel. The 1998 CSHCN provider survey asked providers to indicate the *longest* distances CSHCN patients traveled to receive their services.

Type of Provider	Have Some Patients Who Travel 100+ Miles
Primary Care Physician	17%
Specialist	50%
Dentist	32%

Location of Title V CSHCN Children. Maps with the location of children with selected diagnoses and the location of selected clinics are provided in Section 3.1.2.2.

Other. For other results related to CSHCN, refer to

- Section 2.4. Progress on Annual Performance Measures. Specifically, refer to NPM 01, 02, 03, 04, 10, 11, 14, and 17 as well as SPM 08, 10, 12, and 13.
- Section 2.5. Progress on Outcome Measures 01 through 05.

3.1.2 (A.5.c) Key Conclusions. Based on the JSNA results, the following conclusions were made regarding CSHCN:

- Remove barriers to access for CSHCN. In particular, CSHCNs should have a medical home and access to pediatric specialists.
- Further develop CSHCN data infrastructure. In particular, assure indicators and expertise are available to assist with needs assessment, performance monitoring, population-based outcomes, and program evaluation.

These conclusions have been incorporated into priority needs.

3.1.2 (A.5.d) Priority and Related Performance Measures. Although several priorities relate to CSHCN, one priority in particular addresses CSHCN needs: #2 Improve access to all aspects of health care for CSHCN.

#2 Improve access to all aspects of health care for CSHCN.

Access: Potential and actual entry of the CSHCN population into the health care delivery systems. There are financial, geographic, organizational, and sociological barriers to the access of quality, culturally competent providers.

All aspects of health care: All aspects of care needed for CSHCN. Medical home, primary care, pediatric specialists, case management, oral health, behavioral, speech, nutrition, etc.

Related Performance Measures. The following key MCH performance measures will be used to track progress:

NPM 01 Percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSHCN Program.

NPM 02 Degree to which the State CSHCN Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to the clients.

NPM 03 Percent of CSHCN in the State who have a "medical/health home."

NPM 11 Percent of CSHCN in the State CSHCN program with a source of insurance for primary and specialty care.

Note that no particular state-negotiated performance measure has been chosen for the Access priority at this time because there are several NPM which track this issue.

3.1.2 (A.6) Cross-Cutting Issues. Throughout the JSNA, cross-cutting issues have been identified. Key results are highlighted in this section.

3.1.2 (A.6.a) Overview of Results. Both cross-cutting population groups and cross-cutting needs have been identified. Cross-cutting needs are identified in the "Key Conclusions" section.

Throughout the needs assessment, certain populations were consistently identified as high need across JSNA programs (particularly MCH and PC) and the three MCH population groups:

The JSNA identified cross-cutting high-need population groups as well as cross-cutting issues.

Wyandotte County

Geary County

Southwest Kansas

Southeast Kansas

Spanish-speaking Immigrants

Densely-Setting Rural, particularly D.S.-Rural Hispanic

Black, particularly Semi-Urban and Urban Black

3.1.2 (A.6.b) Key Conclusions. Several issues have been identified as cross-cutting priorities. They include

- Access
- Mental or behavioral health
- Oral health
- Data infrastructure and epidemiological capacity

- Transportation
- Cultural and linguistic competency
- Coordinated, integrated systems of care
- Removal of categorical barriers of programs and funding
- Vision and hearing

All have been incorporated, in some way, into one or more priority needs.

3.1.2 (A.6.c) Priorities and Related Performance Measures. The following priorities have been identified as cross-cutting needs:

#1 Improve access to all aspects of primary health care for vulnerable populations.

#4 Increase data infrastructure, epidemiological capacity, and products of analyses for improved community and state problem-solving.

#8 Develop oral health capacity.

#9 Develop behavioral health infrastructure.

#10 Improve systems coordination and remove barriers caused by categorical programs and funding.

#1 Improve access to all aspects of primary health care for vulnerable populations.

Access: Potential and actual entry of the population into the health care delivery systems for primary care. Barriers to access include financial, geographic, organizational, and sociological.

All aspects of health care: Not limited to physicians. Includes medical, case management, vision, hearing, oral, and mental health care.

Vulnerable populations: From a JSNA perspective, includes underinsured, uninsured, limited English proficiency, special populations, geographically isolated (rural and frontier), urban inner city, migrant & farmworker, undocumented, elderly.

#1 Improve access to all aspects of primary health care for vulnerable populations, cont.

Related Performance Measures. Although other indicators related to this need will be reviewed, the following key MCH performance measures will be used to track progress:

NPM 12 Percent of children without health insurance.

NPM 13 Percent of potentially Medicaid-eligible children who have received a service paid for by the Medicaid program.

NPM 17 Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

NPM 18 Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

CHSI 01 Rate per 100,000 hospitalizations for asthma among children less than five years old.

CHSI 03 Percent of women with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80% on the Kotelchuck (APNCU) Index.

Note that no particular state-negotiated performance measure has been chosen for CSHCN access at this time because there are several NPM which track this issue.

#4 Increase data infrastructure, epidemiological capacity, and products of analyses for improved state and community problem-solving.

This priority encompasses two identified needs: increasing (1) all levels of state capacity and (2) tools and capacity for community-based problem-solving.

Related Performance Measures. The following MCH indicator directly relates to this need:

CHSI 08 State MCH data capacity

SPM 09 MCH Data, Epidemiologic, and Analysis Score

Rationale for State Performance Measure: *Core health status indicator 08 has been tailored to measure the specific needs of Kansas' MCH data infrastructure.*

Examples of three community-based tools are given in Section 3.1.2(C). We plan to

develop additional community-based materials during JSNA follow-up activities.

#8 Develop <u>oral health capacity</u>.

Oral Health Capacity: Includes provider availability (general and Medicaid populations); state dental director; data and epidemiological resources available to identify, analyze and track oral health problems; the extent to which oral health is incorporated into a system of primary care.

<u>Related Performance Measures</u>. Although other indicators related to this need will be reviewed, the following key MCH performance measures will be used to track progress:

NPM 07 Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

DHSI 04 Percent of EPSDT eligible children aged 6 to 9 years who have received any dental services during the year.

SPM 13 Percent of Kan Be Healthy (EPSDT)-eligible children aged 6 to 9 years who have received at least one dental screen.

Rationale for State Performance Measure: *SPM 13 has been based on DHSI 04. Currently, DHSI 04 is reported using the definition for SPM 13 (EPSDT dental screen rather than any dental service).*

#9 Develop <u>behavioral health infrastructure.</u>

First, we are committed to better understanding and defining issues related to behavioral health and behavioral health capacity.

<u>Related Performance Measures</u>. There is only one national MCH performance measure which may relate to behavioral health:

NPM 16 Rate per 100,000 of suicide deaths among youths aged 15-19.

SPM 14 Behavioral health infrastructure score.

Rationale for State Performance Measure: *As a first step, SPM 14 has been developed to measure Kansas' ability to understand and respond to issues related to mental health needs and the behavioral health system.*

#10 Improve systems coordination and remove barriers caused by categorical programs and funding.
Systems coordination: Includes coordination between state agencies, within state agencies, agencies and providers, agencies and not-for-profit organizations, state agencies and local health departments and other providers, etc.
Related Performance Measures. Although other indicators related to this need will be reviewed, the following key MCH performance measures will be used to track progress: NPM 05 Percent of children through age 2 who have completed immunizations. CHSI 02 Percent of Medicaid/CHIP enrollees whose age is less than one year during the reporting year who received at least one initial or periodic screen. SPM 15 Observed to expected Kan Be Healthy (EPSDT) screening ratio for infants less than age one. ***Rationale for State Performance Measure:*** *Children not receiving EPSDT screenings was clearly identified by local health departments and case managers as an unintended consequence of Medicaid managed care and a breakdown in the system of care. SPM 15 is taken from a required HCFA report and is similar to CHSI 02 except it incorporates the periodicity schedule and other factors.*

3.1.2 (B) Summary of Results: JSNA Priority Needs. A summary table of JSNA priority needs and their relationship to JSNA programs is provided below.

#	Priority Need	HIV / AIDS	PC	MCH			CC / Infra.
				M&I	Children	CSHCN	
JSNA HIV/AIDS Priorities Submitted for Ryan White Title II Grant							
1	Medication: Insure medication availability.	**					
2	Access: Insure all clients have access to care.	**	*				
3	Access: Insure all clients have access to maternal child programs.	**		*	*		

#	Priority Need	HIV / AIDS	PC	MCH			CC / Infra.
				M&I	Children	CSHCN	
4	Access: Assess access for prenatal testing.	**		*			
5	Providers: Increase professional providers of all care services.	**	*				
6	Assessment: Continue assessment for 3-5 years annually.	**					*
Draft JSNA MCH, PC, and Cross-Cutting Priorities Submitted for Title V and Primary Care Office Grants							
1	**Access**: Improve access to all aspects of primary health care for vulnerable populations.	*	**	*	*	*	**
2	**CSHCN Access**: Improve access to all aspects of health care for CSHCN.		*			**	
3	**Disparities**: Reduce reproductive health demographic and geographic disparities.		*	**			**
4	**Data, Epi, and Analysis Resources**: Increase data infrastructure, epidemiological capacity, and products of analyses for improved state and community problem-solving.	*	*	*	*	*	**
5	**Unintentional Injuries**: Reduce unintentional injuries.		*		**		
6	**Intentional Injuries**: Reduce intentional injuries.		*	*	**	*	
7	**Nutrition / Physical Activity**: Increase proper nutrition and physical activity, particularly among children and adolescents.		*	*	**	*	
8	**Oral health**: Develop oral health capacity.		**	*	*	*	**
9	**Behavioral health**: Develop behavioral health infrastructure.		**	*	*	*	**
10	**Coordinated Systems of Care**: Improve systems coordination and remove barriers caused by categorical programs and funding.	*	*	*	*	*	**

** = Very high priority for this particular program or MCH population group
* = High priority for this particular program or MCH population group
CC / Infra: Cross-cutting or infrastructure. Applies to several programs and population groups.

C. Example JSNA Community-Based Planning Tools

Kansas Priority Need #4, Data, Epi, and Analysis Resources, identifies the need for community-based planning tools. Here are three tools developed as a result of JSNA-related efforts. All tools feature Finney County.

Feature County: Finney

Finney County is a Densely-Settled Rural county in Southwest Kansas with a relatively high proportion of Spanish-speaking immigrants.

C1. County Health Profile Example Pages (Primary Care Tool)

Each County Health Profile contains 155 pages. Only 2 pages have been included as an example.

C2. Family Planning County Summary

The Family Planning County Summary, developed as part of the JSNA, is being used by the Title X Family Planning Program

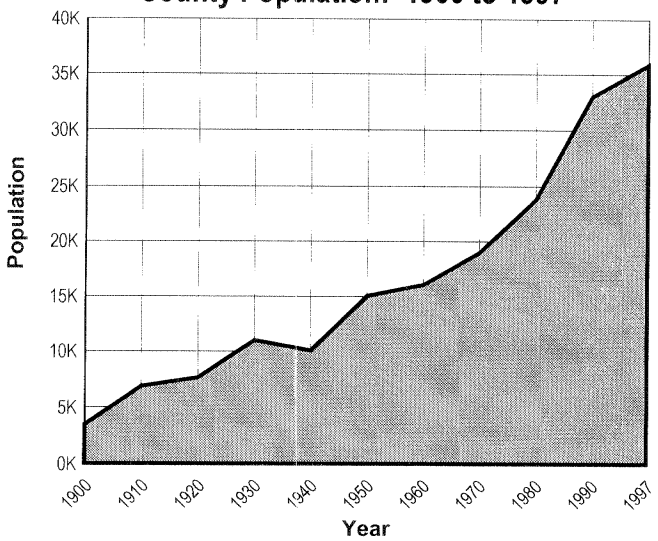
C3. JSNA Index County Summary

Population Trends

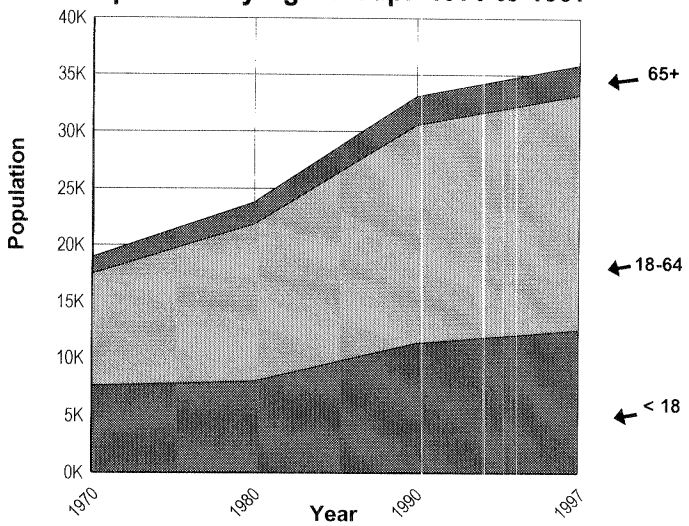
FINNEY County

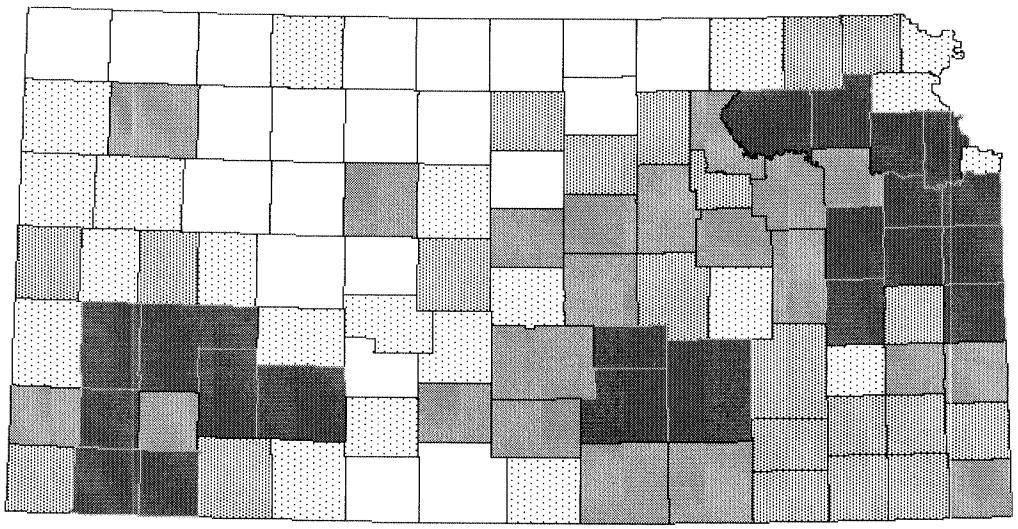
	Under 18			65 and Over			Median Age		Total	
Year	Number	Percent	Rank	Number	Percent	Rank	Number	Rank	Number	Rank
1970	7,592	40.1%	4	1,470	7.8%	97	24.1	100	18,947	28
1980	7,980	33.5%	3	1,951	8.2%	100	26.2	101	23,825	23
1990	11,334	34.2%	2	2,546	7.7%	103	27.2	102	33,137	15
1997	12,517	34.9%	1	2,607	7.3%	104			35,909	14
% Change	**64.9%**		**1**	**77.3%**		**5**			**89.5%**	**2**

County Population: 1900 to 1997



Population by Age Group: 1970 to 1997





Percent Change in Population (1970 to 1997)

- Low (-35.0% to -21.7%)
- Lower Middle (-20.2% to -14.2%)
- Middle (-13.3% to -4.9%)
- Upper Middle (-4.2% to 14.6%)
- High (16.0% to 91.7%)

From 1970 to 1997, Kansas experienced a 15.5% increase in population. During the same time period, the U.S. experienced a 38.1% population growth rate.

Counties are grouped into quintiles. For example, counties labeled as "High" are among the 20% of Kansas counties with the highest rate of population growth from 1970 to 1997.

Data Source: U.S. Census Bureau (1900 - 1997)

User Notes:

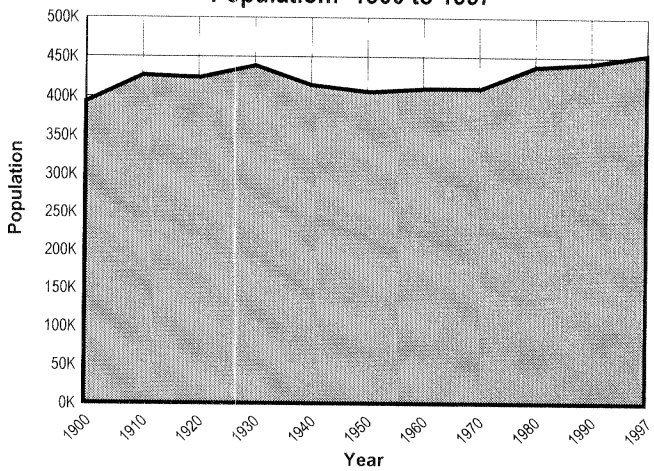
1. Median Age is not available for 1997.
2. "% Change" represents percent change in population from 1970 to 1997.
3. Rank: Counties are ranked from 1 = largest percentage to 105 = smallest percentage.
4. Refer to the *County Health Profile User's Guide* for a more detailed explanation of this data.

Population Trends

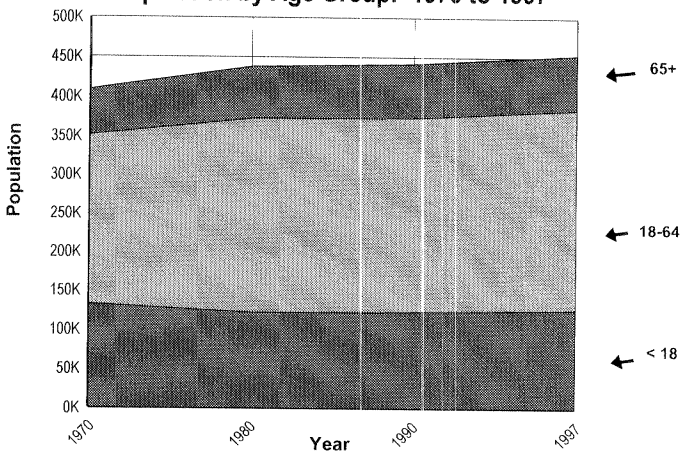
Population Density Peer Group: DENSELY-SETTLED RURAL Counties

Year	Under 18 Number	Under 18 Percent	65 and Over Number	65 and Over Percent	Total
1970	132,367	30.9%	58,176	19.2%	409,796
1980	121,834	27.4%	64,954	18.2%	438,091
1990	122,917	27.3%	68,004	18.9%	442,185
1997	125,821	26.8%	69,325	19.0%	453,900
% Change	-4.9%		19.2%		10.8%

Population: 1900 to 1997



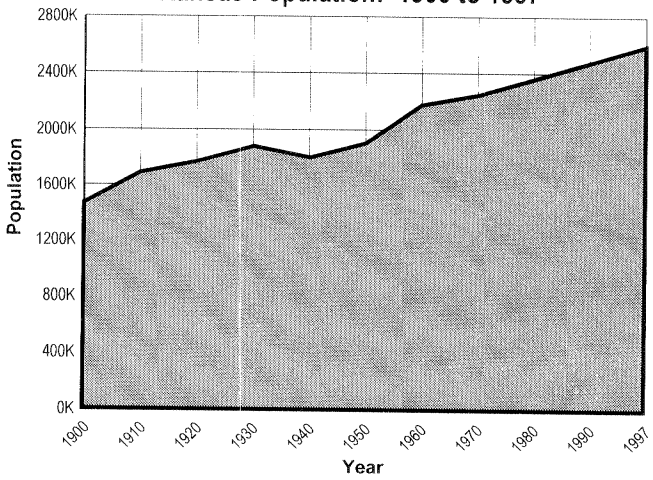
Population by Age Group: 1970 to 1997



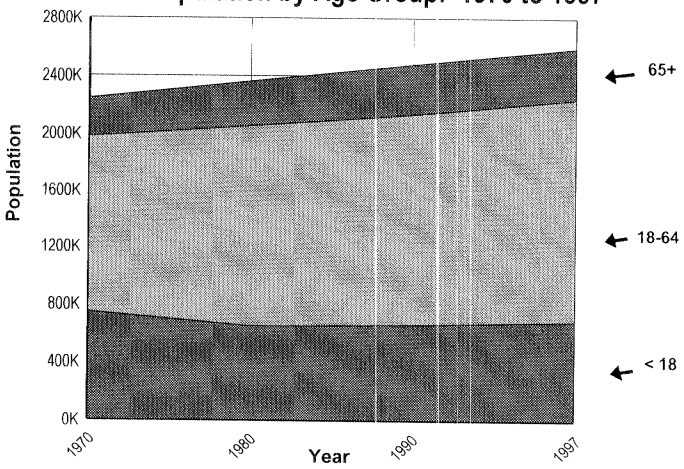
Kansas and Selected U.S. Statistics

Year	Under 18 Kansas	Under 18 KS %	Under 18 US %	65 and Over Kansas	65 and Over KS %	65 and Over US %	Median Age Kansas	Median Age US	Total Kansas	Total US
1970	746,354	33.2%	34.3%	266,201	11.9%	9.9%	28.7	28.1	2,246,578	203,211,926
1980	649,032	27.5%	28.1%	306,263	13.0%	11.3%	30.1	30.0	2,363,679	226,545,805
1990	662,137	26.7%	25.7%	342,811	13.8%	12.5%	32.9	34.0	2,480,587	249,439,000
1997	687,931	26.5%	26.0%	351,595	13.5%	12.8%		34.9	2,594,840	267,744,000
% Change	-7.8%	US % Change:	-0.1%	32.1%	US % Change:	70.4%			15.5%	31.8%

Kansas Population: 1900 to 1997



Kansas Population by Age Group: 1970 to 1997



Data Source: U.S. Census Bureau (1900-1997)

User Notes:

1. Median Age is not available for Population Density Peer Groups and Kansas (1997).
2. "% Change" represents percent change in population from 1970 to 1997.
3. See the *County Health Profile User's Guide* for a more detailed explanation of this data.

County Health Profiles are produced by the Office of Local and Rural Health, Kansas Department of Health and Environment (1999).

Family Planning County Summary

FINNEY County — Family Planning Index: 13.14 — Rank: 2

Health Outcome/ Health Risk Indicators	Number	Rate or Percent	Rank	Standardized Score[5,6]
Pregnancy Rate, Ages 15-17 (1994-1998)[1]	342	71.0	4	2.02
Pregnancy Rate, Ages 18-19 (1994-1998)[1]	568	187.5	8	0.77
Pregnancy Rate, Ages 20-34 (1994-1998)[1]	3,529	171.0	4	2.28
Pregnancy Rate, Ages 35-44 (1994-1998)[1]	405	32.3	1	2.82
Adolescent Mother, More than One Birth (1994-1998)[2]	197	24.8	13	1.16
Interbirth Spacing Less than 18 Months (1994-1998)[3]	366	13.5	12	1.22
Socio-Economic Indicators				
Births to Mothers with Less than 12 Years Education (1994-1998)[4]	1,994	46.1	2	3.18
Per Capita Income (1997)	$20,384	-	57	0.19
Unemployment Rate (1998)	578	3.0	65	-0.49
Family Planning Index[5]			**2**	**13.14**

Population by Race and Hispanic Ethnicity

	1990 Population				1998 Population			
Race/Ethnicity	Total	Females	F 15-44	% F 15-44	Total	Females	F 15-44	% F 15-44
White Non-Hisp.	22,982	11,773	5,527	46.9%	22,604	11,568	5,113	44.2%
White Hispanic	8,122	3,626	1,808	49.9%	11,403	5,271	2,595	49.2%
Black	483	191	97	50.8%	562	230	127	55.2%
Native American	296	148	87	58.8%	281	141	89	63.1%
Asian	1,262	582	303	52.1%	1,664	811	388	47.8%
Total	**33,145**	**16,320**	**7,822**	**47.9%**	**36,514**	**18,021**	**8,312**	**46.1%**
Hispanic (all races)	8,397	3,757	1,879	50.0%	11,816	5,476	2,705	49.4%

Interbirth Spacing by Age Group of Mother (1994 - 1998 Live Births)

	< 18 Months		18 -24 Months		25-60 Months		61-120 Months		>120 Months	
Age Group	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
15-19	66	34.0%	60	30.9%	68	35.1%	0	0.0%	0	0.0%
20-34	273	12.2%	329	14.8%	1,149	51.5%	437	19.6%	41	1.8%
35-44	27	9.5%	27	9.5%	83	29.3%	81	28.6%	65	23.0%
All Ages	**366**	**13.5%**	**416**	**15.4%**	**1,302**	**48.0%**	**519**	**19.2%**	**107**	**3.9%**

Educational Attainment by Age Group of Mother (1994 - 1998 Live Births)

	< 12 Years Ed.		12 Years Ed.		1-3 Years College		4+ Years College	
Age Group	Count	Percent	Count	Percent	Count	Percent	Count	Percent
10-17	294	93.3%	19	6.0%	2	0.6%	0	0.0%
18-24	896	49.9%	530	29.5%	328	18.3%	40	2.2%
25-34	673	36.0%	455	24.3%	444	23.8%	297	15.9%
35-44	129	38.6%	78	23.4%	73	21.9%	54	16.2%
All Ages	**1,994**	**46.1%**	**1,083**	**25.1%**	**851**	**19.7%**	**393**	**9.1%**

Bureau for Children, Youth, and Families, KDHE. See documentation for original data source information.

1. Pregnancy rate: Live births, fetal deaths, and abortions per 1,000 female population of given age group.
2. Indicator is percent of live births to adolescent mothers (less than age 20) with one or more living children.
3. Indicator is percent of second or higher order live births to mothers with a previous live birth less than 18 months earlier.
4. Indicator is percent live births to mothers with less than 12 years education (presumably, less than high school education).
5. In general, the larger the family planning index or standardized score, the greater the need.
6. "Standardized" scores are weighted z-scores. All z-scores have a weight of "1" except 15-17 and 18-19 teen pregnancy rates which are weighted 0.75 and 0.50, respectively. See documentation for further explanation.
7. For referencing companion reports, FINNEY County is in the DENSELY-SETTLED RURAL Population Density Peer Group.
8. See "Using Your Family Planning County Summary" for more infomation.

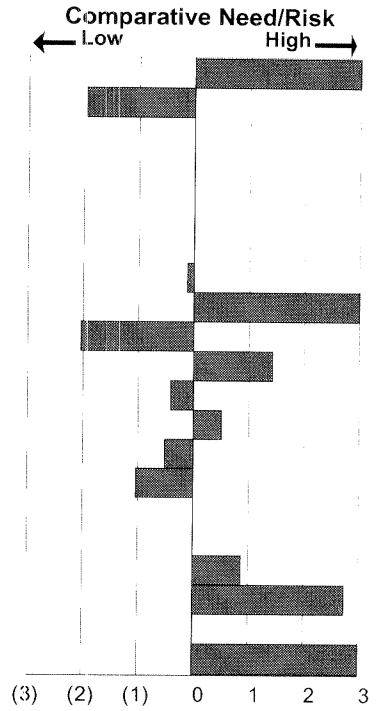
Draft JSNA County Summary

FINNEY County

Primary Care

Primary Care Index: 11.54 Rank: 3

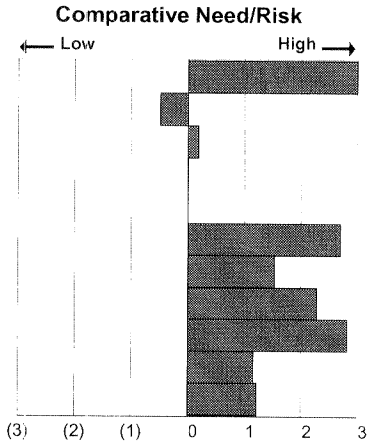
Demographic Indicator	Number	Rate or Percent	Rank	Z-score
Percent Minority Population	13,910	38.1%	2	3.59
Percent Aged 65 and Older Population	3,161	8.7%	103	-1.96
Socio-Economic Indicator				
Percent Below Poverty	4,274	12.0%	49	0.00
Health Status / Health Risk				
Percent Low Weight Birth	266	6.1%	59	-0.12
Births per 1,000 Population	4,357	24.5	2	3.60
Deaths per 1,000 Population	993	5.6	103	-2.04
Violent Crime Rate	171	4.8	7	1.42
Unintentional Injury Death Rate	89	50.0	66	-0.42
Unintentional Injuries Years Potential Life Lost	2,714	16.5	25	0.50
Percent of Preventable Cancers	55	53.9%	78	-0.52
Preventable Hospitalization Rate per 1,000 Population	7,177	40.7	90	-1.04
Access / Resources				
Percent Immunized by Age 2 with 4-3-1 Combination		69.2%	84	0.87
Adequacy of Prenatal Care Utilization Index	476	54.3%	105	2.73
Population to Primary Care Physician Ratio	36,046	2,017	47	0.00
Percent Linguistically Isolated (Age 5+)	2,577	8.08%	2	4.97
Primary Care Index			**3**	**11.54**



Family Planning

Family Planning Index: 13.14 Rank: 2

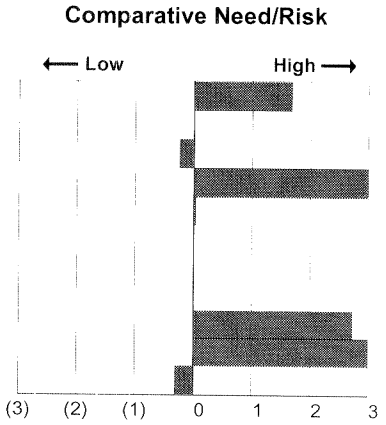
Socio-Economic Indicators	Number	Rate or Percent	Rank	Z-score
% Live Births to Mothers with Less than 12 Years Edu.	1,994	46.1%	2	3.18
Per Capita Income	$20,384		57	0.19
Unemployment Rate	578	3.0	65	-0.49
Health Risk / Health Outcome Indicators				
Pregnancy Rate, Ages 15-17	342	71.0	4	2.70
Pregnancy Rate, Ages 18-19	568	187.5	8	1.53
Pregnancy Rate, Ages 20-34	3,529	171.0	4	2.28
Pregnancy Rate, Ages 35-44	405	32.3	1	2.82
Mother Less than Age 20, More than One Live Birth	197	24.8%	13	1.16
Interbirth Spacing Less than 18 Months	366	13.5%	12	1.22
Family Planning Index			**2**	**13.14**



Perinatal

Perinatal Planning Index: 12.00 Rank: 3

Demographic Indicator	Number	Rate or Percent	Rank	Z-score
Percent Female Population Age 15-44	8,312	46.1%	6	1.68
Socio-Economic Indicators				
Percent Children (Age 0-17) Below Poverty Level	1,811	14.4%	64	-0.24
% Live Births to Mothers with Less than 12 Years Edu.	1,994	46.1%	2	3.18
Medicaid Deliveries per 100 Live Births	585	32.0	50	0.04
Health Risk / Health Status				
Percent Low Birth Weight Singleton Births	215	5.0%	58	0.00
Percent Adequate Prenatal Care Using APNCU Index	476	54.3%	105	2.73
Infant Birth Rate to Mothers Age 15-17	299	32.4	3	3.34
Percent WIC Mothers Breastfeeding at Postpartum	422	45.1%	46	-0.31
Perinatal Index			**3**	**12.00**



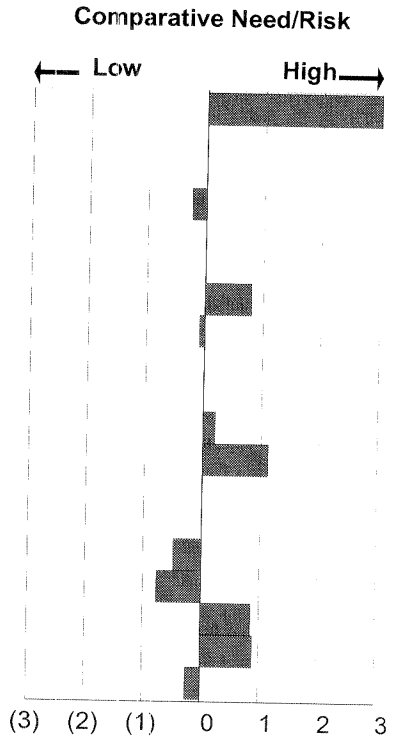
Draft JSNA County Summary

FINNEY County

Child Health Index

Child Health Index: 5.74 Rank: 16

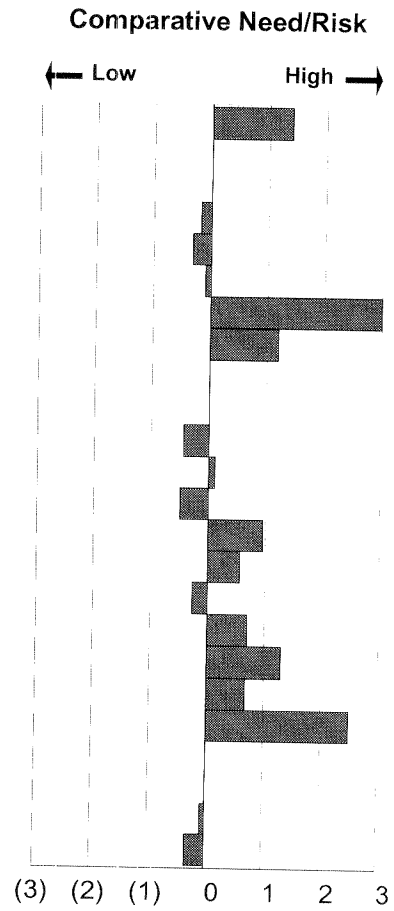
Demographic Indicator	Number	Rate or Percent	Rank	Z-score
Percent Population Age 0-9	7,401	20.3%	1	3.68
Socio-Economic Indicators				
Percent Children (Age 0-17) Below Poverty Level	1,811	14.4%	64	-0.24
Health Status / Health Risk				
Percent WIC Children with High Weight for Height	302	9.8%	15	0.80
Percent MV Accident Victims Not Using Safety Equip.	630	31.2%	50	-0.09
Reported Child Abuse Cases per 1,000 Children	712	55.9	48	0.00
Deaths per 100,000 Age 1-14	16	33.0	47	0.01
Respiratory Hospitalizations per 10,000 Age 0-17	284	46.8	38	0.20
Hospitalizations: Mental Disorders per 10,000 Age 0-14	139	268.2	10	1.13
Access / Resources				
Percent Participation Age 0-9 in KBH Medical Program	831	42.6%	33	-0.48
Percent Participation Age 5-9 in KBH Dental Program	221	32.0%	23	-0.77
Percent Immunized with 4-3-1 Combo		69%	84	0.87
Child Care Availability per 100 Age 0-12	1,657	17.7	87	0.89
Head Start Slots Available per 100 Age 3-5 Below Poverty	167	85.0	51	-0.26
Child Health Index			**16**	**5.74**



Adolescent Health Index

Adolescent Health Index: 9.78 Rank: 7

Demographic Indicator	Number	Rate or Percent	Rank	Z-score
Percent Population Age 10-24	9,373	25.7%	6	1.40
Socio-Economic Idnicators				
Percent Age 5-17 Below Poverty Level	1,085	12.7	59	-0.18
Percent Age 10-21 Eligible for Medicaid	985	10.5%	66	-0.32
Juvenile Court Filings per 1,000 Age 0-17	273	21.5	54	-0.09
Graduation Rate	287	55.9%	105	3.92
Percent HS Grads Pursuing Post-Secondary Education	196	68.3%	95	1.19
Health Status / Health Risk				
Suicide Deaths per 100,000 Age 15-24	2	6.8	58	-0.44
Homicide Deaths per 100,000 Age 15-24	2	6.8	21	0.10
Motor Vehicle Deaths per 100,000 Age 15-24	12	41.0	68	-0.49
Alcohol-Related MV Crashes per 10,000 Age 15-24	289	100.4%	13	0.96
Chlamydia & Gonorrhea Cases per 100,000 Ages 15-19	149	119.7	12	0.56
Percent Teens Who Smoked Within Last 30 Days		18.7%	65	-0.27
Percent Teens Who Used Marijuana Within Last 30 Days		11.2%	30	0.70
Percent Teens Who Used Inhalants Within Last 30 Days		7.5%	13	1.29
Alcohol-Related Hospitalizations per 10,000 Age 15-	17	60.0	14	0.68
Mental Hospitalizations per 10,000 Age 15-24	247	87.2	3	2.49
Access / Resources				
Percent Participation Age 10-21 in KBH Medical Program	235	23.9%	44	-0.08
Percent Participiation Age 10-21 in KBH Dental Program	240	24.4%	34	-0.34
Adolescent Health Index			**7**	**9.78**



Section 3.1.2.1. Overview of the Maternal and Child Health Population's Status

A. Indicator Detail Sheets

Indicator Detail Sheet Notes

Demographics
01 Percent Children (Age 0-9)
02 Percent Adolescents (Age 10-24)
03 Percent Females Age 15-44
04 Percent Age 65 and Over
05 Percent Minority

Socioeconomic Indicators
06 Percent Children (Age 0-17) Below Poverty
07 Percent Below Poverty
08 Percent Mothers with Low Education
09 Medicaid Deliveries per 100 Live Births
10 Children Enrolled in Medicaid
11 Juvenile Court Filing Rate
12 Graduation Rate
13 Percent Post-Secondary Ed
14 Per Capita Income
15 Unemployment Rate

Health Status/Health Risk Indicators
16 Pregnancy Rate: Age 15-17
17 Pregnancy Rate: Age 18-19
18 Teen Pregnancy Disparities
19 Percent Teen Mothers with Repeat Birth
20 Pregnancy Rate: Age 20-34
21 Pregnancy Rate: Age 35-44
22 Percent with Short Interbirth Spacing
23 Percent Very Low Birth Weight Births
24 Percent Low Birth Weight Births
25 Percent Low Birth Weight Singleton Births
26 Percent Breastfeeding (WIC)
27 Percent Overweight WIC Children
28 Infant Mortality Rate
29 Child Death Rate (Age 1-14)
30 Reported Child Abuse
31 Violent Crime Rate

Health Status/Health Risk Indicators, cont.
32 Adolescent (Age 15-24) Intentional and Unintentional Injury Rates
33 Safety Equipment Non-Use (Age 1-15)
34 Alcohol-Related Accident Rate (Age 15-24)
35 Reported STD Rate (Age 15-19)
36 Adolescent Tobacco Use
37 Adolescent Alcohol Use
38 Adolescent Drug Use
39 "Preventable" Hospitalization Rate
40 Percent Early Cancer Detection
41 Respiratory Inpatient Hospitalizations
42 Crude Death Rate
43 Unintentional Injury Death Rate
44 Unintentional Injury YPLL Rate

Access/Resources Indicators
45 Percent Immunized by Age 2
46 Population per Primary Care Physician FTE
47 Dental Providers
48 Percent First Trimester Prenatal Care
49 Percent Adequate Prenatal Care
50 Percent Linguistically Isolated
51 Child Care Availability
52 Child Participation in Medicaid

Section 3.1.2.1.

A. Indicator Detail Sheets (IDS)
Notes

Complete technical notes are not provided. However, they will be available in the JSNA final document. A few explanations of the Indicator Detail Sheets are given below.

County Map: For most indicators, counties with small numbers (usually less than 10 incidents) are excluded. In general, the county maps divide the counties into quintiles. Approximately one-fifth of Kansas counties are assigned to each map grouping; this allows counties to observe how they perform on a particular indicator relative to other counties.

Demographic Disparities: Where applicable, demographic disparities are highlighted. Generally, disparities by race and ethnicity are displayed.

Extremes Map: Shows the notable highs and lows in the state; counties mapped are plus or minus 1.5 standard deviations (i.e., z-score greater than 1.5 or less than -1.5).

Geographic Disparities: Where applicable, geographic disparities are highlighted by County and by Population Density peer Group (PDG).

Index: Most of the JSNA indicators included in this section are also in a JSNA Index. If applicable, an Index is referenced on the IDS.

Indicator: Some JSNA indicators are the same as Title V indicators. On the IDS, "Indicator" references any National Outcome Measure (OM), National Performance Measure (NPM), Developmental Health Status Indicator (DHSI), or Core Health Status Indicator (CHSI).

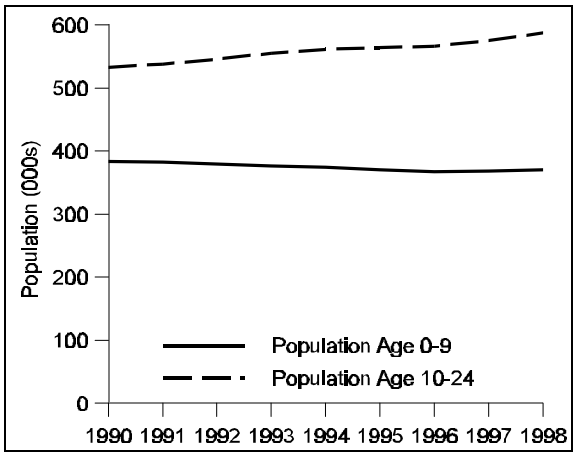
Related Priority Need: References the newly adopted priority needs.

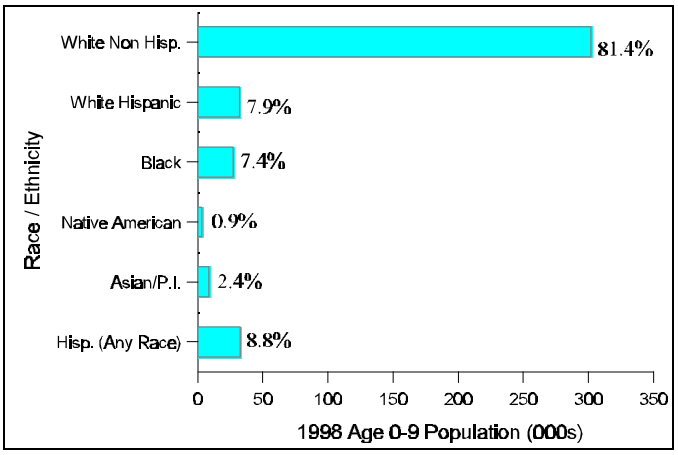
IDS 01. Percent Children Age 0-9

Detailed Data Report

Title V Indicator: DHSI #06 (related) **Related Priority Need**: No specific priority need

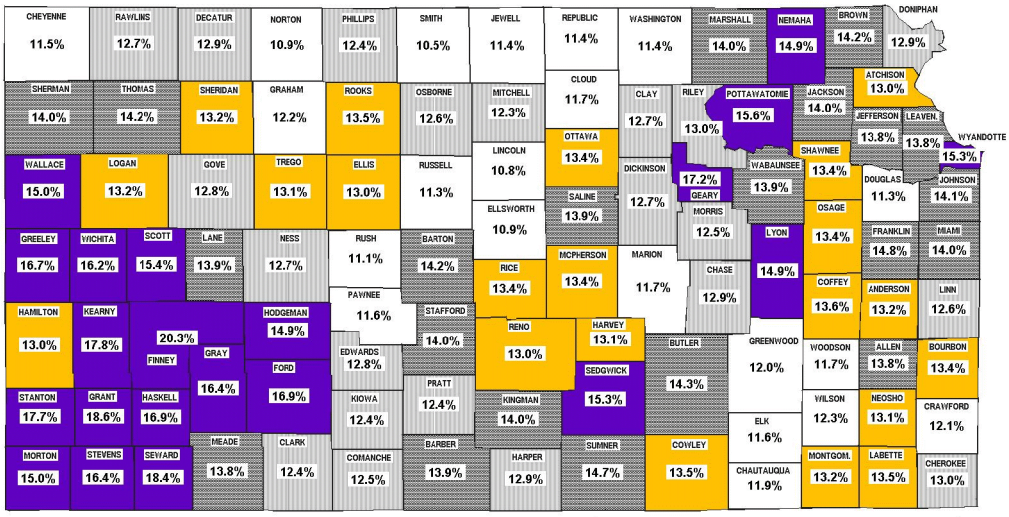
Index: Child Health



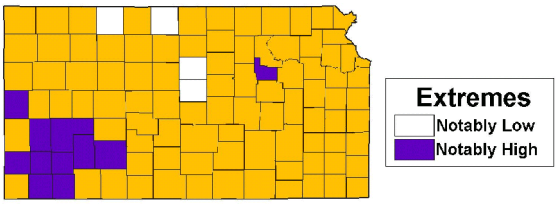


Recent Trend. While the adolescent population in Kansas has been increasing, the child population has been decreasing slightly since 1990; this parallels the national trend. In 1990, 15.5% of the population in Kansas was aged 0 to 9, while in 1998 an estimated 14.1% of the population was in that age group.

Race/Ethnic Diversity. According to Census estimates, 18.6% of the child population is of a racial or ethnic minority. Hispanic is the largest minority group with 8.8% of the child population (7.9% White Hispanic; Hispanic persons may be of any race); Black is the second largest with 7.4% of the population.



Data Source: 1998 Census Estimates



Geographic Disparities.

County. The proportion of children compared to the total population varies widely across the state. Most notably, Southwest Kansas has the youngest population in the state. Geary County also has a relatively high proportion of children.

PDG. D.S.-Rural Counties have the highest proportion

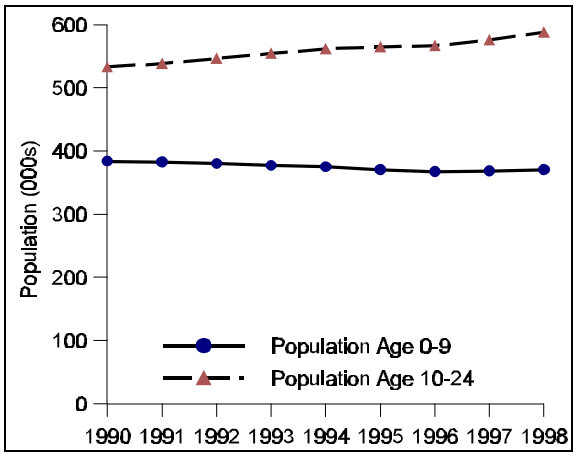
of children (14.7%) while Rural and Frontier Counties have only 13.2%.

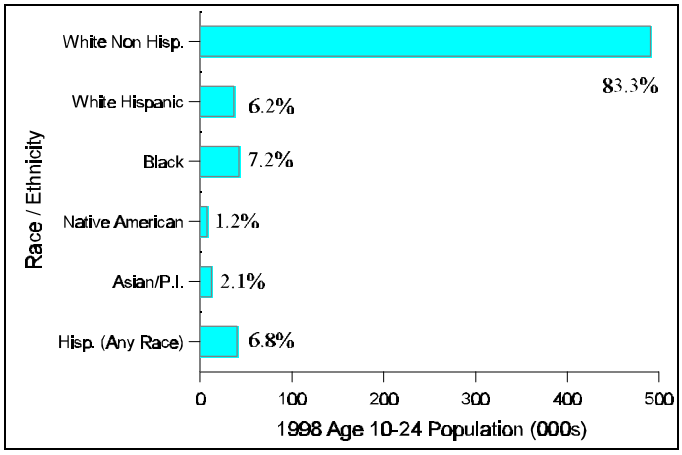
IDS 02. Percent Adolescents Age 10-24

Detailed Data Report

Title V Indicator: DHSI #06 (related) **Related Priority Need**: No specific priority need

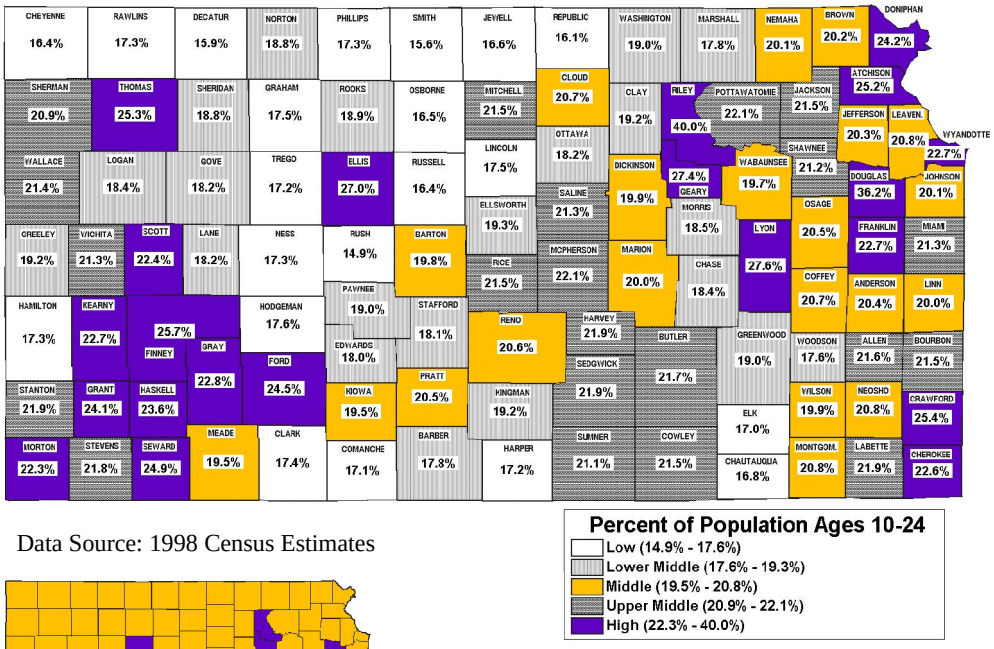
Index: Adolescent Health



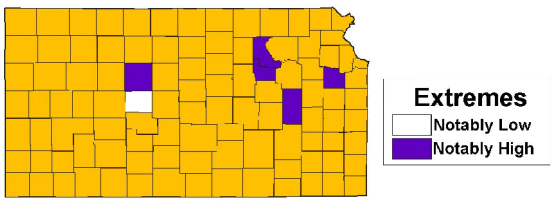


Recent Trend. While the child population in Kansas has decreased slightly since 1990, the adolescent population has increased; this parallels the national trend. In 1990, 21.5% of the population in Kansas was aged 10 to 24, while in 1998 an estimated 22.4% of the population was in that age group.

Race/Ethnic Diversity. According to Census estimates, 16.7% of the youth population is of a racial or ethnic minority. African Americans are the largest minority group with 7.2% of the 10-24 population; Hispanic is the second largest with 6.8% (6.2% White Hispanic; Hispanic persons may be of any race).



Data Source: 1998 Census Estimates



Geographic Disparities.

County. The proportion of youths compared to the total population varies widely across the state. Most notably, Riley, Douglas, and Lyon with universities and Geary with the military base have a high proportion of adolescents and young adults.

PDG. Semi-Urban Counties (many with universities and colleges) have the highest proportion of population age

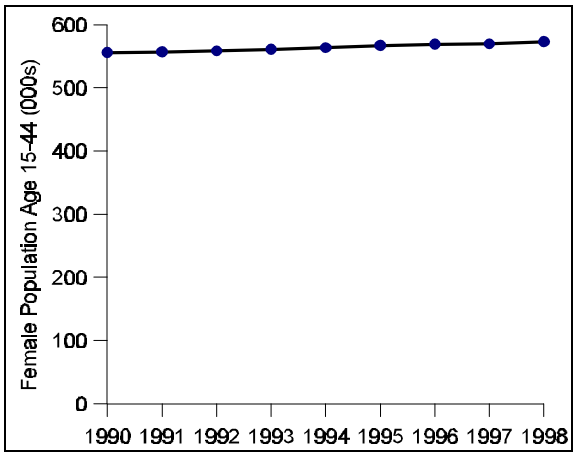
10-24 (24.9%).

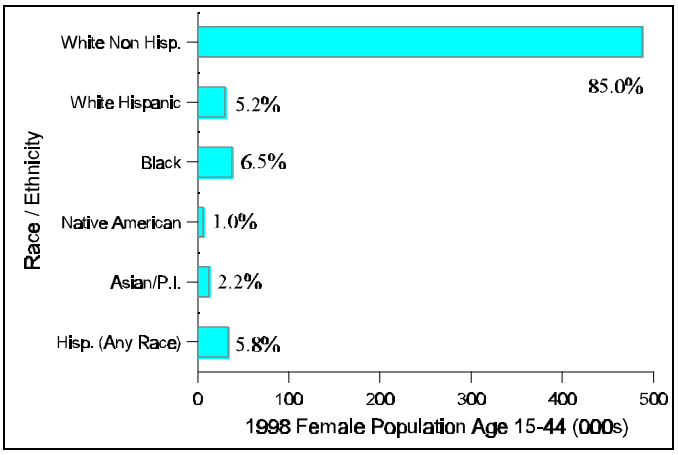
IDS 03. Percent Females Age 15-44

Detailed Data Report

Indicator: DHSI 06 (related) **Related Priority Need**: No specific priority need

Index: Perinatal

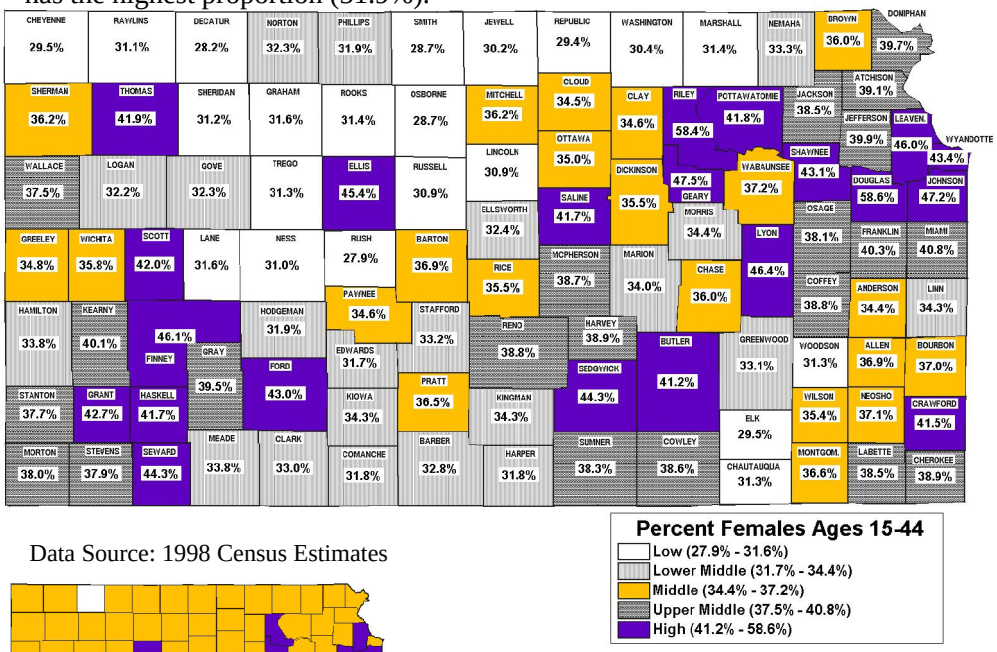




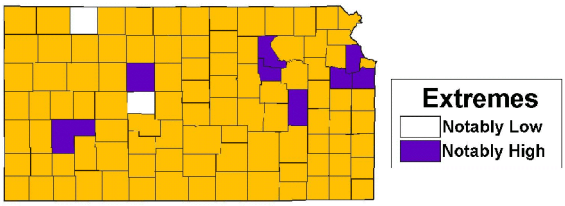
Recent Trend. The population of reproductive-age females (ages 15 to 44) has increased 3% from 1990 to 1998. Overall, 42.9% of Kansas females are of reproductive age.

Racial/Ethnic Diversity. Of all females aged 15 to 44 years in Kansas, 15.0% are of a racial or ethnic minority group. The White Non Hispanic population has the lowest proportion of females of reproductive age (41.9%) while the Asian/Pacific Islander population has the highest proportion (51.9%).

Race/Ethnicity	Proportion of Females Aged 15-44
White Non Hispanic	41.9%
Black	48.1%
Native American	50.5%
Asian/Pacific Islander	51.9%
Hispanic (Any Race)	48.5%



Data Source: 1998 Census Estimates



Geographic Disparities

County. As expected, counties with universities, Geary (military base), and Kansas City suburbs have higher than average proportions of females in the reproductive age group. Perhaps even more interesting, many of the rural and frontier counties have proportions of reproductive-age females well below the state average.

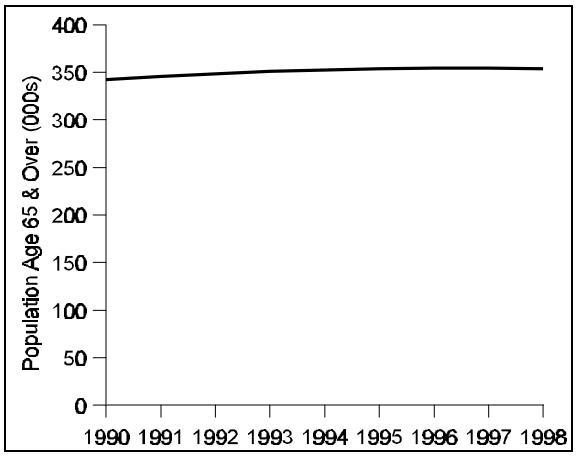
PDG. Frontier counties have only 32.3% of females aged 15 to 44 years while urban counties have the highest proportion at 46.0%.

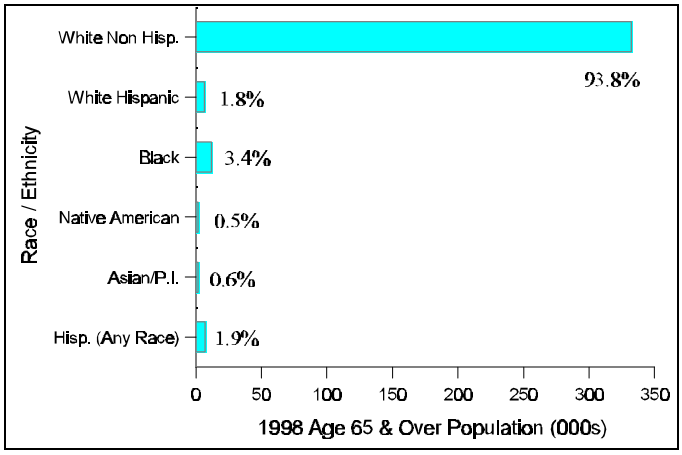
IDS 04. Percent Age 65 & Over

Detailed Data Report

Title V Indicator: None
Index: Primary Care

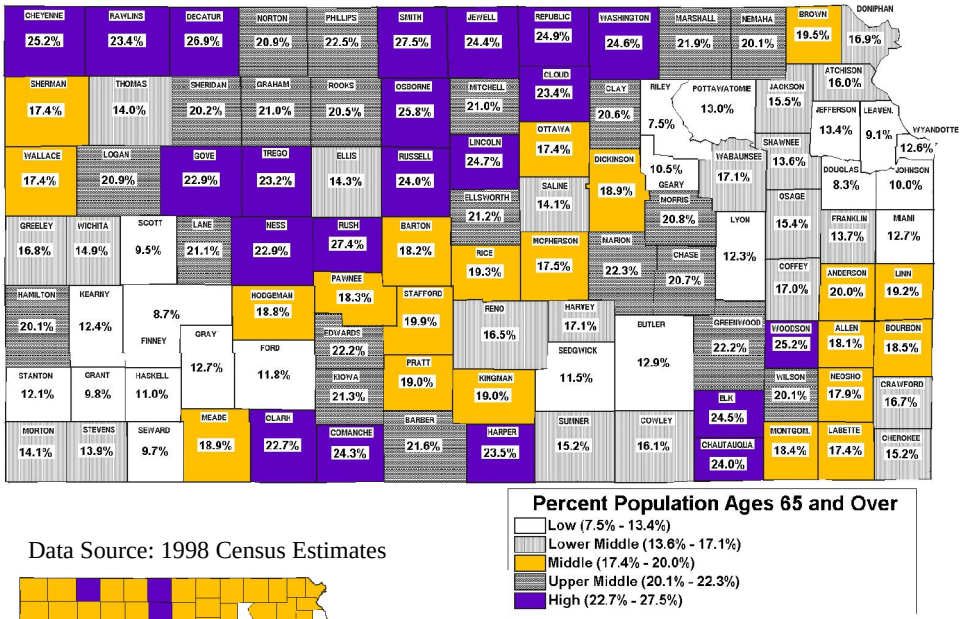
Related Priority Need: No specific priority need



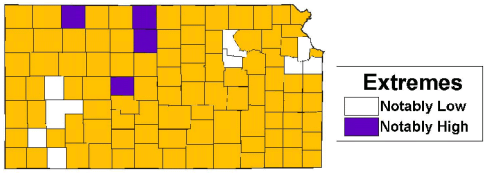


Recent Trend. The population of persons age 65 and over has increased 3.3% from 1990 to 1998. However, the proportion of older people has decreased slightly. In 1990, 13.8% of the population was age 65 and over, while in 1998 an estimated 13.5% was in that age group.

Race/Ethnic Diversity. According to 1998 census estimates, 6.2% of the 65 and over population is of a racial or ethnic minority. Black is the largest minority group with 3.4% of the older population. Hispanic is the second largest minority at 1.9% (1.8% White Hispanic; Hispanic persons may be of any race). The elderly population in Kansas is much less diverse than the racial/ethnic population.



Data Source: 1998 Census Estimates



Geographic Disparities.

County. The counties with the largest proportion of older people are in the north-central part of the state. Percentages in the mid-20's are not uncommon. Counties with universities (Riley, Douglas, etc.) have the lowest percentage of people age 65 and over.

PDG. Frontier counties have the highest percentage of older people (21.6%); Urban counties have only 11%.

IDS 05. Percent Minority Population

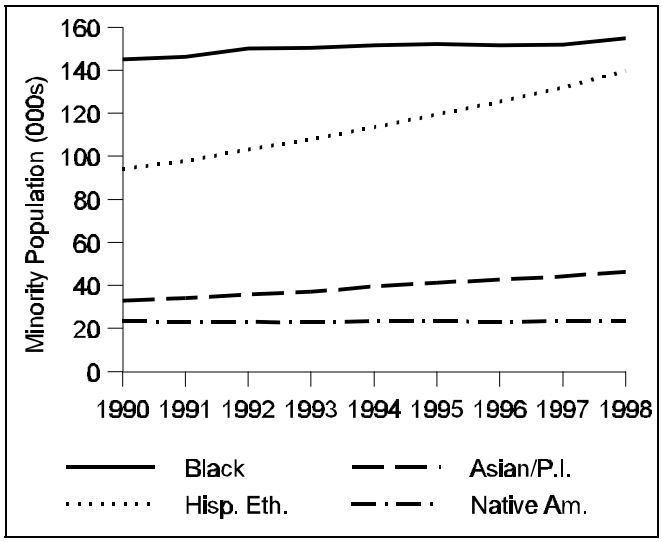
Detailed Data Report

Title V Indicator: No specific indicator **Related Priority Need**: No specific priority need

Index: Primary Care

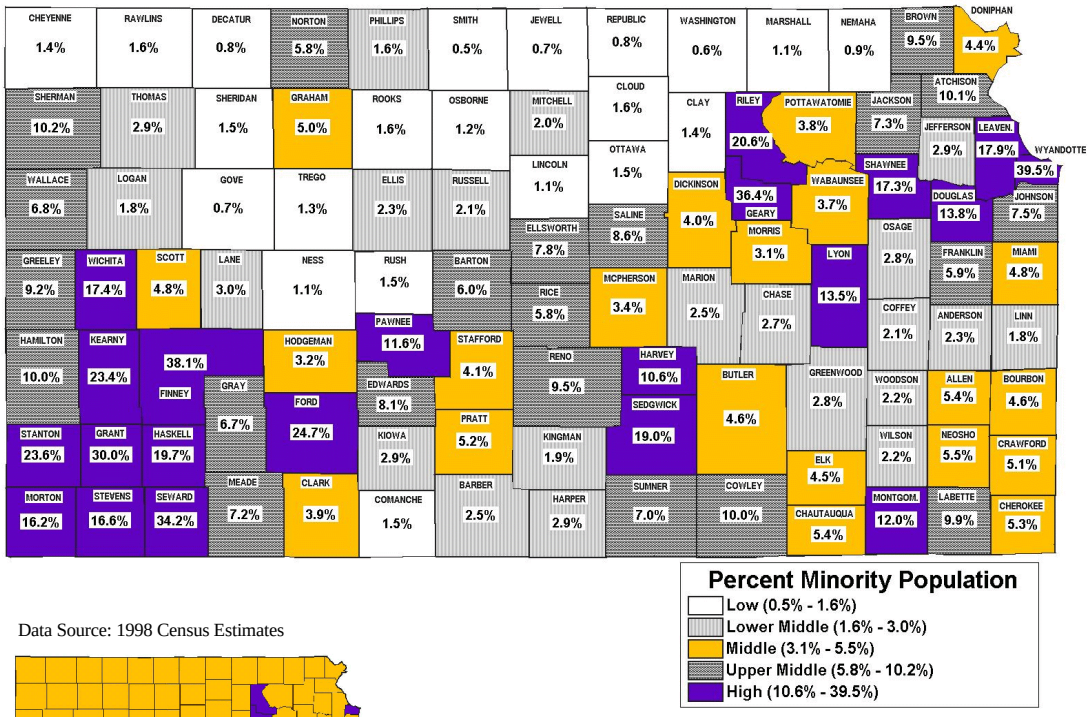
Total 1998 Minority Population

Group	Number	Percent
White Hispanic	126,503	4.6%
Black	154751	5.6%
Native American	23,333	0.8%
Asian/P.I.	46,367	1.7%
Hispanic (All Races)	139,724	5.0%

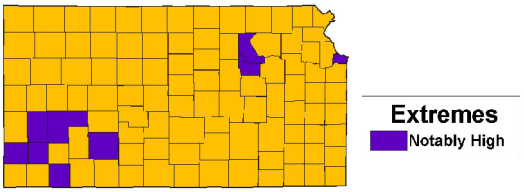


Recent Trend. The total minority population in Kansas has been increasing. In 1990, 11.6% of the population was of a racial or ethnic minority. By 1998, census estimate showed that the proportion had increased to 13.3%. The Hispanic population has seen by far the most dramatic rise, increasing 48% from 1990 to 1998.

Geographic Disparities. County. The counties with the highest proportion of minorities are located in the southwest part of the state and the urban areas. Southwest Kansas has a large Hispanic population, and the urban areas have larger Black populations. PDG. Frontier and Rural counties have the smallest percentages of minorities (about 5% each), while urban counties have



Data Source: 1998 Census Estimates



the greatest proportion at 17%.

IDS 06. Percent Children Age 0-17 Below Poverty

Detailed Data Report

Title V Indicator: DHSI 12 **Related Priority Needs**: #1 Access, #2 CSHCN Access

Index: Child Health

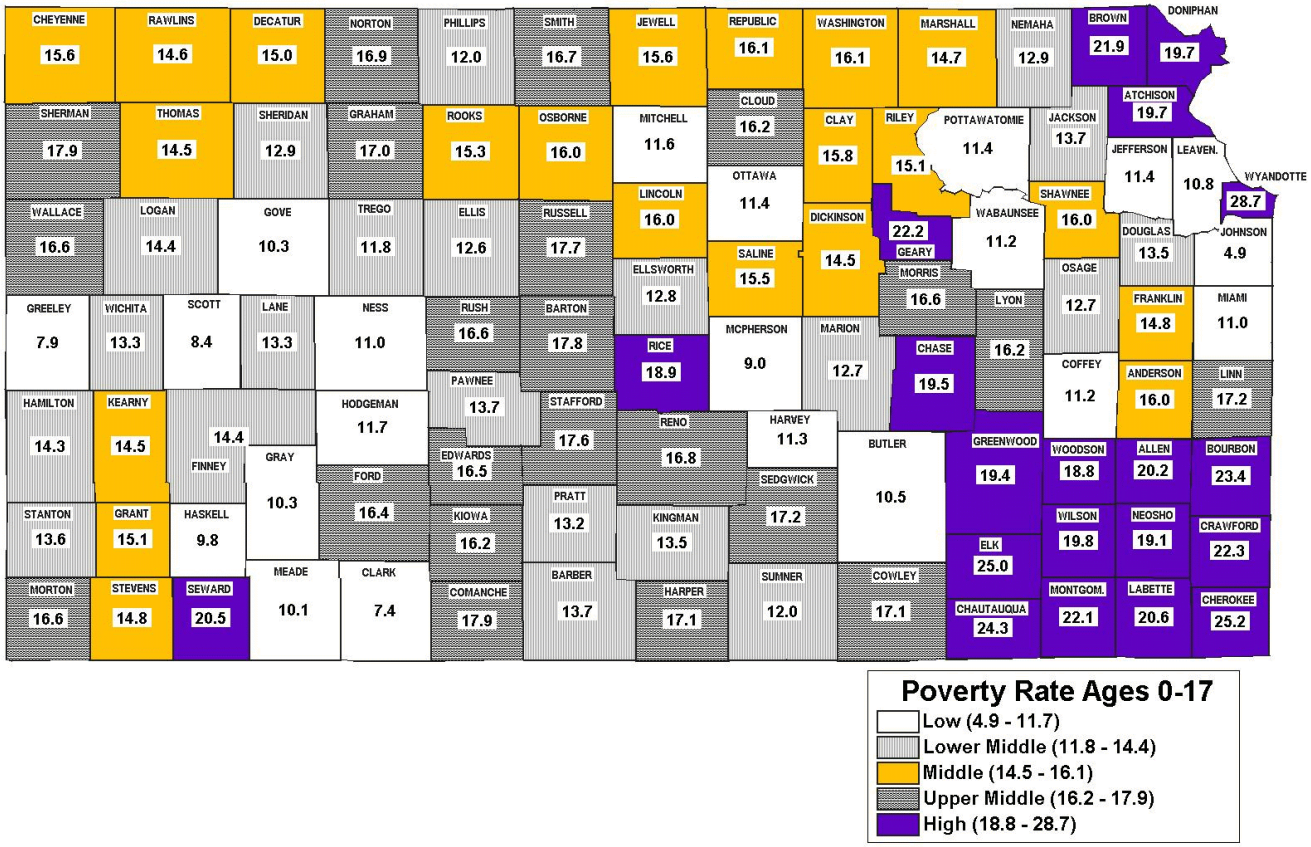
Recent Trend. According to the 1995 Census estimate, 14.9% of Kansas children were living below the poverty level. The 1996 estimate decreased slightly to 14.4%.

Demographic Disparities. Children are more likely to live in poverty than the general population. According to the 1996 Census estimate, 14.4% of children were below poverty, compared to 9.6% of the general population. Younger children appear to be at greater risk for living in poverty as there are 14.4% of children aged 0 to 17 years below poverty versus 13.0% of the population aged 5 to 17 years.

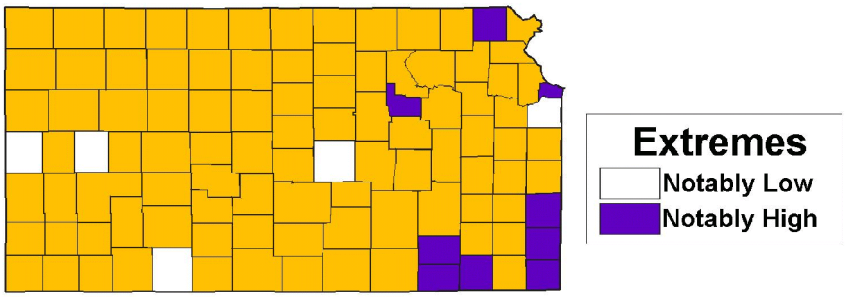
Geographic Disparities.

PDG. Densely-settled Rural Counties have the highest proportion of children in poverty (16.2%) while Urban Counties have the lowest (14.1%)

County. The highest rates of poverty in Kansas are found in the Southeast portion of the state as well as Geary and Wyandotte Counties.



Data Source: 1995 Census Estimate (map)



IDS 07. Percent Below Poverty

Detailed Data Report

Title V Indicator: DHSI 11 **Related Priority Need**: #1 Access

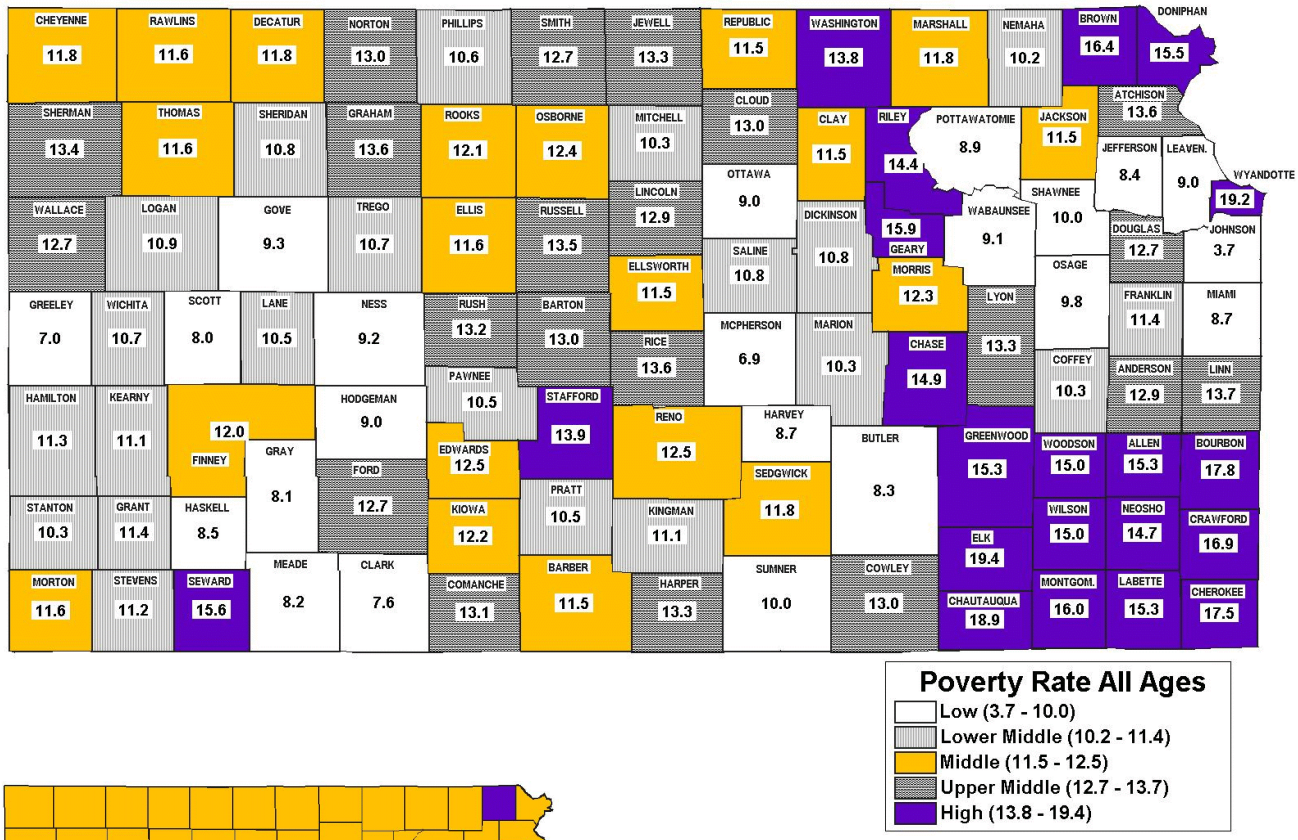
Index: Primary Care #2 CSHCN Access

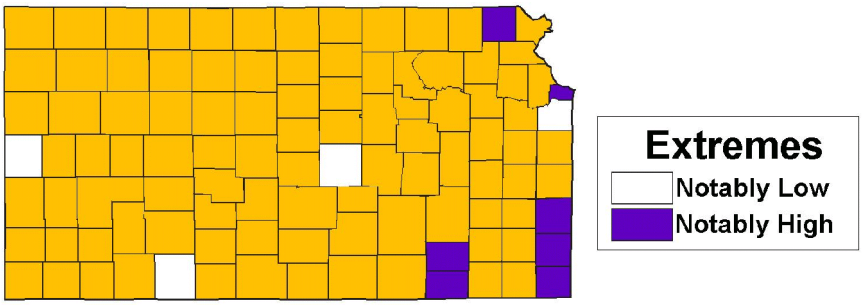
Recent Trend. According to the 1998 Census estimate, 9.6% of the Kansas population is below poverty. This shows a 13% decrease from the 11.0% 1995 poverty estimate.

Geographic Disparities

PDG. Densely-settled Rural Counties have the highest poverty rate (12.6%) while Urban Counties have the lowest rate (9.8%). Several of Southeast Kansas counties are D.S.-Rural Counties.

County. Wyandotte and the Southeast cluster show high rates of poverty. Interestingly, the group of Southwest Kansas counties which performs poorly on many other indicators does not have a particularly high poverty rate.





IDS 08. Percent Mothers with Low Education

Detailed Data Report

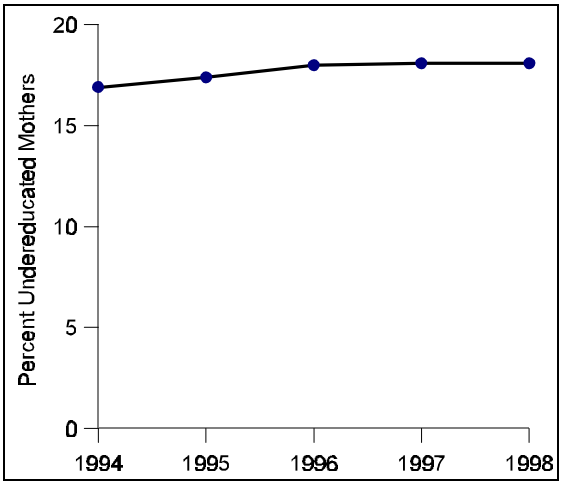
Title V Indicator: No specific indicator **Related Priority Need**: #3 Disparities

Index: Family Planning

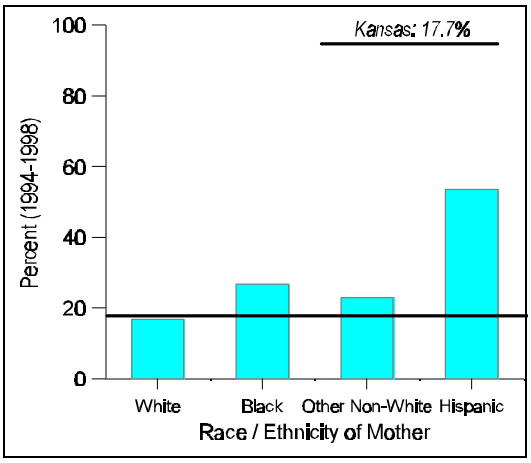
Recent Trend. Leveling off.

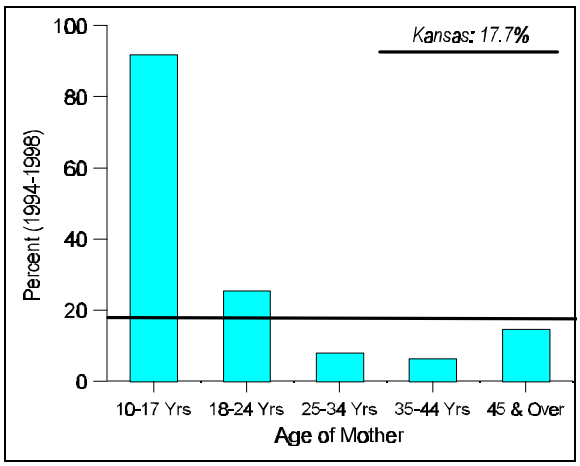
The percent of live births to women with less than twelve years of education increased from 1994 to 1996, then has shown signs of leveling off from 1996 to 1998.

Year	Number	Percent
1994	6,255	16.9%
1995	6,421	17.4%
1996	6,568	18.0%
1997	6,729	18.1%
1998	6,930	18.1%



Demographic Disparities. Adolescent and Hispanic women display highest percentages.

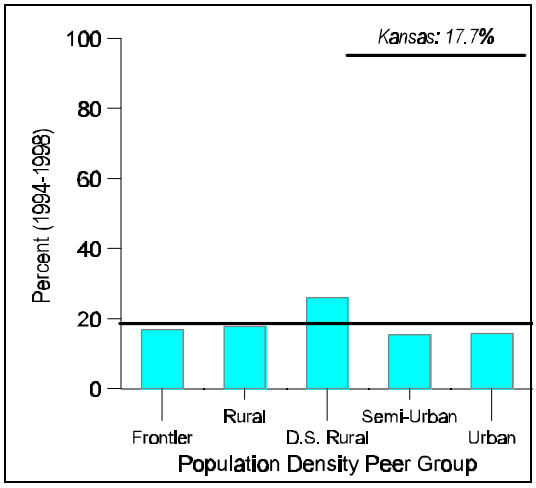




The Kansas five-year average for percent of women with less than twelve years education giving birth is 17.7% (1994-1998). This compares to a rate of 26.8% for Black women and 52.8% - a rate three times the state average - for Hispanic women.

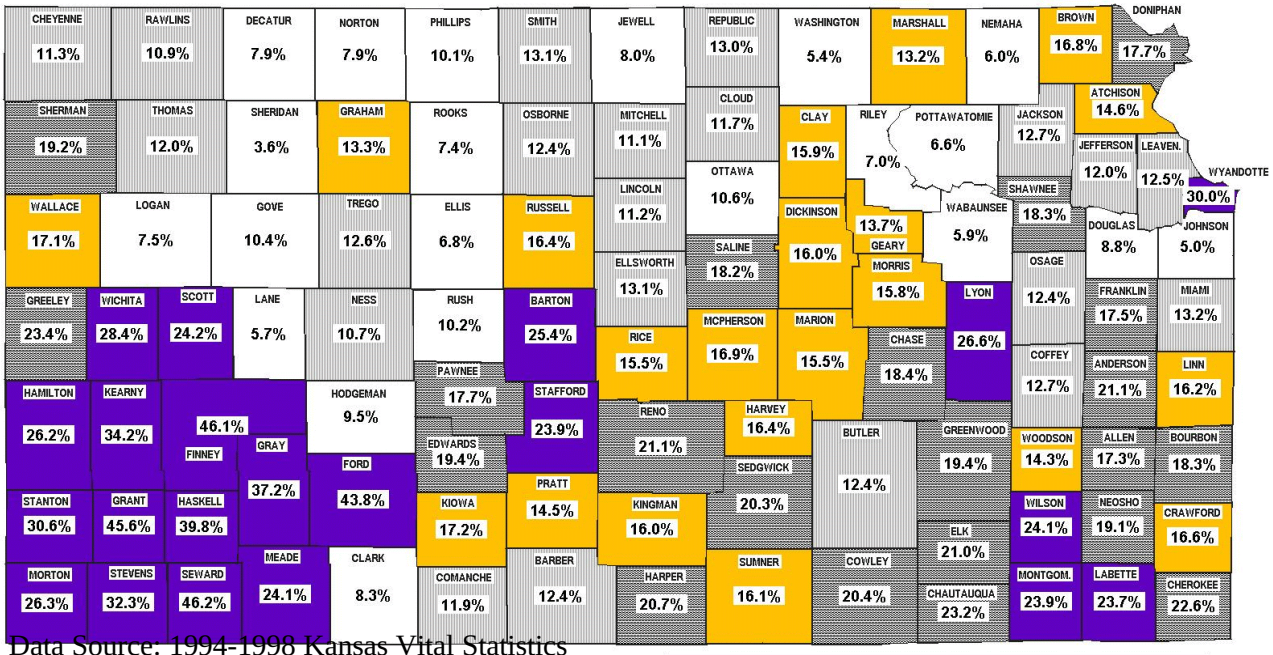
Understandably, adolescent mothers (age 10-17) have the lowest educational attainment. There are also a relatively high percentage of young mothers 18-24 years with less than twelve years of education (25.4%).

Geographic Disparities. The Densely-Settled Rural group has the highest percentage.

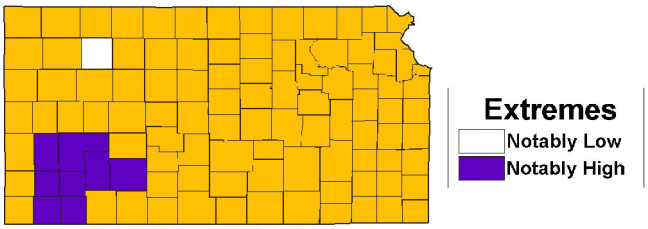


By Population Density Peer Group. Geographic disparities are less extreme than the demographic disparities. Densely-Settled Rural Counties have the highest proportion of mothers with less than twelve years education (25.8%) while Semi-Urban Counties (many have a university or college) have the lowest (15.3%). PRE groups show greater disparity. The D.S.-Rural Hispanic population has the highest percentage (65.1%) while White women in Urban counties have one of the lowest (13.9%).

By County. The Southwest Kansas counties form a striking cluster area with a high proportion of women with live births having less than twelve years education. Wyandotte County is also high.



Data Source: 1994-1998 Kansas Vital Statistics



IDS 09. Medicaid Deliveries per 100 Live Births

Detailed Data Report

Title V Indicator: No specific indicator **Related Priority Need**: #3 Disparities

Index: Perinatal

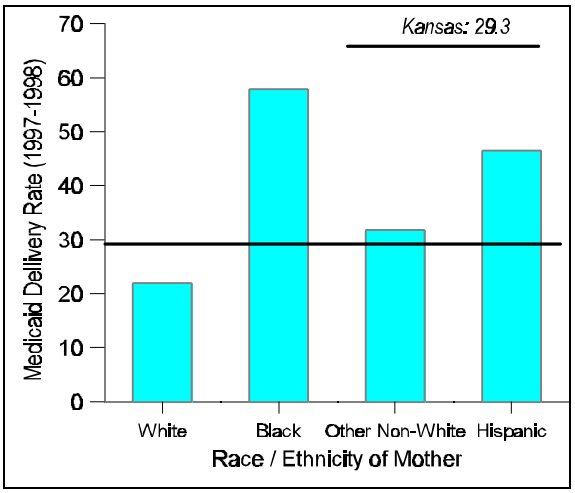
Data Note. Trend information has not yet been established for this indicator. It was difficult to accurately pull Medicaid deliveries from the complex claims- and encounter-based data system. Throughout the JSNA, we worked with Kansas SRS to improve the quality of data from our adhoc Medicaid requests.

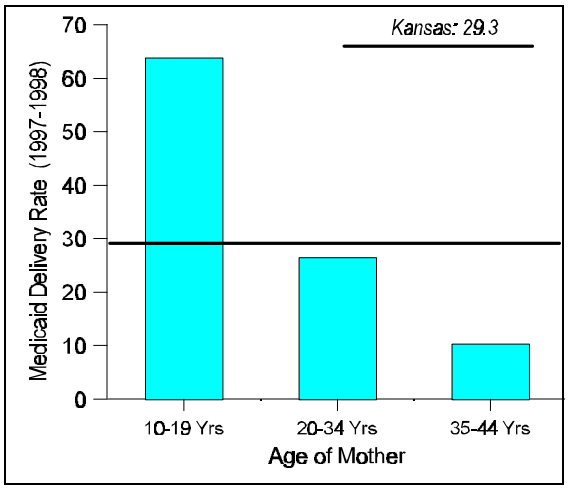
Demographic Disparities.

Age Group	Medicaid Deliveries	Percent of Total	All Live Births	Percent of Total	Medicaid Deliveries per 100 Live Births
10-19	6,161	27.8%	9,674	12.8%	64
20-34	15,141	68.3%	57,448	76.1%	26
35-44	863	3.9%	8,350	11.1%	10
Total	22,159	100.0%	75,472	100.0%	29

1997-1998 Medicaid Data

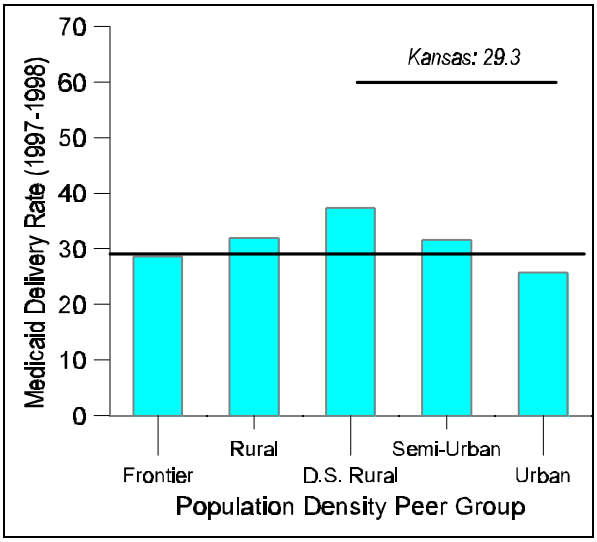
Age. In 1997-1998, there were approximately 29 Medicaid deliveries per 100 live births. The rate was highest among teens: approximately 64 out of 100 births were Medicaid births. Also note the difference in distribution of all live births to Medicaid deliveries. Of all Medicaid deliveries, 27.8% were to adolescents versus 12.8% of all live births.





Race/Ethnicity. By race, the Black and Hispanic Medicaid delivery rates were each over twice the White rate.

Geographic Disparities

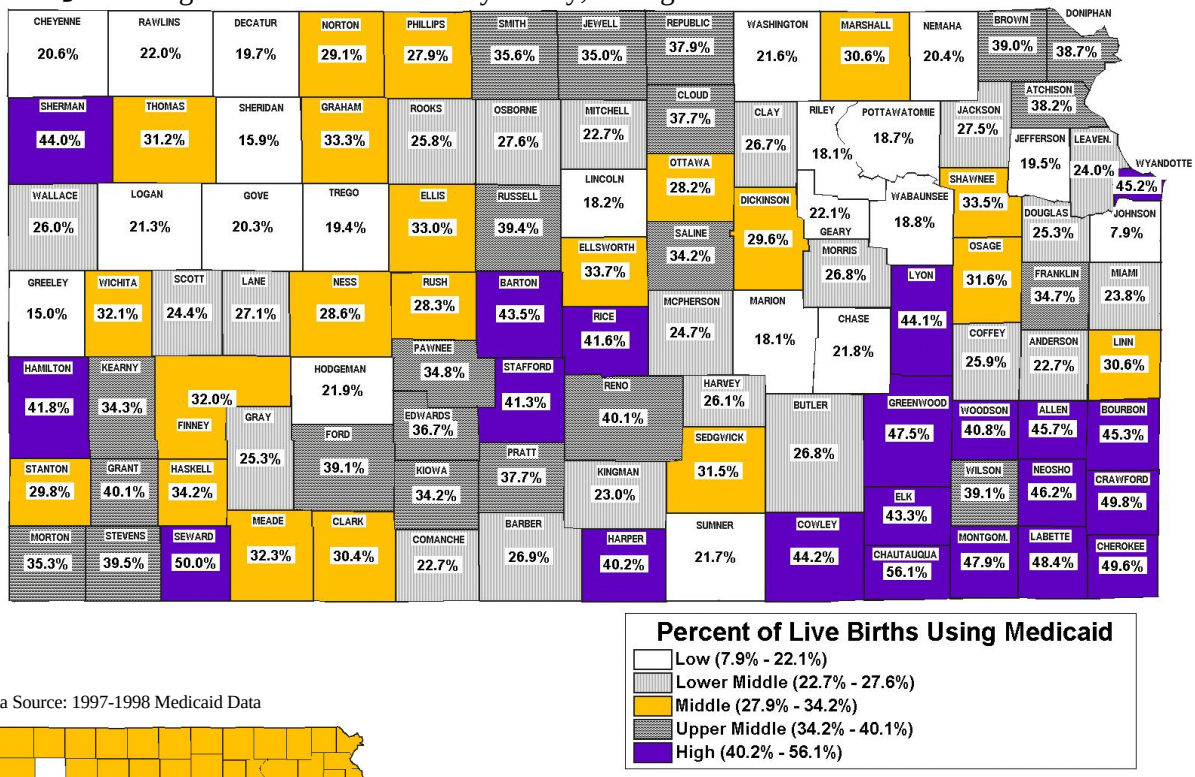


By Population Density Peer Group

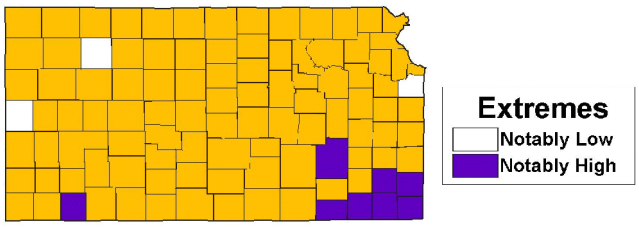
Although there are geographic disparities, they are not as great as the disparities by age and race. Densely-Settled Rural Counties had the highest rate of Medicaid deliveries (37.3 per 100 live births) while Urban Counties had the lowest (25.7).

The PRE groups showed greater differences. The Densely-Settled Rural Black group had the highest rate: approximately three-quarters of the births are Medicaid-reimbursed. The lowest rate was for the Urban White group (17.0).

By County. Looking at Medicaid deliveries by county, the highest rates are in Southeast Kansas.



Data Source: 1997-1998 Medicaid Data



IDS 10. Children Enrolled in Medicaid

Detailed Data Report

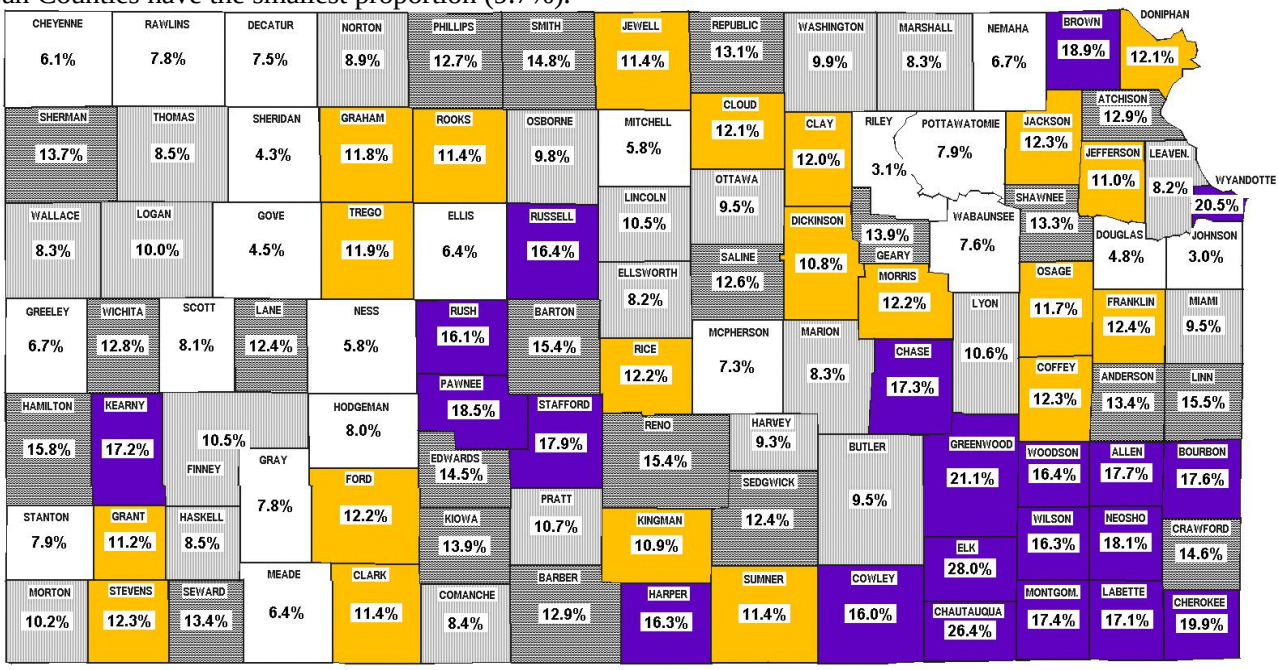
Title V Indicator: DHSI 09 (related) **Related Priority Need**: #1 Access

Index: Adolescent Health

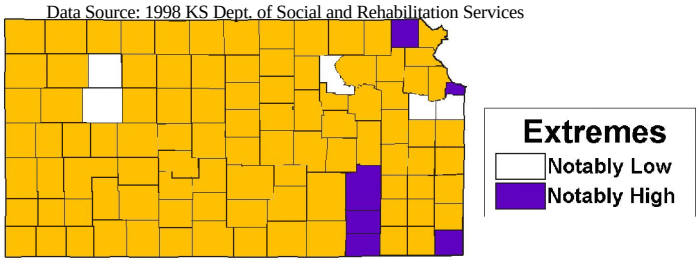
	1998 Medicaid Enrollment Percentage		
Age Group	**Male**	**Female**	**Total**
<1	36.3	36.9	36.7
1-2	31.2	31.5	31.4
3-4	24.4	24.5	24.5
5-9	20.1	19.9	20.0
10-14	14.0	14.0	14.0
15-17	11.7	12.5	12.1
18-19	6.8	15.9	11.2
20-21	2.7	16.6	9.3

The table below shows Medicaid enrollment by age. The **total** enrollment percentage decreases as age increases. The enrollment percentage for **females**, however, begins to increase again in the mid to late teens due to pregnant teens.

The map below shows the percentage of children age 10-21 enrolled in Medicaid in 1998 (Adolescent Health Index indicator). The 1998 Kansas Medicaid enrollment for children 10-21 was 10.6%. By PDG, adolescent enrollment in Medicaid decreases across the rural/urban continuum: Frontier Counties have the largest percentage enrolled (11.3%); Urban Counties have the smallest proportion (9.7%).



Data Source: 1998 KS Dept. of Social and Rehabilitation Services



IDS 11. Juvenile Court Filing Rate

Detailed Data Report

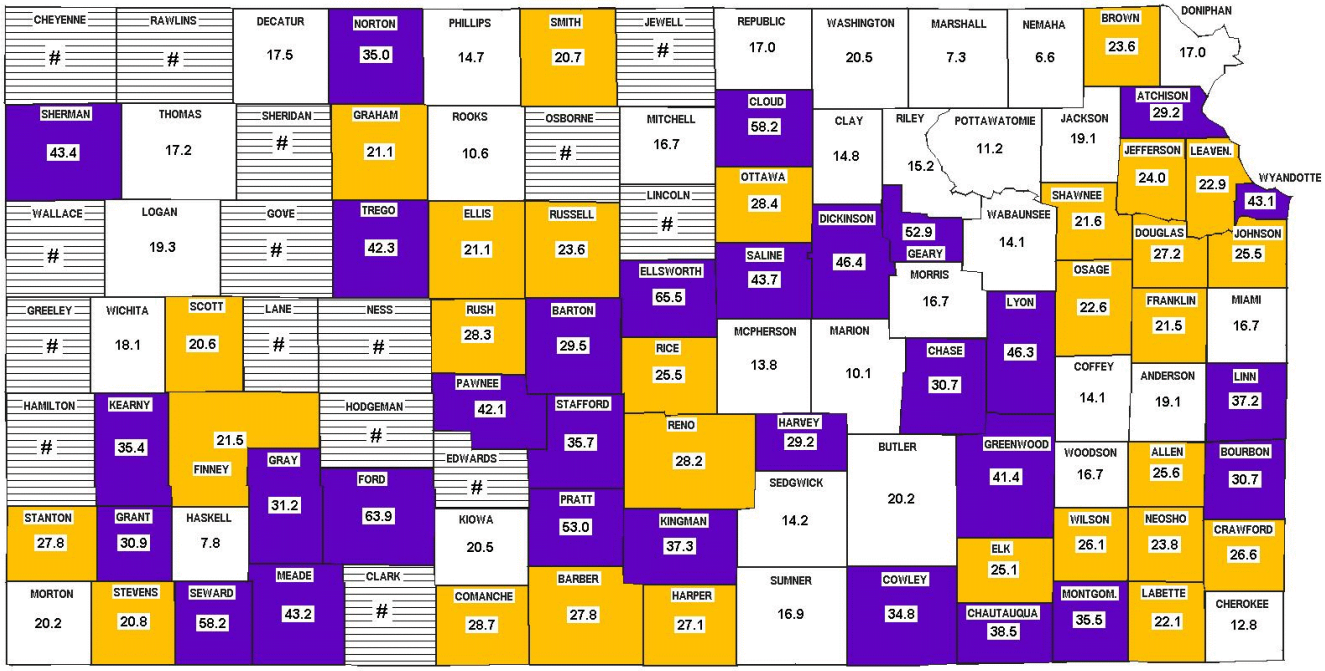
Title V Indicator: SPM 11 **Related Priority Need**: No specific priority need

Index: Adolescent

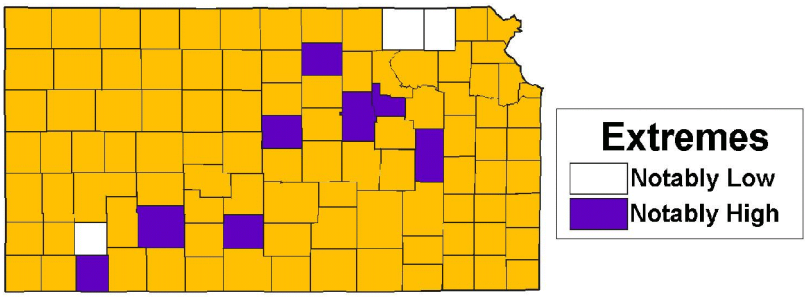
Data Note: Juvenile crime data is limited in Kansas. Thus, the juvenile court filing rate has been used in the Adolescent Health Index.

Geographic Disparities. County. The map below shows the juvenile court filing rate per 1000 youths aged 0 to 17 (1998). The 1999 Kansas juvenile court filing rate is 25.2. The juvenile court filing rate varies across the state with Ellsworth in central Kansas having the highest rate (65.5). Geary also has a high rate (52.9). Many of the Frontier and Rural Counties may have very erratic rates because of small populations. The rates for counties with less than 10 court filings are not shown.

PDG. Frontier Counties have the lowest rate of juvenile court filings (17.1), while Densely-Settled Rural Counties have the highest rate (29.8). The Urban rate falls right in between (23.2).



Data Source: 1998 Office of Judicial Administration



Frontier and Rural Caution: Even though counties with less than 10 court filings are not mapped, some "extremes" may be the result of small numbers producing an

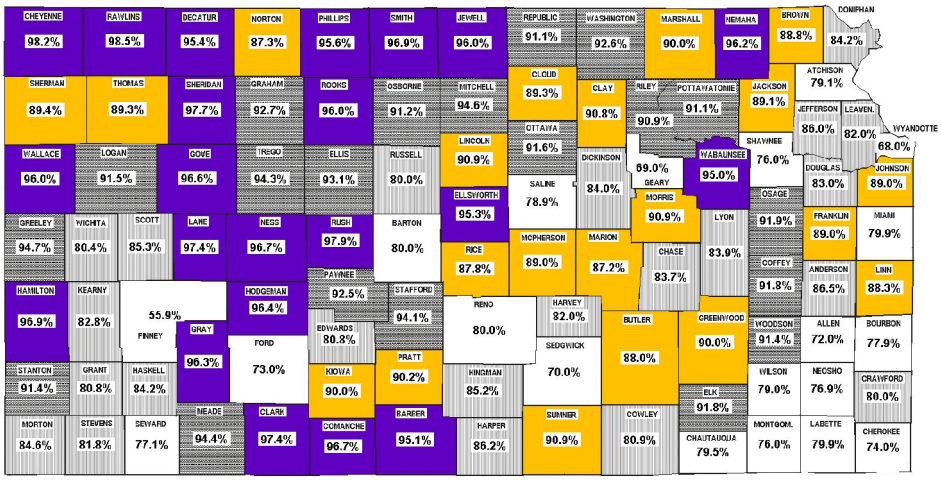
erratic rate rather than a truly high incidence.

IDS 12 & 13. Graduation Rate and Percent Post-Secondary Ed

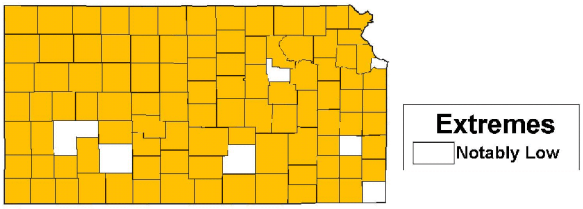
Detailed Data Report

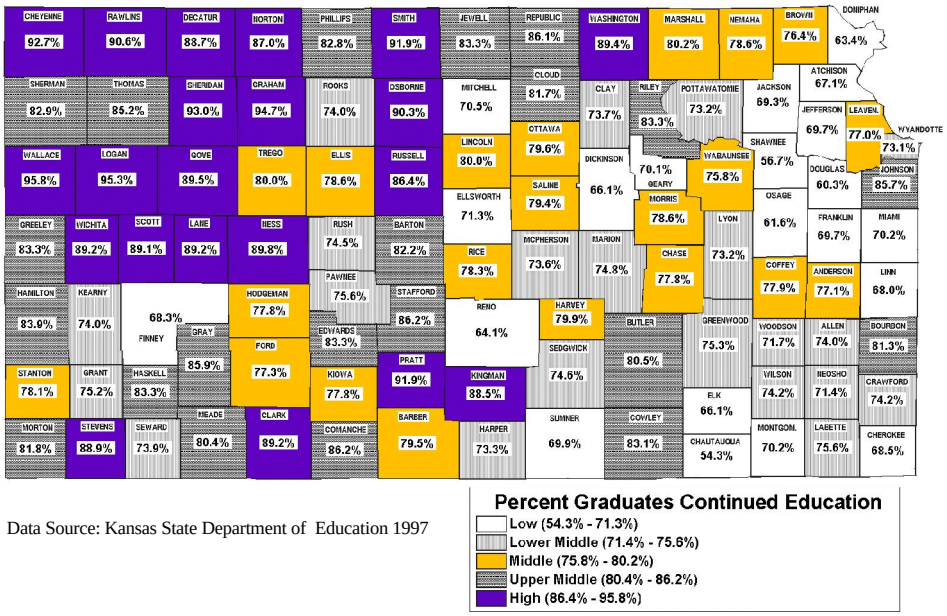
Title V Indicator: None
Index: Adolescent Health

Related Priority Need: No specific priority need

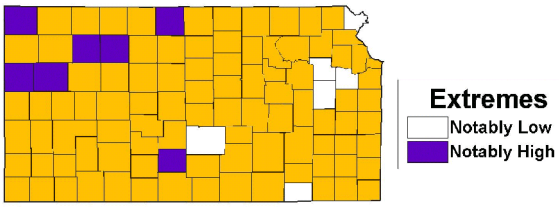


Data Source: Kansas State Department of Education 1997





Data Source: Kansas State Department of Education 1997



Geographic Disparities.

County. In the maps to the left are 1997 high school graduation rates and 1997 rates of those seeking higher education (college or vocational training). Rates for both tend to be lower in eastern counties of Kansas. However, Finney county in Southwest Kansas has the lowest graduation rate at 55.9%. The High School graduation rate for Kansas is 81.1%. The post-secondary Education percent is 75.8%.

PDG. Frontier counties perform the best in both indicators. Urban counties have the lowest graduation rate while Densely-Settled Rural Counties have the lowest proportion seeking post-secondary education.

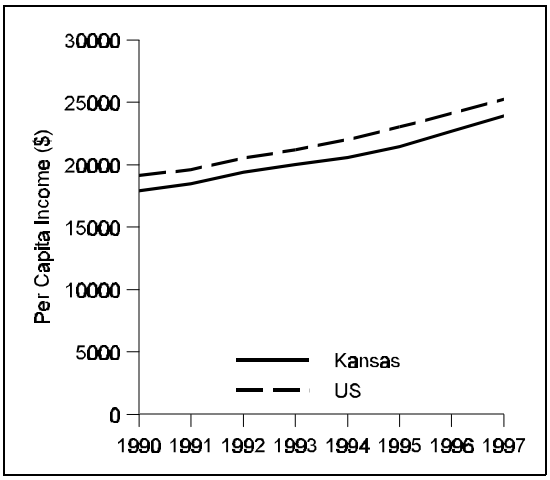
PDG	Grad Rate	Sec-Ed Rate
Frontier	92.7%	84.5%
Rural	89.3%	78.7%
DSR	80.1%	73.4%
Semi-Urban	82.0%	74.8%
Urban	77.8%	75.3%

IDS 14. Per Capita Income

Detailed Data Report

Title V Indicator: None **Related Priority Need**: No specific priority need

Index: Family Planning

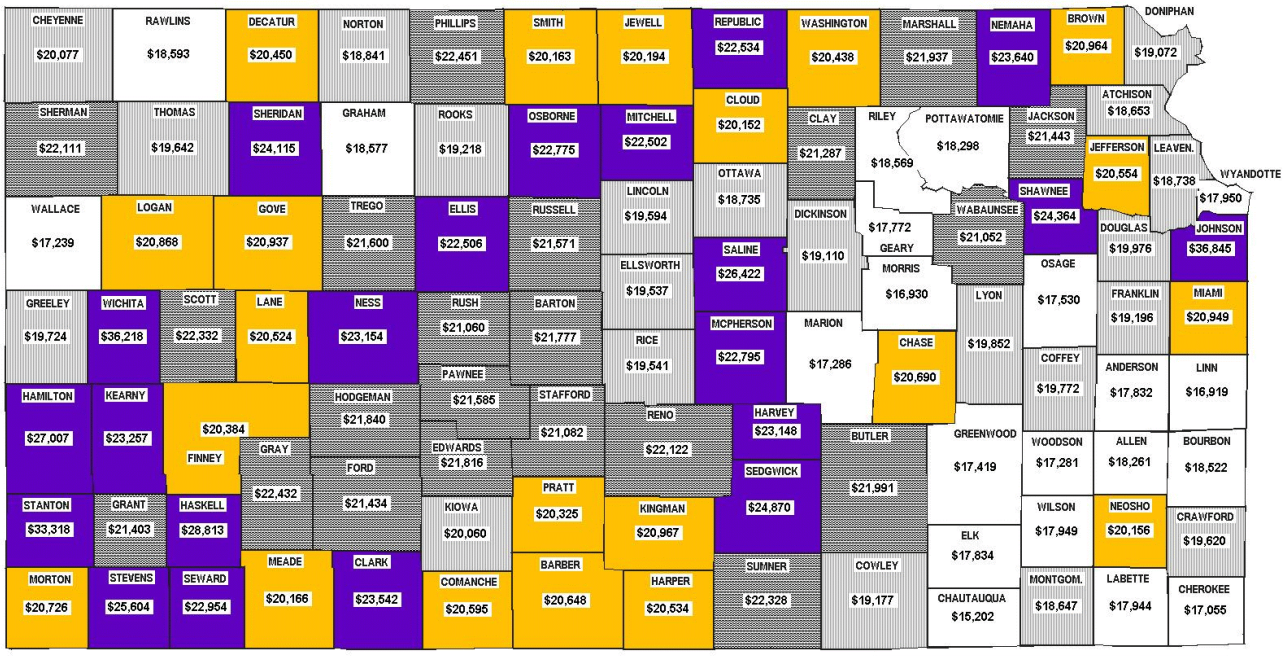


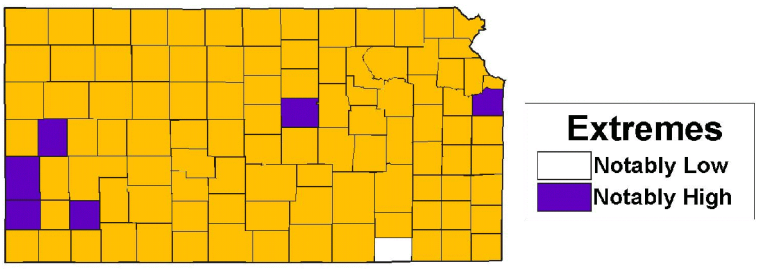
Recent Trend and U.S. Comparison. Kansas per capita income lags behind the U.S. trend by between $1000 and $2,000 per year. In Kansas per capita income has increased 33.6% from $17,940 per year in 1990 to $23,972 per year in 1997.

Geographic Disparities.

County. The map below shows the 1997 per capita income by county. The Southeastern counties of the state have the lowest per capita income with Chautauqua county the lowest at $15,202 per year. Johnson County in the suburbs of Kansas City has the highest per capita income ($36,845).

PDG. Urban Counties have the highest per capita income in the state ($27,112), while Densely-settled Rural counties have the lowest ($20,143).





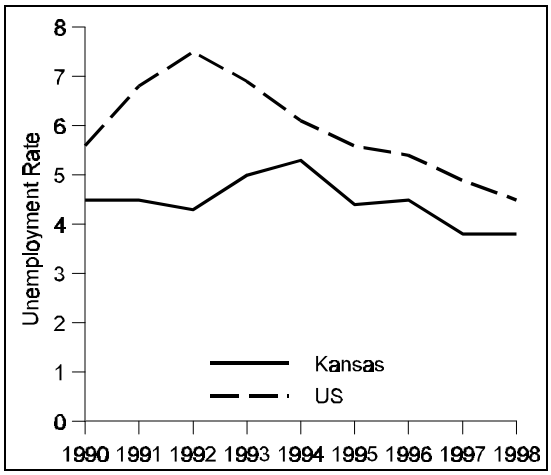
IDS 15. Unemployment Rate

Detailed Data Report

Title V Indicator: None

Related Priority Need: No specific priority need

Index: Family Planning



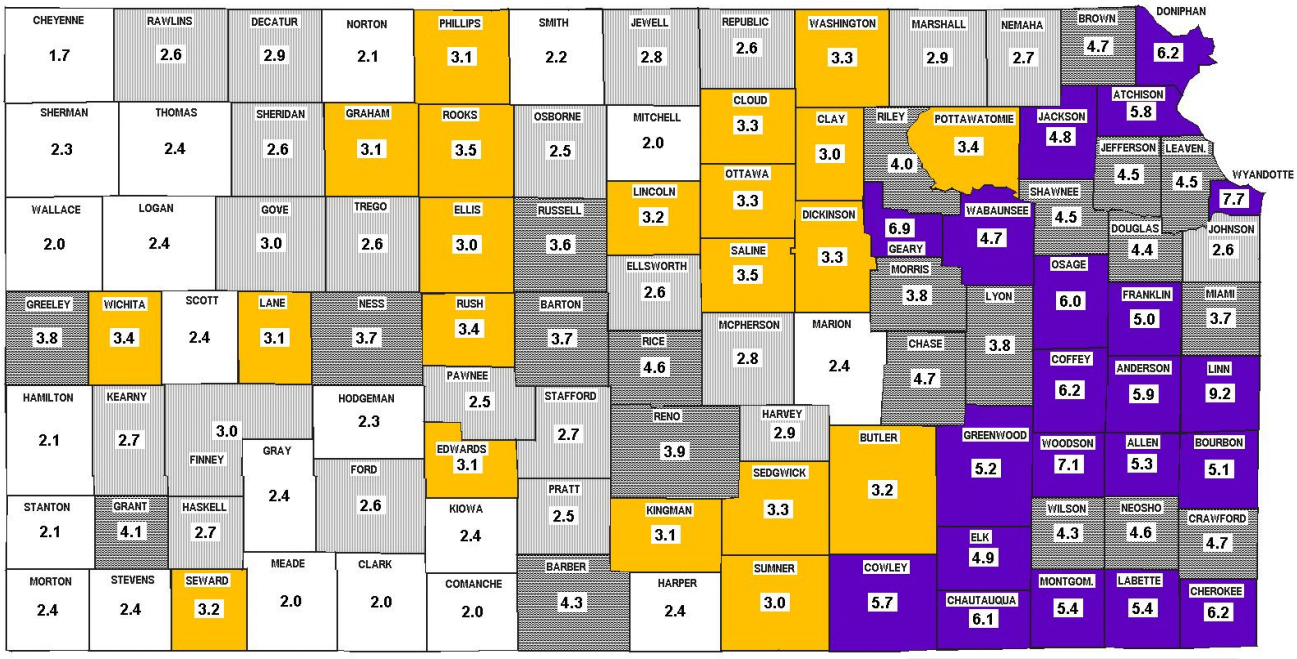
Recent Trend and U.S. Comparison.

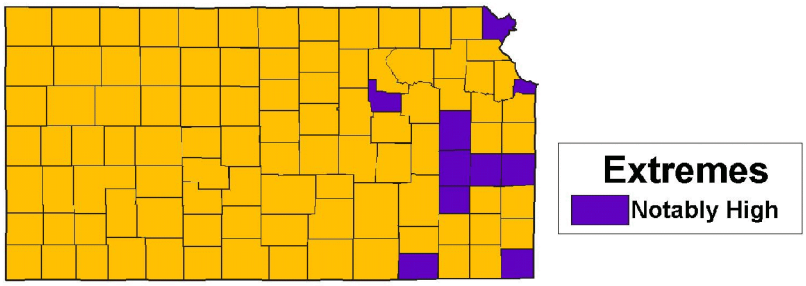
The Kansas unemployment rate has been consistently lower than the U.S. rate. However, in 1998 the gap had closed with the U.S. rate at 4.5% and the Kansas rate at 3.8%.

Geographic Disparities.

County. The map below shows the 1998 unemployment rate by county. The western two-thirds of the state enjoys very low unemployment rates. Many jobs and industries in this part of the state are agricultural-related. The eastern part of the state has higher rates of unemployment with Geary and Wyandotte having the highest rates of 6.9% and 7.7%, respectively.

PDG. D.S.-Rural and Semi-Urban Counties have the highest unemployment rate (4.1%) while Frontier Counties have the lowest (2.9%).





IDS 16. Pregnancy Rate Ages 15-17

Detailed Data Report

Title V Indicator: NPM 06 (Related) **Related Priority Need**: #3 Disparities

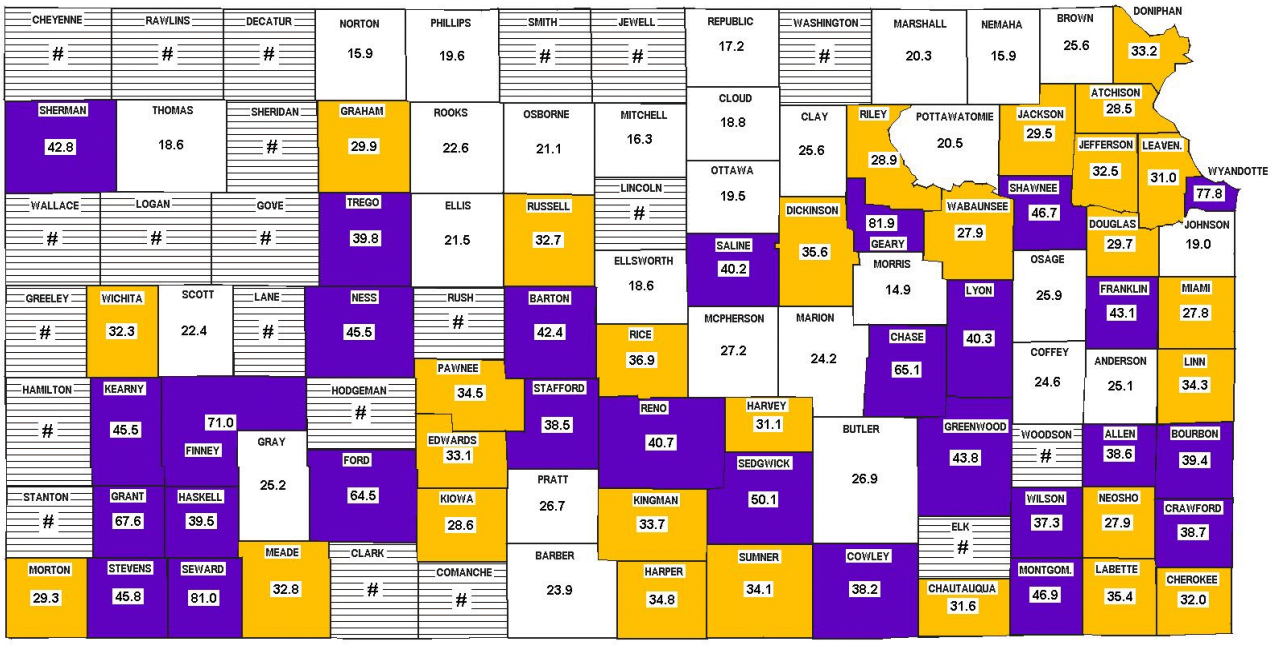
Index: Family Planning

In order to account for small numbers on the county level, 1994-1998 data has been combined.

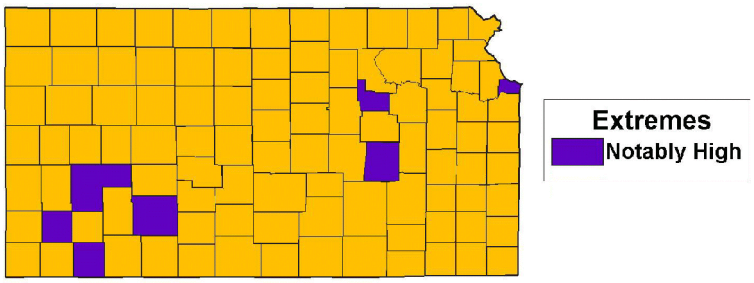
The Kansas rate of 38.7 per 1,000 (1994-1998) is approximately half of the national baseline of 72 (1995) and below the Healthy People 2010 objective of 46 pregnancies per 1,000.

Although the pregnancy rate for ages 15-17 has not been reported annually, it is expected to closely parallel the pregnancy rate for ages 10-17. The pregnancy rate for ages 10-17 in Kansas varied little between 1993 and 1995, declined slightly in 1996 and 1997, then decreased 10% in 1998.

Although Kansas is performing below the HP objective, several counties have pregnancy rates well above the Healthy People 2010 objective. Most notably, high pregnancy rates for ages 15-17 are found in Southwest Densely-Settled Rural Counties and as well as Geary and Wyandotte counties.



Data Source: 1994-1998 Kansas Vital Statistics



Frontier and Rural Caution: Even though rates for counties with less than ten pregnancies are not shown, some "extremes" may still be the result of relatively small numbers producing an erratic rate rather than a truly high incidence of adolescent pregnancy.

IDS 17. Pregnancy Rate Ages 18-19

Detailed Data Report

Title V Indicator: No specific indicator **Related Priority Need**: #3 Disparities

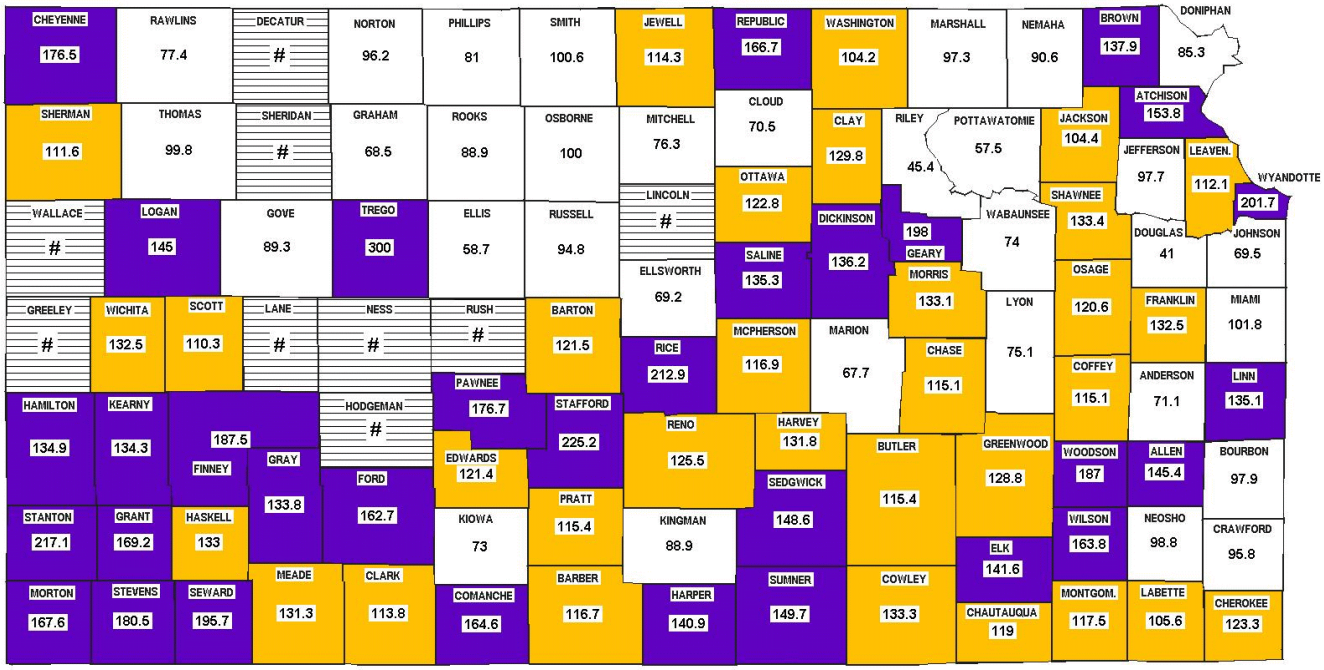
Index: Family Planning

In order to account for small numbers on the county level 1994-1998 data has been combined.

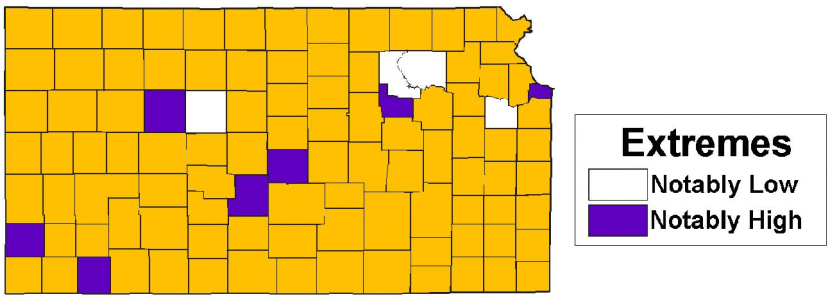
The Kansas rate of 111.9 for young women aged 18 to 19 is expectedly much higher than the rates for the younger age groups, about three times that for 15 to 17 year olds.

Although trend data is not readily available for this age group, it is expected to parallel the pregnancy rate for 15 to 19 year olds, which has decreased 14% from 1994 to 1998.

Counties performing well above the state average include Wyandotte, Geary, Southwest Kansas counties, and Central Kansas counties. Note, however, that a particularly high or low rate in a Rural or Frontier County may be due to relatively small numbers producing an erratic rate rather than a truly high pregnancy rate.



Data Source: 1994-1998 Kansas Vital Statistics



Frontier and Rural Caution: Even though rates for counties with less than ten pregnancies are not shown, some "extremes" may still be the result of relatively small numbers producing an erratic rate rather than a truly high incidence of adolescent pregnancy.

IDS 18. Teen Pregnancy Disparities

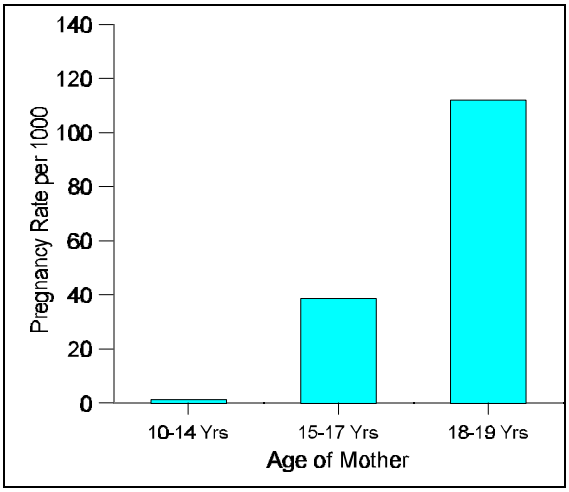
Detailed Data Report

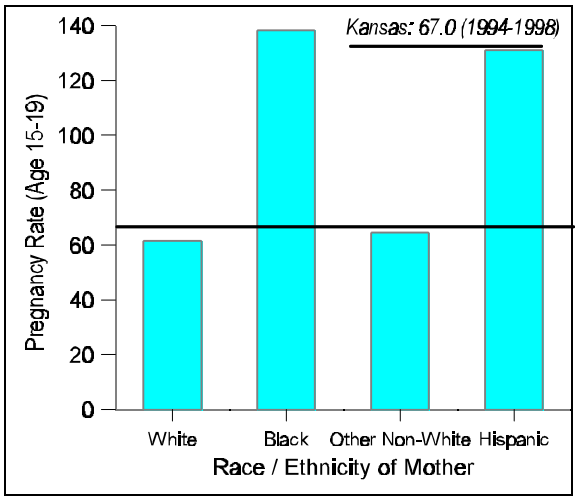
Title V Indicator: DHSI 07 (related) **Related Priority Need**: #3 Disparities

Index: Family Planning (related)

Data Note: All statistics are based on five years of data, 1994-1998.

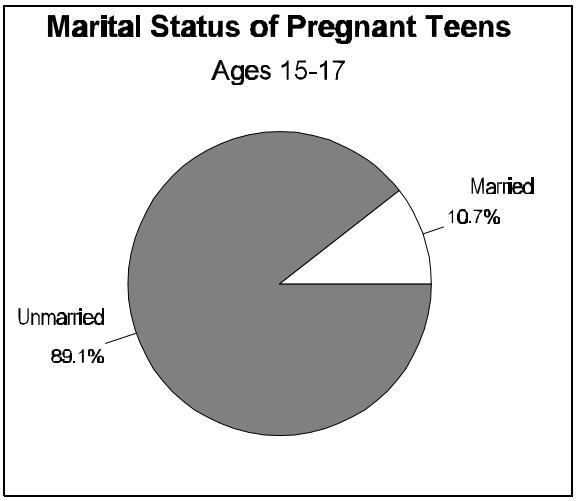
Demographic Disparities. ***Older*** *teens as well as* ***Black*** *and* ***Hispanic*** *have the highest rates of adolescent pregnancy.*

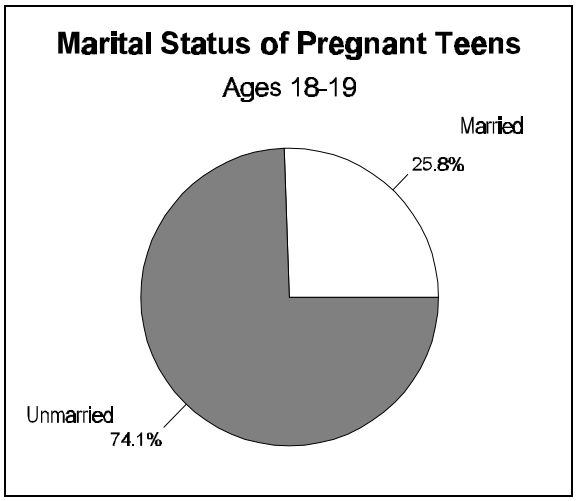




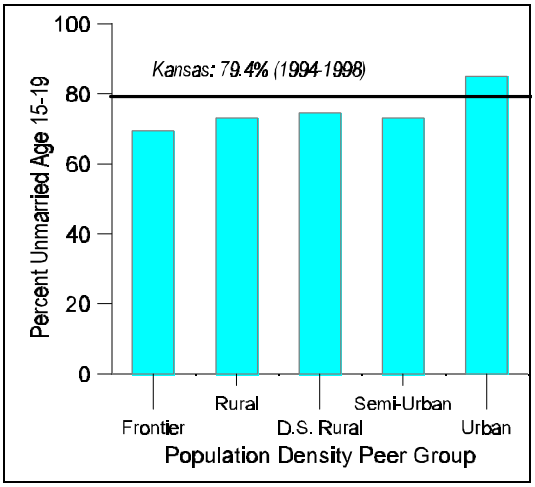
Pregnancy rates are, as expected, highest for the 15-19 age group. Of 15 to 19 year olds, a larger proportion of the 18 and 19 year-olds are married than the 15 to 17 year olds (25.8% versus 10.7%) (see below graphs).

The Black and Hispanic adolescent (ages 15 to 19) pregnancy rates are over twice as high as the White pregnancy rate.





Geographic Disparities - Marital Status



For adolescents age 15 to 19 who are pregnant, 79.4% are unmarried. The highest percentage of unmarried teens is in Urban Counties, while teens in Frontier Counties have the lowest percentage.

Geographic Disparities - Pregnancy Rates

Population Density Peer Group	Preg. Rate (15-17)	Preg. Rate (18-19)
Frontier	25.1	118.0
Rural	28.1	115.3
D.S.-Rural	40.6	119.3
Semi-Urban	38.3	101.9
Urban	41.5	112.2

By PDG, D.S.-Rural Counties have the highest pregnancy rate across both age groups. Of the remaining groups, more urban counties tend to have comparatively higher rates for younger teens, while more rural counties tend to have slightly higher rates among older teens.

PRE. For complete results by PRE group, refer to the Family Planning PRE Index. The top five groups with the highest and lowest pregnancy rate for 15-19 year olds is given below.

Highest Rates	
PRE Group	15-19 Preg. Rate
D.S. Rural Hispanic	172.2
Urban Black	143.8
Rural Hispanic	133.5
Semi-Urban Black	126.3

Lowest Rates	
PRE Group	15-19 Preg. Rate
Frontier Other Non-White (small number issue)	31.4
Frontier White	50.5
Rural White	54.7
Urban White	59.1

Urban Hispanic	118.2

Semi-Urban Other Non-White	60.6

IDS 19. Percent Teen Mothers with Repeat Birth

Detailed Data Report

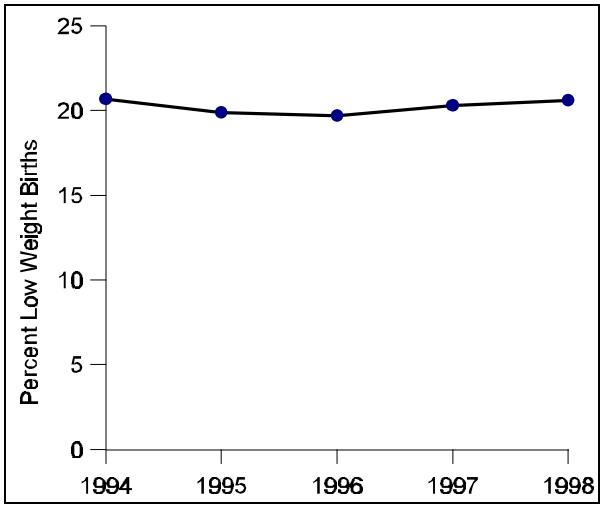
Title V Indicator: No specific indicator **Related Priority Need**: #3 Disparities

Index: Family Planning

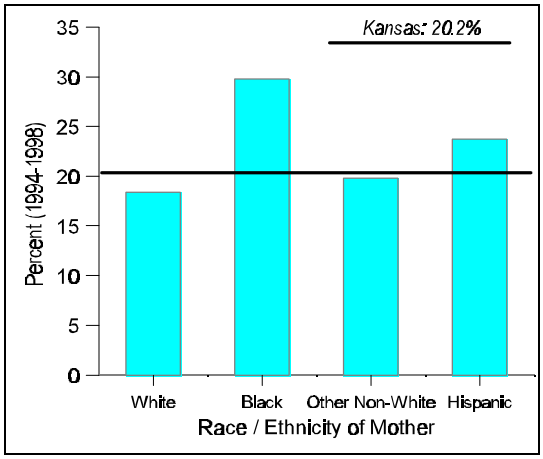
Recent Trend. Little/no change.

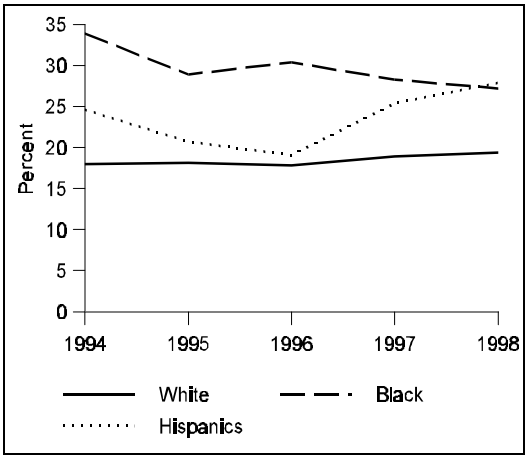
The percentage of teen mothers (less than 20 years) with a repeat birth has remained relatively stable for several years. From 1994 to 1998, there has been less than a 1% statewide decrease in the percentage of teen repeat births

Year	Number	Percent
1994	983	20.7%
1995	963	19.9%
1996	934	19.7%
1997	967	20.3%
1998	991	20.6%



Demographic Disparities. *Black and Hispanic teens have the highest incidence of repeat births.*

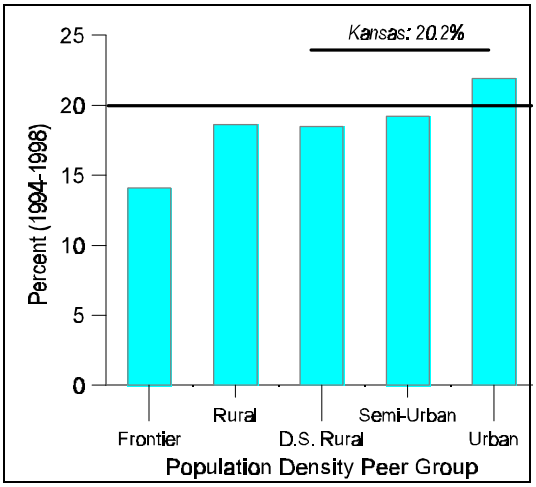




Black teens have the highest incidence of repeat births, although the percentage has decreased from 1994 to 1998. Hispanics are also above the state average and have showed an erratic trend. The percentage of White adolescent females with a repeat pregnancy has increased very slightly.

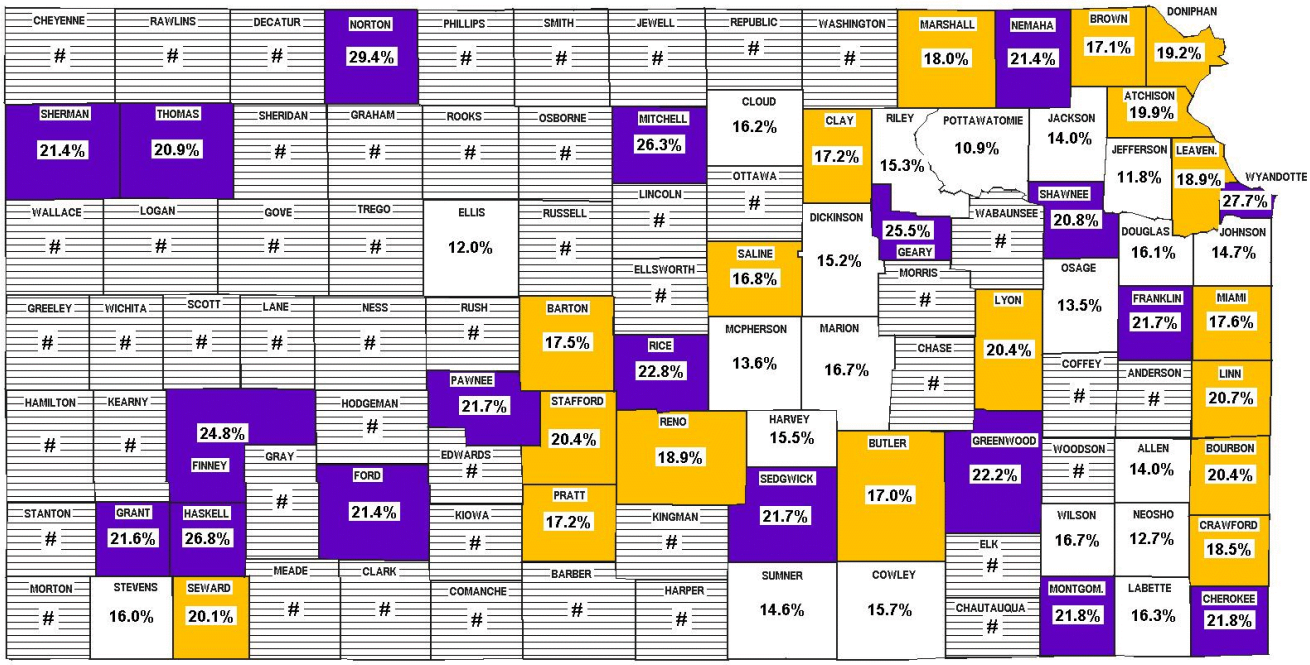
Geographic Disparities

By Population Density Peer Group. *Urban* counties perform poorest.

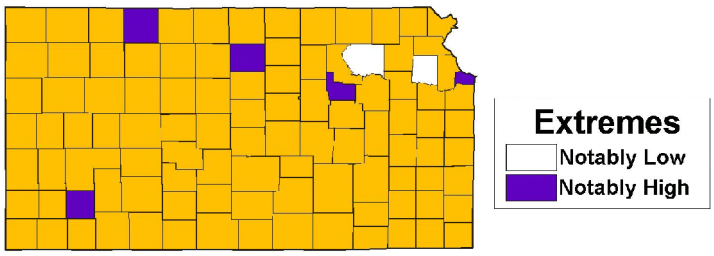


Of teens with live births, those living in Urban Counties were more likely for the birth to be their second or higher order birth. Frontier Counties had the lowest percent of teen births which were repeat births.

By County. Geary, some SW Kansas counties, and Urban Counties had the highest percentages of repeat teen births. Note that most of the Rural and Frontier Counties had less than ten during 1994-1998; thus, their percentages are not mapped.



Data Source: 1994-1998 Kansas Vital Statistics



Frontier and Rural Caution: Even though counties with less than ten repeat births are not mapped, some "extremes" may still be the result of relatively small numbers producing an erratic

rate rather than a truly high incidence.

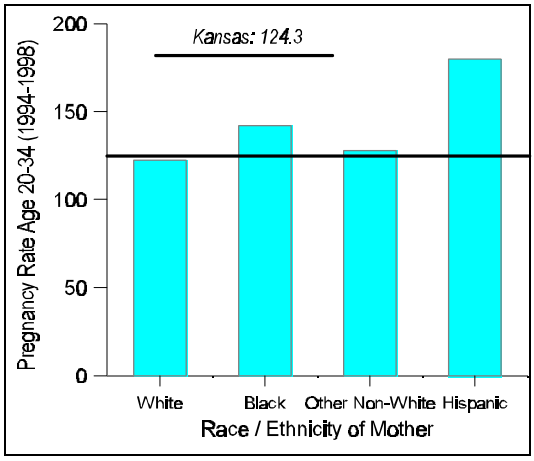
IDS 20. Pregnancy Rate Ages 20-34

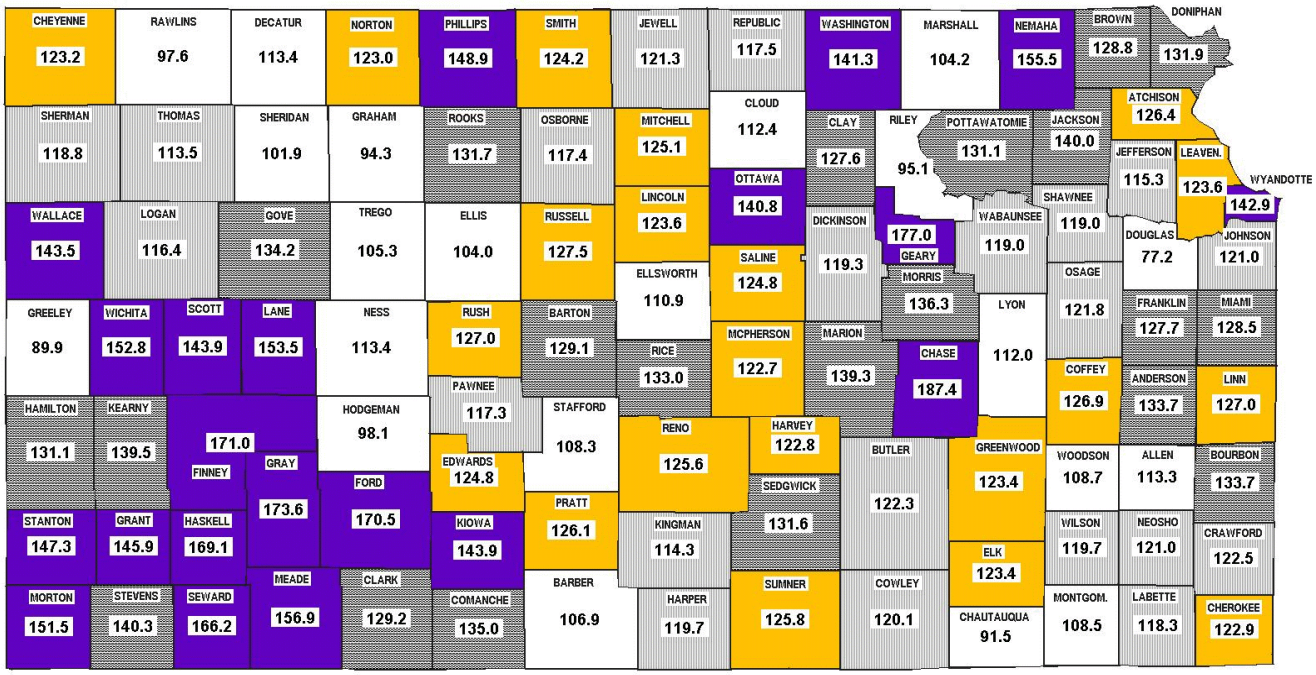
Detailed Data Report

Title V Indicator: No specific indicator **Related Priority Need**: #3 Disparities

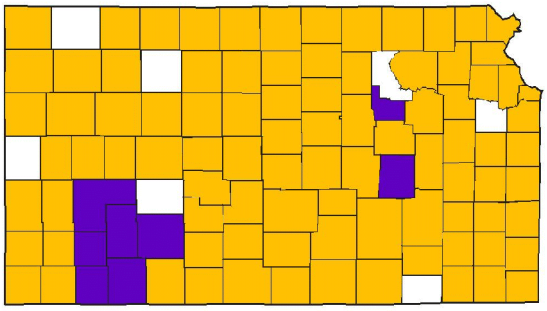
Index: Family Planning

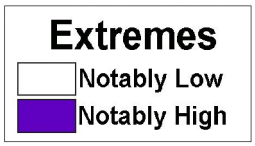
The Kansas pregnancy rate for women aged 20 to 34 years is 124.3. Black and White pregnancy rates are similar for this age group, but the Hispanic rate is approximately 40% higher. Among population density groups, Densely-settled Rural Counties have the highest rate (131) while Semi-Urban Counties have the lowest (121). From the below map, note the high rate in Geary County and the cluster in SW Kansas.





Data Source: 1994-1998 Kansas Vital Statistics





Note: All statistics shown are five years combined, 1994-1998.

IDS 21. Pregnancy Rate Ages 35-44

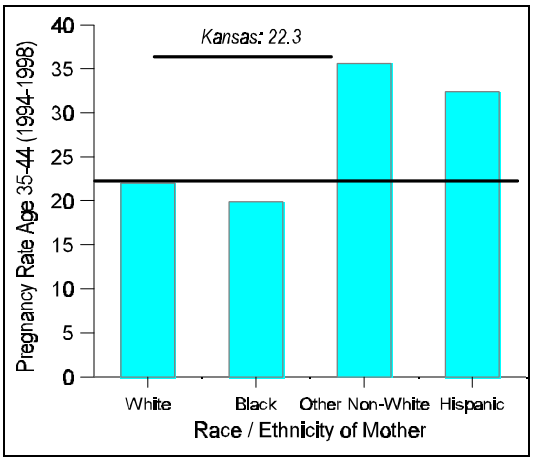
Detailed Data Report

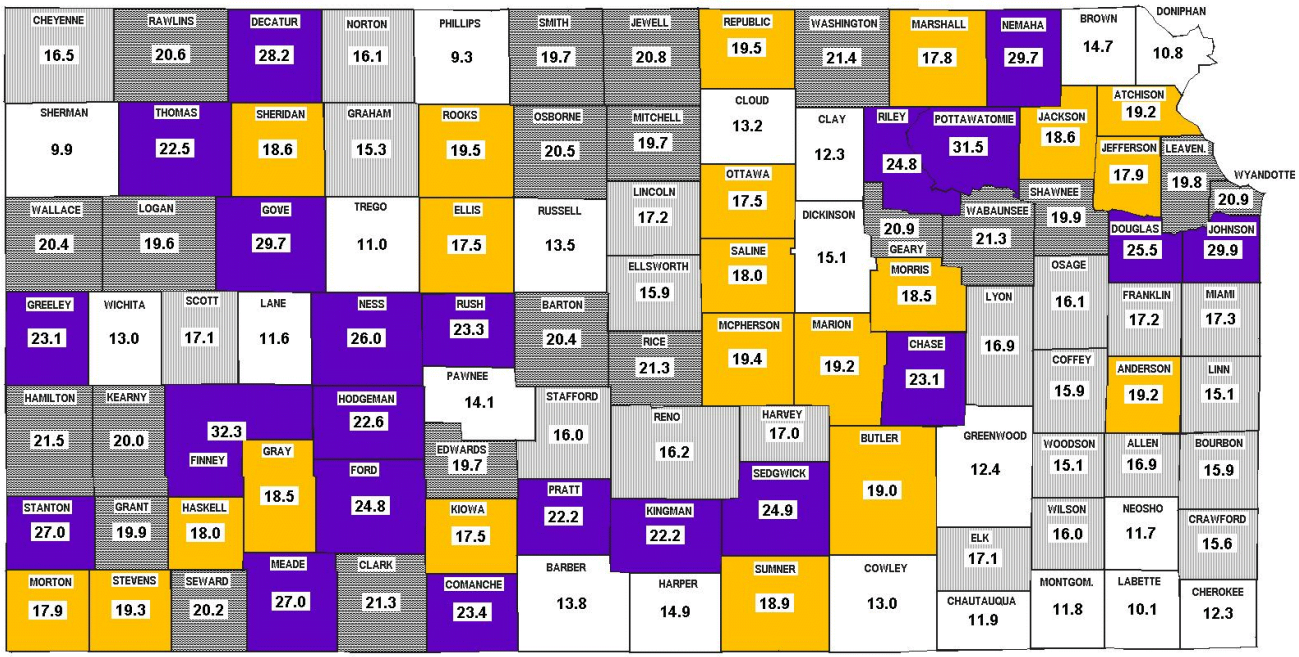
Title V Indicator: No specific indicator **Related Priority Need**: #3 Disparities

Index: Family Planning

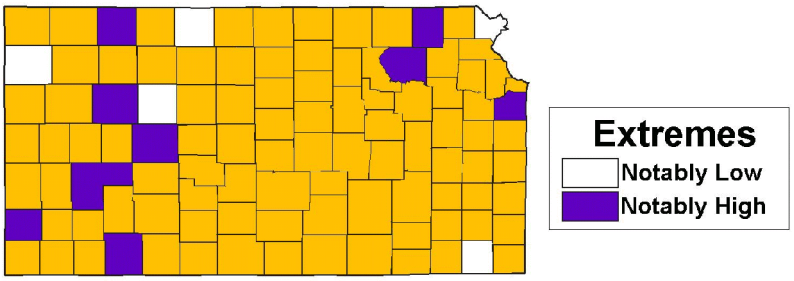
The Kansas pregnancy rate for women aged 35 to 44 years is 22.3. Black females of this group have the lowest pregnancy rate while Hispanics and Other Non-White (includes American Indian, Asian, Pacific Islander and Other races) have the highest.

Among population density groups, Urban Counties have the highest rate (25.5) while Rural Counties have the lowest (17.6). On the map below, notice that Johnson County, Western Kansas Counties, and others scattered across the state have high rates. SE Kansas tends to have lower rates for this age group.





Data Source: 1994-1998 Kansas Vital Statistics



IDS 22. Percent with Short Interbirth Spacing

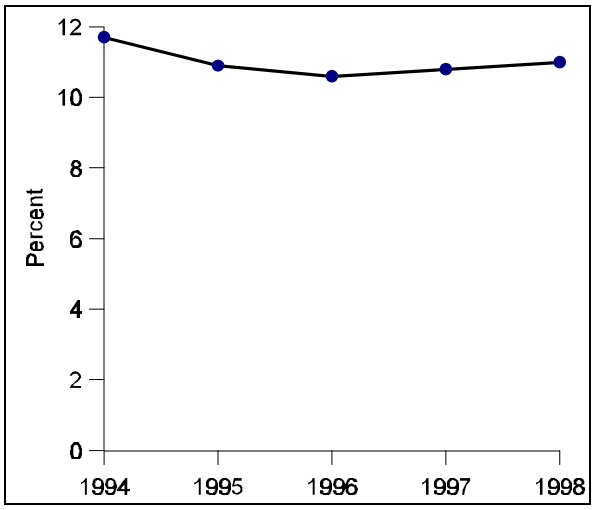
Detailed Data Report

Title V Indicator: No specific indicator **Related Priority Need**: #3 Disparities

Index: Family Planning

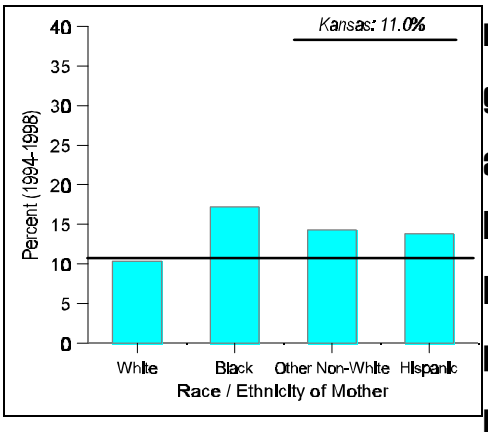
Recent Trend.

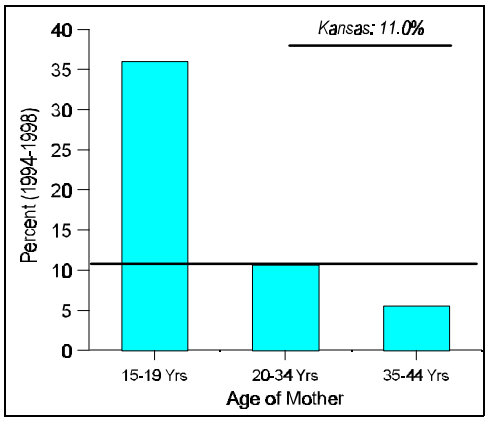
The percent of live births to mothers with a live birth less than 18 months prior has fluctuated slightly over the past five years, decreasing slightly from 1994-1996, then increasing very slightly from 1996-1998. From 1994 to 1998, there has been a 6% statewide decrease in short interbirth space births.



Year	Number	Percent
1994	2,551	11.7%
1995	2,323	10.9%
1996	2,259	10.6%
1997	2,360	10.8%
1998	2,514	11.0%

Demographic Disparities.

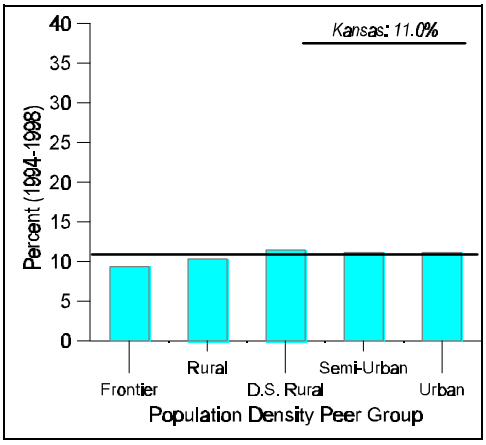




Black and ***teen*** mothers show highest percentage for this indicator.

Based on 1994-1998 vital information, the Black short interbirth spacing percentage is about 50% higher than the White percentage. The percentage for adolescent mothers aged 15 to 19 is 3.5 times higher than that for mothers aged 20 to 34. This is to be expected since there is only 5 years spacing between mothers 15 and 19 years old. If a mother has two children when she is between the ages of 15 and 19, the chances for a short interbirth spacing are proportionally greater than if she were between the ages of 20 and 34.

Geographic Disparities



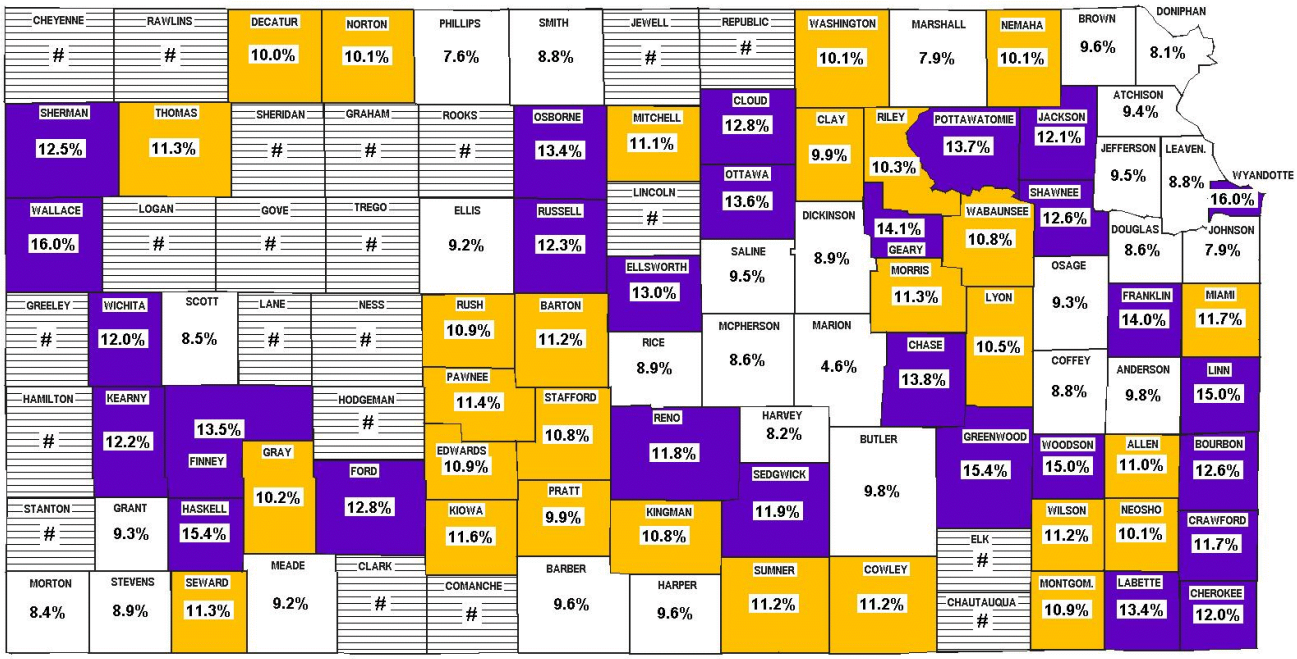
By Population Density Peer Group

There is not a great disparity between population density groups. Frontier Counties have the lowest rate at 9.3% while Densely-settled Rural Counties, the highest, are only slightly above that with 11.4%

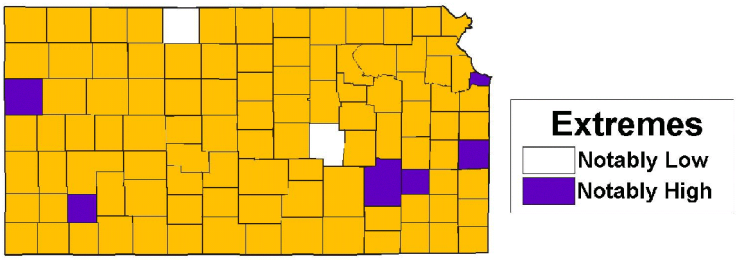
Greater disparities are evident in the PRE groups. Urban Black is the highest at 17.5%.

Demographic, County, PDG, and PRE results can help us determine which groups are most at-risk for short interbirth spacing and target those populations accordingly.

By County. Short interbirth spacing based on less than ten incidents from 1994-1998 are not mapped.



Data Source: 1994-1998 Kansas Vital Statistics



Frontier and Rural Caution: Even though percentages for counties with less than ten incidents are not mapped, some "extremes" may still be the result of small numbers producing an erratic rate rather than a truly high/low percent

short interbirth spacing.

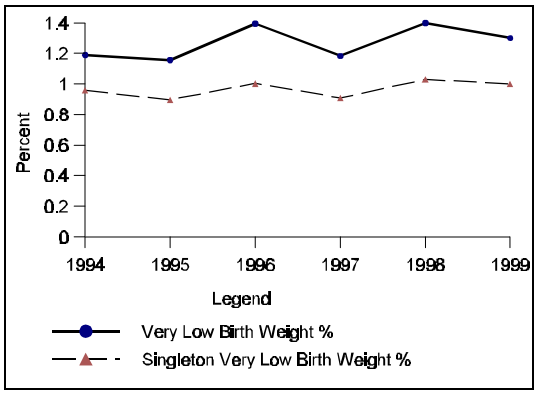
IDS 23. Percent Very Low Birth Weight Births

Detailed Data Report

Title V Indicators: CHSI 05, NPM 15, NPM 17 **Related Priority Need**: #3 Disparities

Index: None

Recent Trend. Slight increase.



Year	Very Low Birth Weight Number	Very Low Birth Weight Percent	Singleton Very Low Birth Weight Number	Singleton Very Low Birth Weight Percent
1994	443	1.19%	349	0.96%
1995	429	1.16%	324	0.90%
1996	509	1.39%	356	1.00%
1997	440	1.18%	328	0.91%
1998	536	1.40%	384	1.03%
1999	514	1.33%	373	0.99%

Percent very low birth weight births and singleton VLW births have fluctuated in parallel over the last six years. Both are showing a slight increase over six years ago.

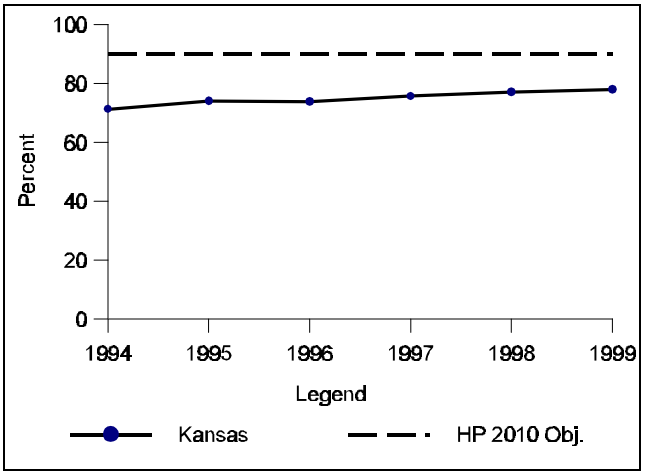
Kansas performed equal to the U.S. in 1998 (1.4). The Kansas rate is higher than the HP 2010 target of 0.9.

The proportion of VLW births which are singleton births has decreased over the past six years. In 1994, 79% of VLW births were singleton. By 1999, this proportion has decreased to 73%.

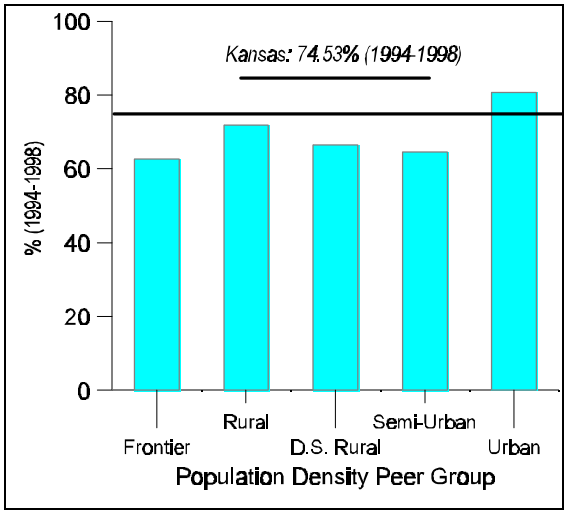
The below graphs show that the proportion of VLW births in "Level III" facilities have increased over the past six years but are still below the HP 2010 objective of 90%. Geographically, those living in urban counties are most likely to deliver at a level III facility while those living in Frontier and Semi-Urban counties are least likely.

Percent Very Low Birth Weight Delivered at a Level III Facility

Recent Trend

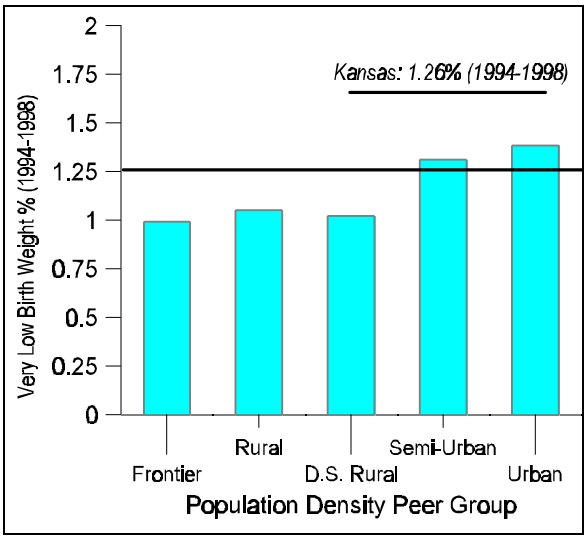


Geographic Disparities



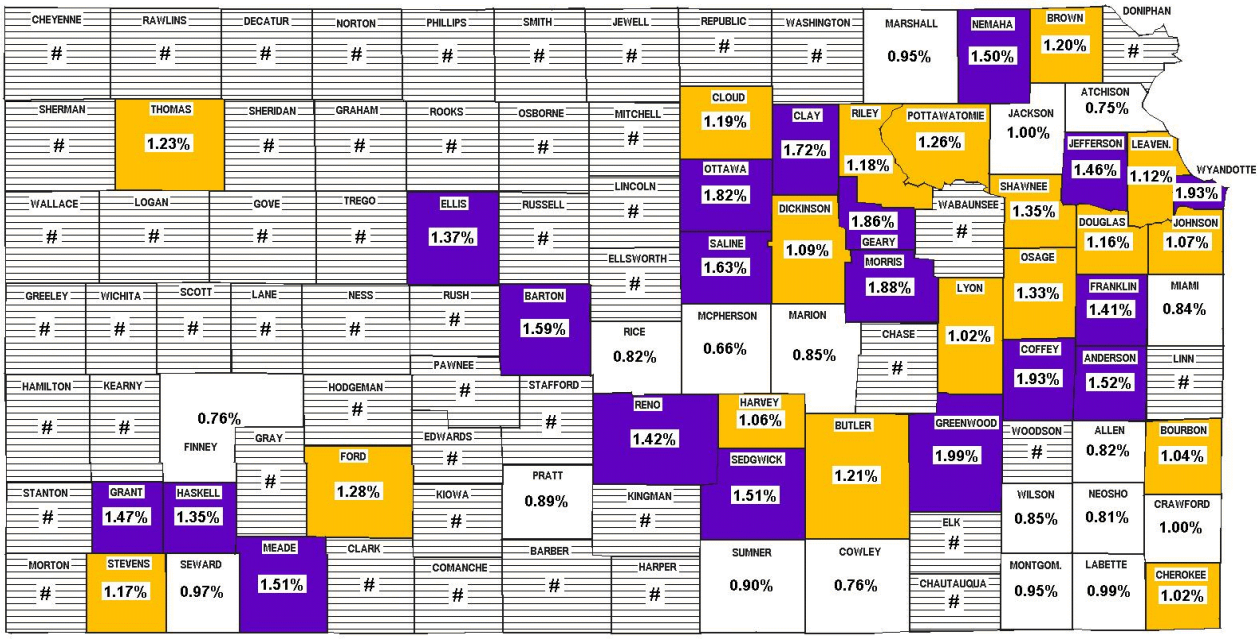
Geographic Disparities

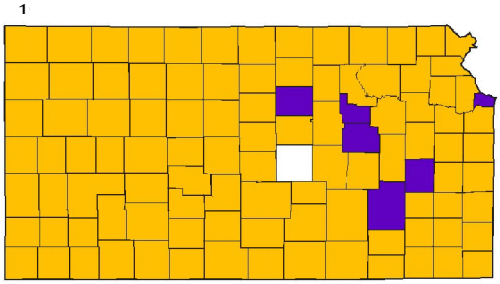
By Population Density Peer Group. *Urban* counties perform poorest.



Urban Counties also have the highest rate of VLW births; their rate is 38% higher than the VLW birth rate for Frontier Counties. D.S.-Rural and Rural also tend to have relatively low rates.

By County. Low birth weights based on less than ten incidents from 1994-1998 are not mapped. Caution: Many of the remaining rural and frontier counties are based on less than 20 incidents, resulting in an unstable rate. Wyandotte and Geary are notably above the state average. Other "Extreme" counties may be due to small numbers rather than a truly high or low rate.





Extremes
- Notably Low
- Notably High

Frontier and Rural Caution: Even though rates for counties with less than 10 very low weight births are not mapped, notably high or low rates may still be the result of small numbers producing an erratic rate rather than a truly high incidence of very low

birth weight births.

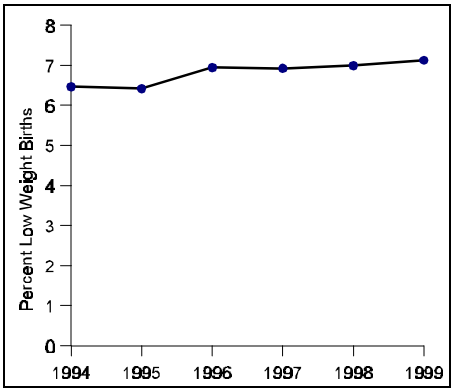
IDS 24. Percent Low Birth Weight Births

Detailed Data Report

Title V Indicator: CHSI 04A **Related Priority Need**: #3 Disparities

Index: Primary Care

Recent Trend. Gradual increase indicates move in the *wrong* direction.



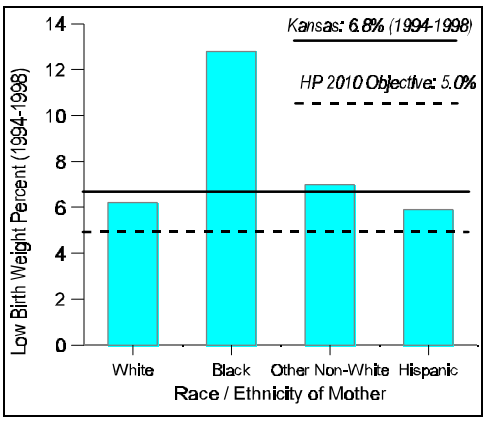
Year	Number	Percent
1994	2,410	6.5%
1995	2,381	6.4%
1996	2,538	7.0%
1997	2,573	6.9%
1998	2,683	7.0%
1999	2,762	7.1%

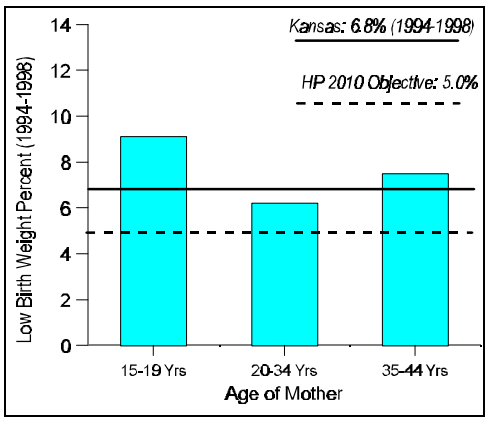
Percent low weight births have fluctuated slightly over the last six years with a general upward trend. From 1994 to 1999, there has been a 9% statewide increase in percent low birth weight births.

Kansas has paralleled the national trend, performing slightly better than the national average (6.9% for Kansas versus 7.5% for U.S. in 1997).

There was some speculation on the recent trend in percent low weight births during our needs assessment: Mothers may indeed be receiving better care and carrying their babies longer. However, there is another group of mothers who, due to medical advancements, may be delivering babies they once would have miscarried. Kansas could benefit from the consultation and research of an MCH epidemiologist on this issue (see Priority Need #4. Data, Epidemiological, and Analysis Capacity).

Demographic Disparities. *Black* and *teen* mothers show highest incidence of low birth weight.



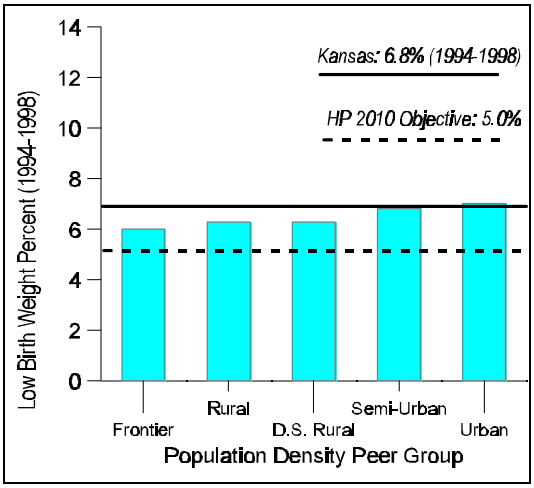


In the above left graph, "Other Non-White" includes Native American, Asian, and Pacific Islander Races. "Hispanic" persons may be of any race.

Based on 1994-1998 vital information, the black low birth weight percentage is over twice as high as the white low birth weight percentage. The low birth weight percentage for adolescent mothers aged 15 to 19 is nearly 50% higher than that for mothers aged 20 to 34. All groups perform below the Healthy People 2010 target of 5.0%.

Geographic Disparities

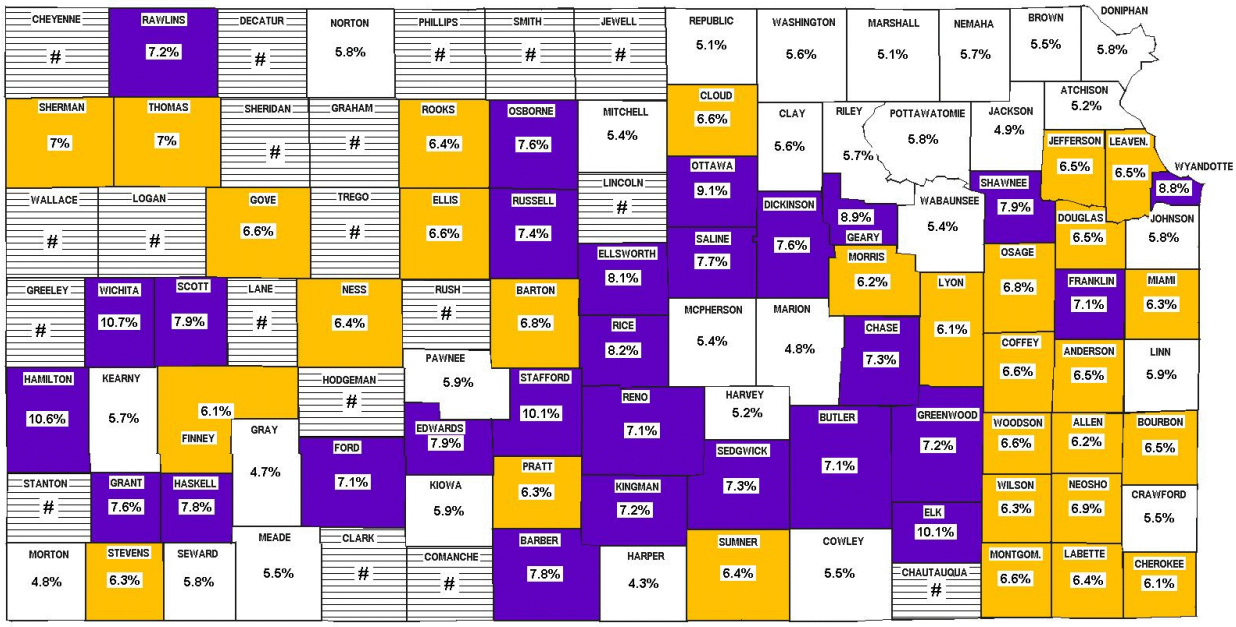
By Population Density Peer Group. ***Urban*** counties perform poorest.



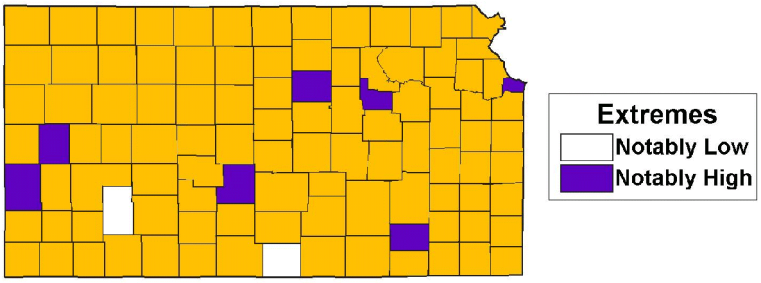
There is not as much geographic variation by population density peer group as by race/ethnicity and age group of mother. However, urban counties perform slightly worse, and frontier counties perform slightly better, than the state across all age groups. For example, among mothers aged 15 to 19, the incidence of low birth weight births is 6.4% in frontier counties versus 9.7% in urban counties. (This may be a function of the age of the teens. Pregnancy rates for older teens [age 18-19] are higher in frontier counties while pregnancy rates for younger teens [age 15-17] are higher in urban counties.)

The urban/rural trend is not as clear by race/ethnicity. This may be due to unstable rates from small numbers; even five-year data yields small numbers for the frontier and rural peer groups by race and ethnicity.

By County. Low birth weights based on less than ten incidents from 1994-1998 are not mapped. Caution: Many of the remaining rural and frontier counties are based on less than 20 incidents, resulting in an unstable rate.



1994-1998 Kansas Vital Statistics



Frontier and Rural Caution: Even though rates for counties with less than 10 low weight births are not mapped, notably high or low rates may still be the result of small numbers producing an erratic rate rather than

a truly high incidence of low birth weight births.

IDS 25. Percent Singleton Low Birth Weight Births

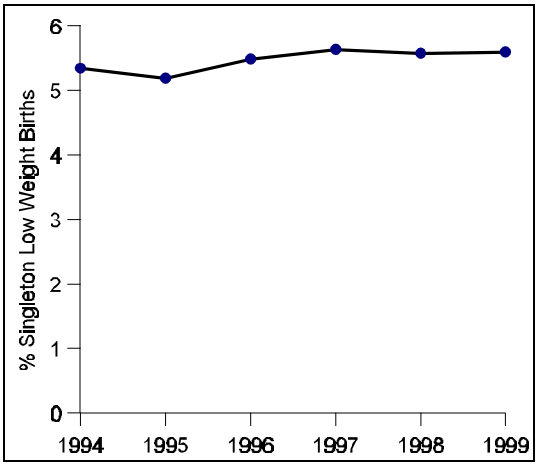
Detailed Data Report

Title V Indicator: CHSI 04B **Related Priority Need**: #3 Disparities

Index: Perinatal

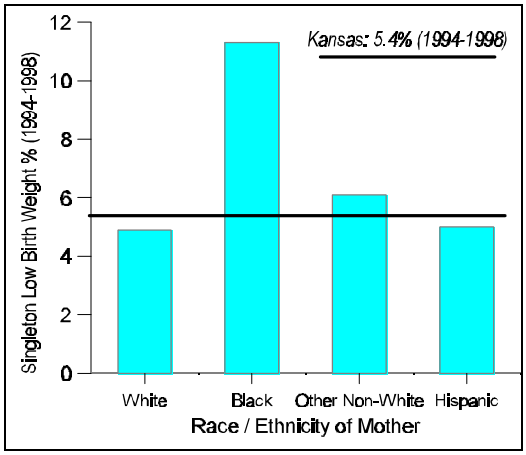
Recent Trend. Little change. Very slight increase since 1994.

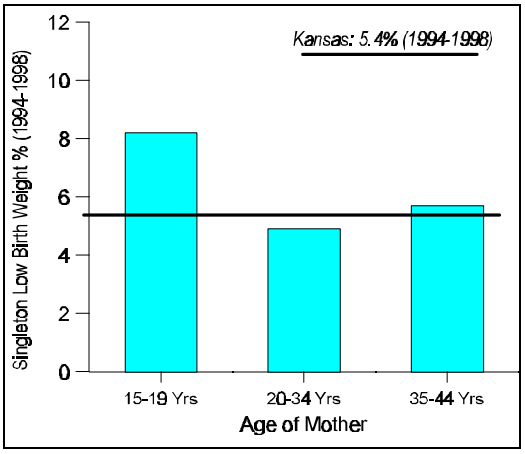
Singleton low births have increased 6% since 1994; this is slightly less than the 9% increase in the rate for all low birth births.



Year	Number	Percent
1994	1,944	5.3%
1995	1,877	5.2%
1996	1,947	5.5%
1997	2,036	5.6%
1998	2,079	5.6%
1999	2,105	5.6%

Demographic Disparities. Black and teen mothers have highest incidence of singleton LBW.

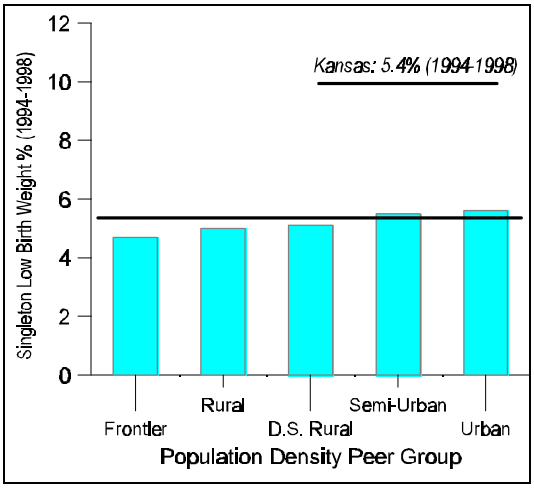




Based on 1994-1998 five-year data, the singleton LBW rate for Black mothers is more than twice that for White mothers. Singleton LBW rates by age also show disparities; the rate for 15 to 19 year olds is 67% higher than the rate for mothers 20 to 34 years.

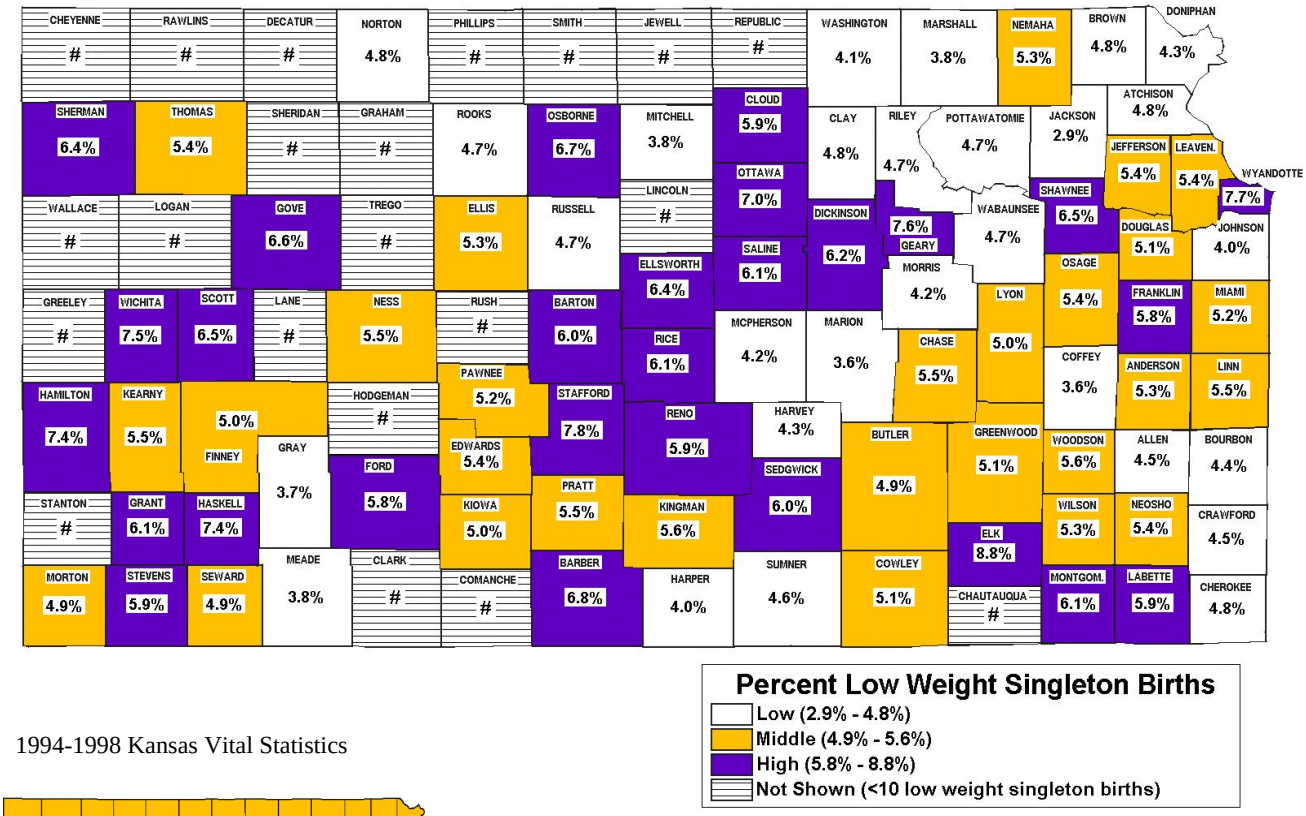
Geographic Disparities

By Population Density Peer Group.

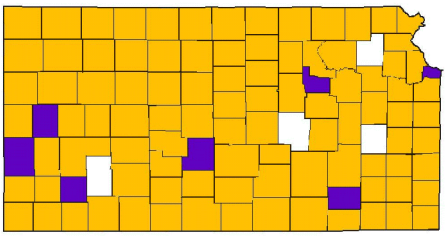


There are not tremendous disparities by Population Density Group. Urban Counties tend to have higher rates while Frontier Counties have the lowest, which would be contrary to what we might expect knowing that there are the least OB/Gyn services in the sparsely-populated Frontier Counties.

By County. Based on 1994-1998 data, the consistently high-need counties of Geary and Wyandotte show above-average rates.



1994-1998 Kansas Vital Statistics



Extremes
Notably Low
Notably High

Frontier and Rural Caution: Even though rates for counties with less than 10 singleton low weight births are not mapped, notably high or low rates may still be the result of small numbers producing an erratic rate rather than a truly

high incidence of singleton low birth weight births.

IDS 26. Percent Breastfeeding (WIC)

Detailed Data Report

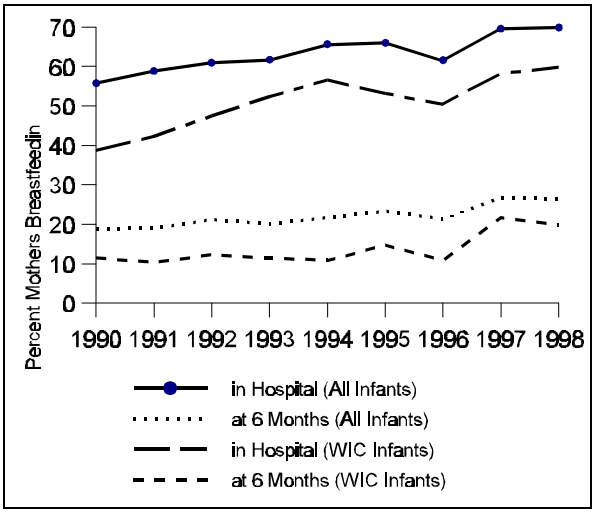
Title V Indicator: NPM #9 (related) **Related Priority Need**: #7 Nutrition/Physical Activity

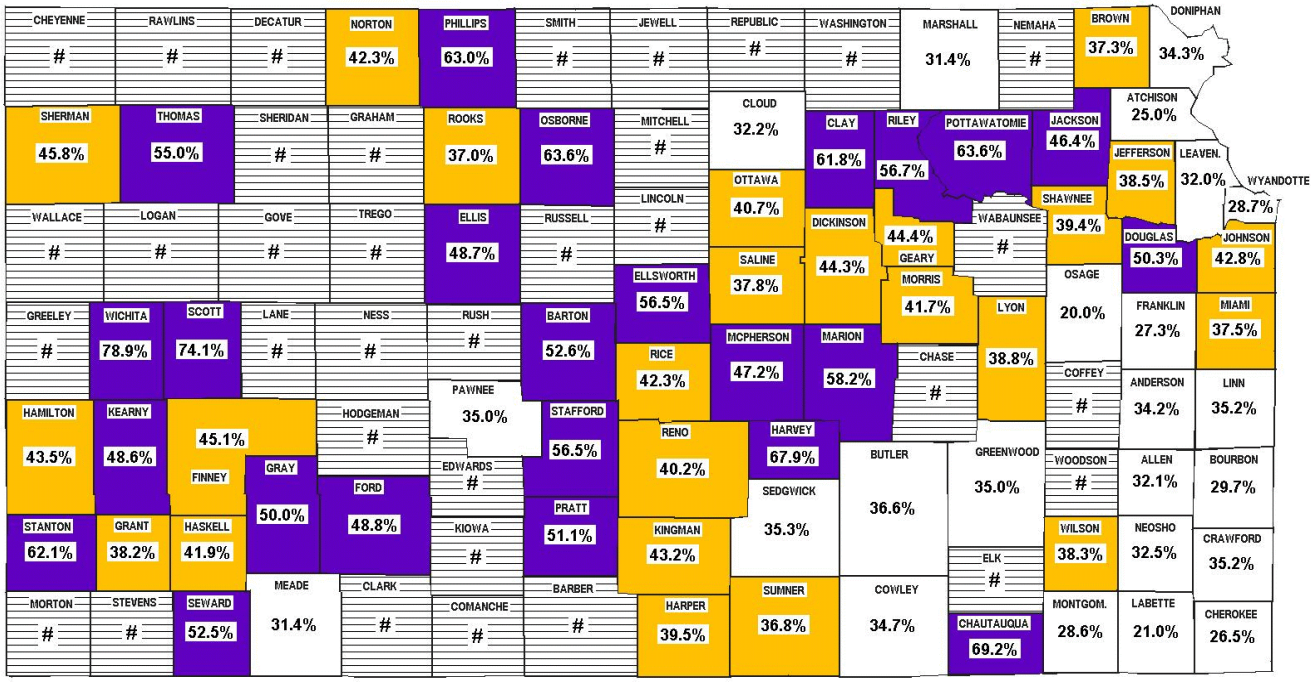
Index: Perinatal

The data to the right is from the Ross Labs Survey and is *not* directly comparable to the data in the county map below, which was based on the Kansas WIC Pregnancy Nutrition Surveillance System.

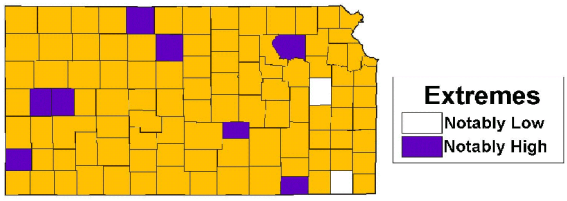
The Ross Labs survey indicates an increase in breastfeeding over the last decade. WIC clients are less likely to breastfeed than the general population.

By PDG (according to WIC data), women in Frontier Counties are 42% more likely to be breastfeeding at their postpartum visit than women in Urban Counties (51.0% versus 35.9%).





Data Source: 1998 WIC Pregnancy Nutrition Surveillance System



Frontier and Rural Caution: Even though percentages based on less than 10 mothers breastfeeding are not mapped, some "extremes" may still be the result of small numbers producing an erratic rate rather than a truly high or low incidence of breastfeeding mothers.

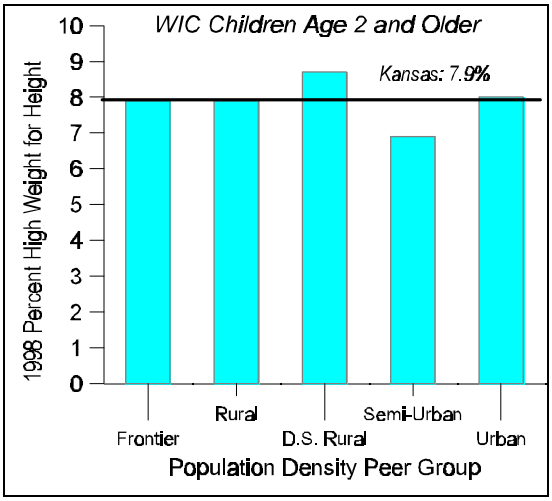
IDS 27. Percent Overweight WIC Children

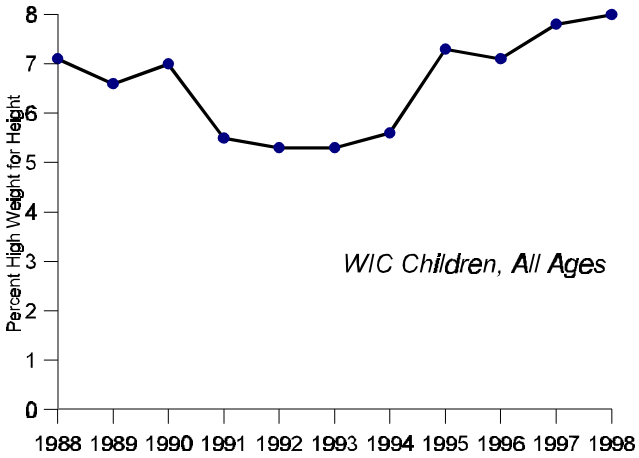
Detailed Data Report

Title V Indicator: SPM 12 (related) **Related Priority Need**: #7 Nutrition/Physical Activity

Index: Child Health

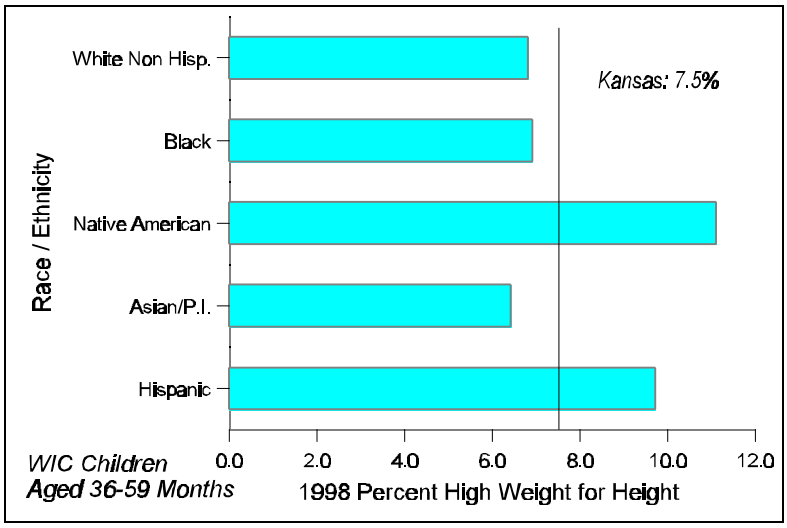
Data Note: Although the target age group for SPM 05 is 36-59 months, this age stratification is not readily available by county and for past years. Note age groups reported for each graph and on the Child Health Index.





Geographic Disparities. The Child Health Index as well as the PDG graph on the above left reports the proportion of WIC children aged 2 years and older with high weight for height (overweight). D.S.-Rural Counties have the highest percentage of overweight WIC children while Semi-Urban Counties have the lowest.

Recent Trend. The trend graph above reports percent overweight for WIC children of all ages. According to the WIC Pediatric Nutrition Surveillance System, the proportion of children at risk for low weight-for-height (underweight) has decreased while the high weight-for-height (overweight) trend has been increasing for the past several years, and in 1998 was the highest (8.0%) that it has been in the last decade.



Racial/Ethnic Disparities.

The bar graph to the left shows the 1998 percent overweight for ages 36-59 months by race and ethnicity. Note that the Native American (11.1%) and Hispanic (9.7%) populations have higher than the Kansas average of 7.5% for the state.

Source for all data: 1998 WIC Pediatric Nutrition Surveillance System

IDS 28. Infant Mortality Rate

Detailed Data Report

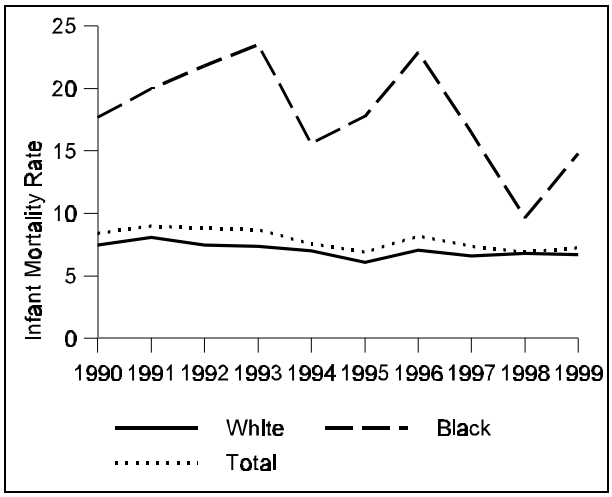
Title V Indicator: OM 01, OM 02 **Related Priority Need**: #3 Disparities

Index: Perinatal

Recent Trend. ***Little change.*** Very slight decrease in past ten years.

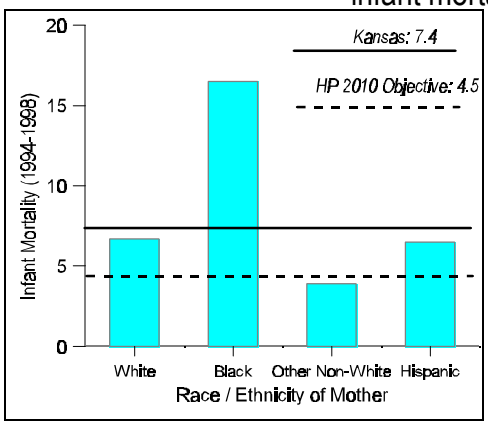
Infant Mortality Rate

Year	White	Black	Total
1990	7.5	17.7	8.4
1991	8.1	20.0	9.0
1992	7.5	21.8	8.8
1993	7.4	23.5	8.7
1994	7.0	15.6	7.6
1995	6.1	17.8	6.9
1996	7.1	22.9	8.2
1997	6.6	16.5	7.4
1998	6.8	9.7	6.9
1999	6.7	14.8	7.3



Infant mortality rate has fluctuated slightly over the last six years. From 1990 to 1999, there has been a 13% statewide decrease in the infant mortality rate. Kansas has paralleled the national trend, performing slightly better than the national average (6.9 for Kansas versus 7.2 for U.S. in 1998).

Demographic Disparities. During 1994-1998, ***black*** infant mortality rate is twice as high as other infant mortality for other racial groups.



	Rate
Medicaid*	9.8
Non-Medicaid*	5.7

*Based on in-process partial match of Medicaid claims data and birth records (1999).

Based on 1994-1998 vital information, the black infant mortality rate is over twice as high as the white infant mortality rate. All groups, with the exception of "Other Non-White" perform poorer than the Healthy People 2010 target of 4.5. On the PRE Perinatal Index, the black infant mortality rate is high across all population density groups.

In the above left graph, "Other Non-White" includes Native American, Asian, and Pacific Islander Races. "Hispanic" persons may be of any race.

Preliminary matching of Medicaid and birth records (1999 data) indicates that the infant mortality rate for non-Medicaid births is 42% lower than the infant mortality rate for Medicaid

births.

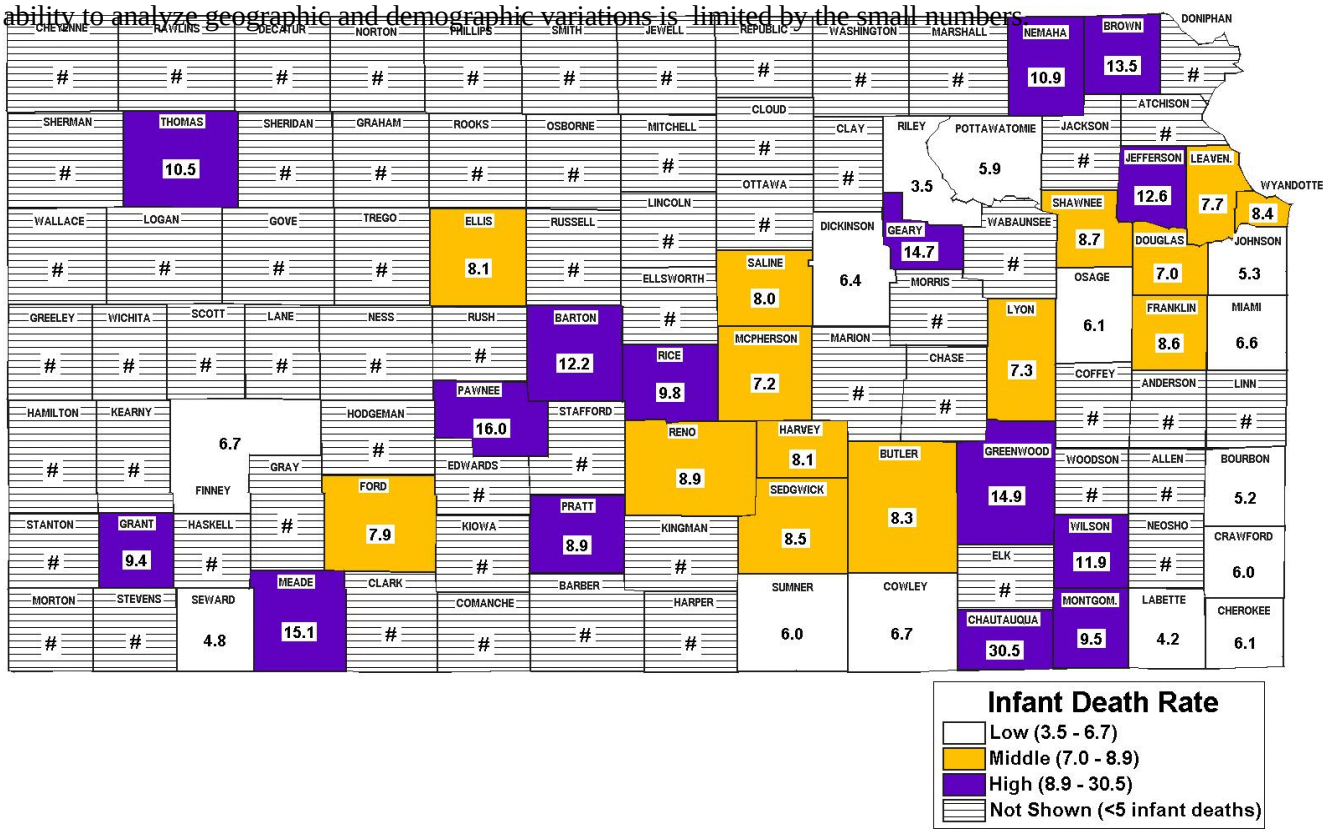
Geographic Disparities

By Population Density Peer Group. ***Frontier*** *counties have the lowest rate.*

Population Density Peer Group	Infant Deaths	Infant Mortality Rate (1994-1998)
Frontier	32	5.9
Rural	126	7.5
Densely-Settled Rural	221	6.7
Semi-Urban	244	8.1
Urban	754	7.4

There is not tremendous variation in infant mortality by PDG. Frontier counties have the lowest rate, while semi-urban counties have a rate 10% higher than the state average (1994-1998).

By County. Infant mortality rates based on less than five deaths from 1994-1998 are not mapped. Caution: Rates for many of the remaining counties are based on less than 20 incidents, resulting in an unstable rate. In general, our ability to analyze geographic and demographic variations is limited by the small numbers.



IDS 29. Child Death Rate

Detailed Data Report

Title V Indicator: OM 06 **Related Priority Need**: #5 Unintentional Injuries

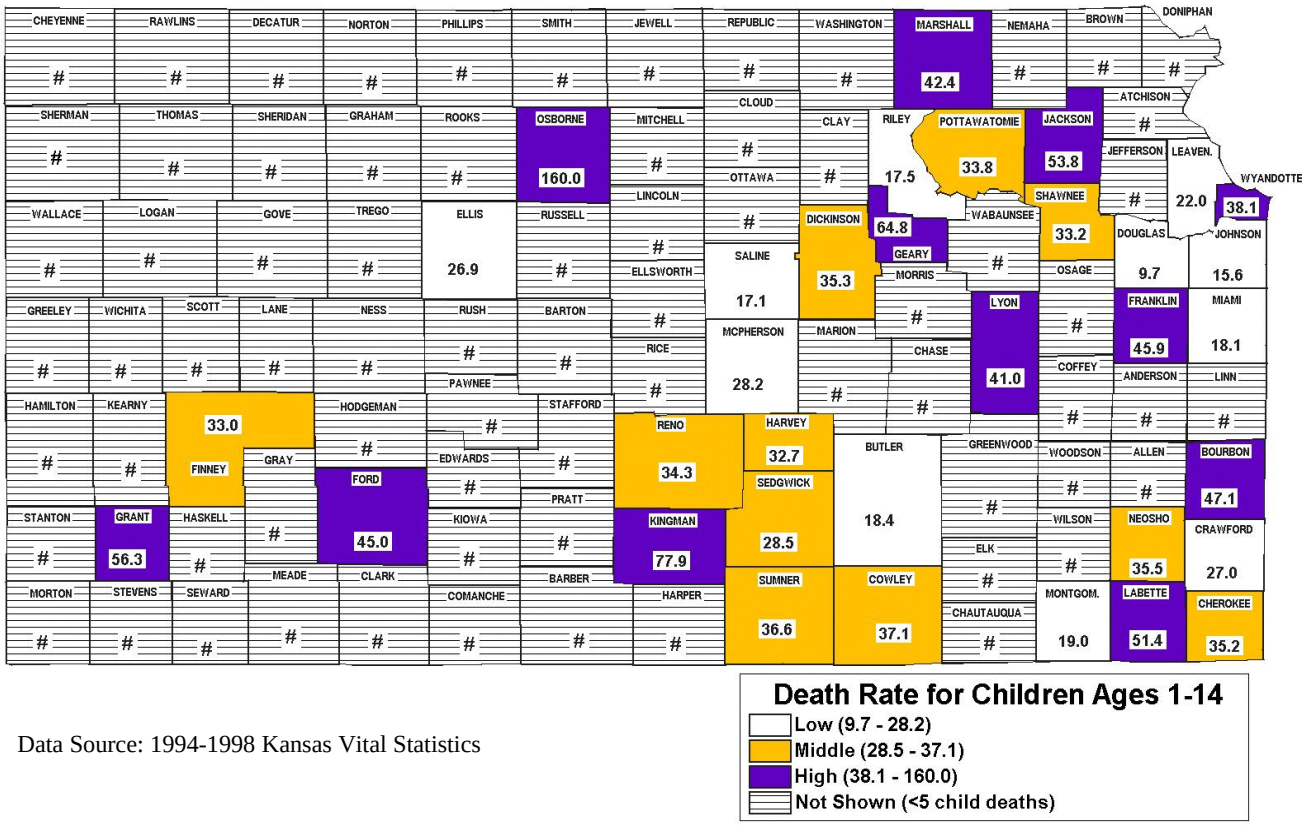
Index: Child Health #6 Intentional Injuries

The Kansas death rate per 100,000 children age 0-14 was 27.9 for data combined from 1994-1998.

By PDG, Frontier Counties have the highest child death rate of 39.4. Urban Counties have the lowest death rate of 24.9.

The map below shows the child death rate by county. Even though data from 1994-1998 was combined, most counties still had less than 10 deaths for the period and their rates are not shown.

An extremes map is not provided since most of the counties in Kansas have a very small number of child deaths making rates erratic.



Data Source: 1994-1998 Kansas Vital Statistics

IDS 30. Reported Child Abuse

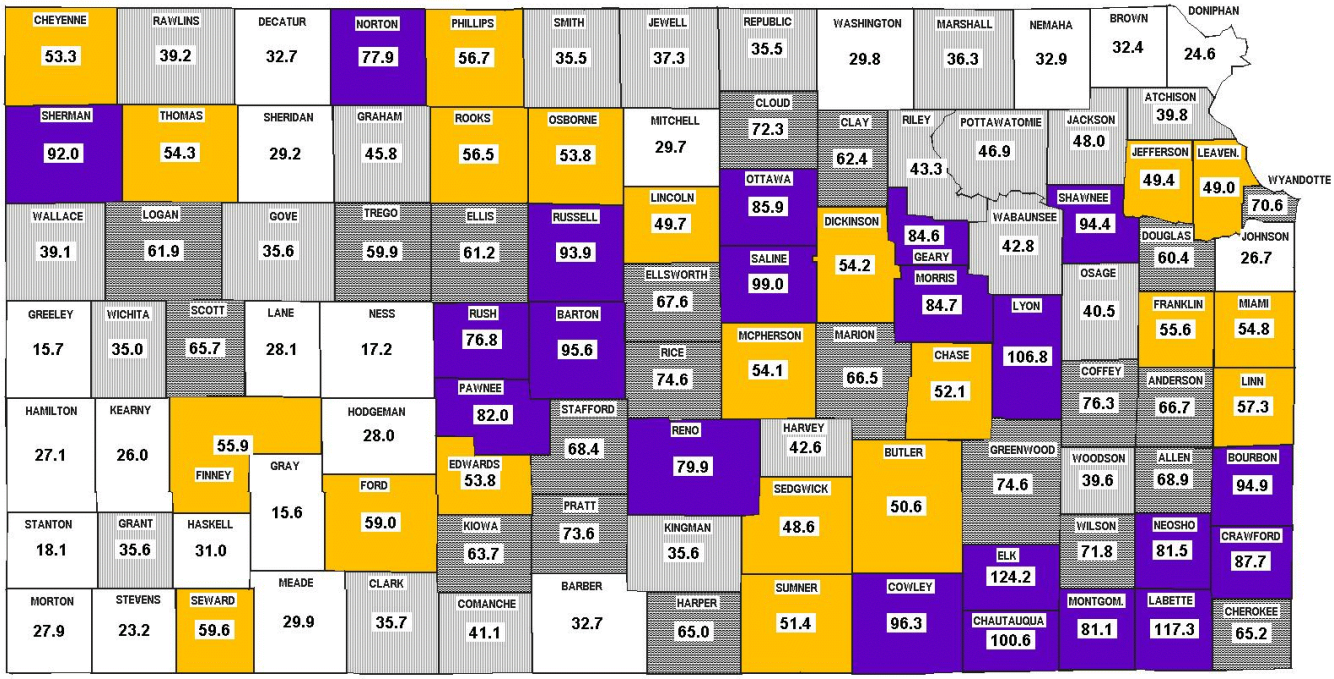
Detailed Data Report

Title V Indicator: No specific indicator **Related Priority Need**: #6 Intentional Injuries

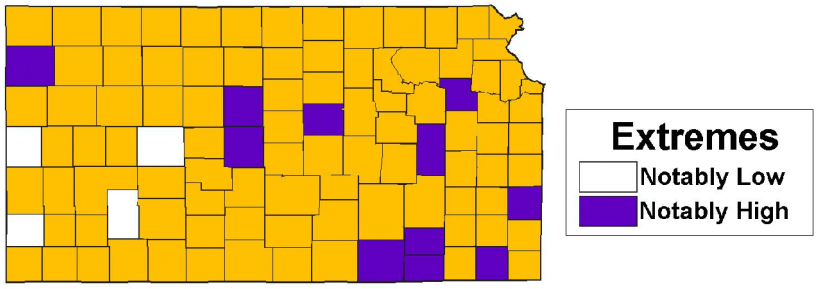
Index: Child Health

The Kansas reported child abuse rate for 1998 was 57 cases per 1,000 children age 0-17 according to SRS. This is an increase of 13% from 1997 (49.7) and an increase of 31% from 1996 (39.2). The increases, however, may be partially due to changes in data collection and reporting as the child abuse reporting system has undergone changes in the past three years.

By PDG, Densely-settled Rural counties have the highest rate of child abuse (68.7). Frontier counties report the lowest rate of 41.8. By county, the rates vary widely across the state. The Southwest portion of Kansas seems to have the lowest rates of child abuse; however, small numbers in the Frontier and Rural counties produce erratic rates. There could also be variances in the data reporting and collection across the state which cause these differences rather than a true difference in the incidence of child abuse.



Data Source: 1998 Social and Rehabilitation Services



IDS 31. Violent Crime Rate

Detailed Data Report

Title V Indicator: DHSI 09 (related) **Related Priority Need:** #6 Intentional injuries

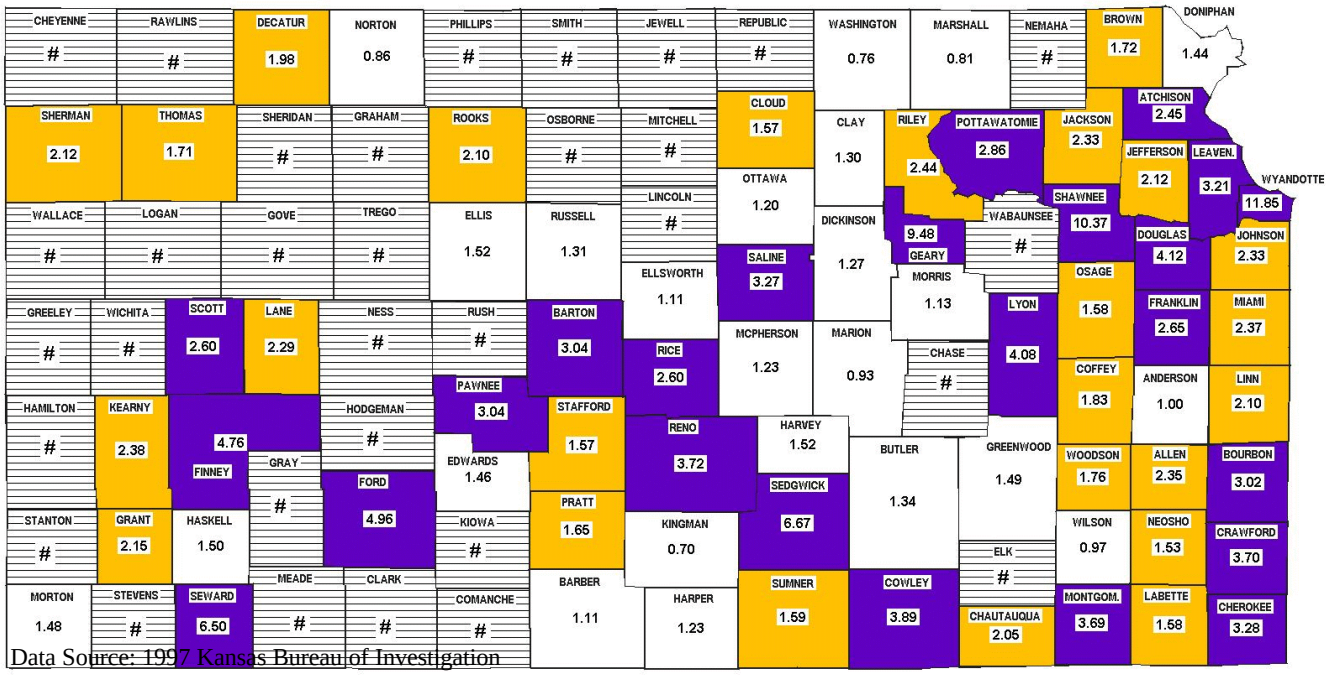
Index: Primary Care

The 1997 violent crime rate per 1000 persons in Kansas was 4.3, which is below the U.S. rate of 6.1. By PDG, Urban Counties have the highest rate by far (6.01), while Frontier Counties have the lowest rate (.80).

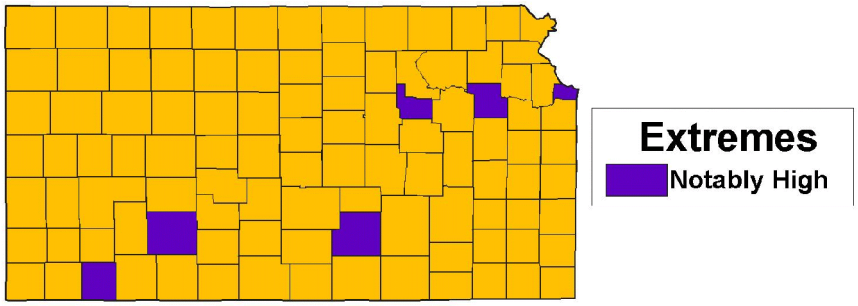
Type of Crime	Number
Murder	150
Attempted Murder	60
Rape	1,179
Robbery	2,535
Aggravated Assault/Battery	7,232

The table shows the total number of selected violent crimes in Kansas in 1997.

The map below shows the violent crime rate by county. Wyandotte and Geary Counties have the highest rates.



Data Source: 1997 Kansas Bureau of Investigation



Frontier and Rural Caution: Even though rates for counties with less than five violent crimes are not shown, some "extremes" may still be the result of small numbers producing an
erratic rate rather than a truly high incidence of violent crime.

IDS 32. Adolescent (Age 15-24)
Intentional and Unintentional Injury Rates
Detailed Data Report

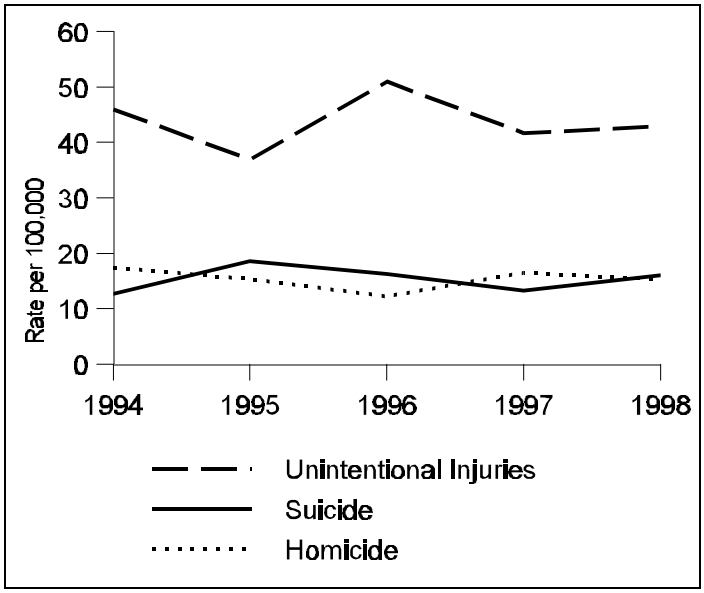
Title V Indicator: NPM 16, DHSI 1C & 2C (related) **Related Priority Need**: #5 Unintentional Injuries
Index: Adolescent Health #6 Intentional Injuries

Number of Deaths (Age 15-24)

Year	Unintentional Injuries	Suicide	Homicide
1994	166	46	63
1995	135	68	56
1996	188	60	43
1997	157	50	62
1998	167	62	59

Source:1994-1998 Vital Statistics

The table to the right displays the number of unintentional injury deaths as well as suicides and homicides by year for persons aged 15 to 24 years. The below graph shows the resulting rate. All three have been rather erratic over the last five years, showing no clear recent trend.



The majority of unintentional injury deaths to 15 to 24 year olds are due to motor vehicle accidents. The bottom table shows rates by population density peer group for motor vehicle crashes, suicides, and homicides. All three are Adolescent Health Index indicators, although the small numbers make county rates difficult to interpret, even for combined five-year data.

Note the death rate due to motor vehicle crashes in Frontier Counties is nearly four times the rate for Urban Counties. Suicide also tends to be higher in Frontier Counties, while homicide is much higher in Urban Counties.

Rate Per 100,000 (Age 15-24)

Population Density Peer Group	Motor Vehicle Deaths	Suicide	Homicide
Frontier	100.7	24.2	2.0
Rural	67.5	15.8	3.0
D.S.-Rural	42.9	18.0	5.6
Semi-Urban	32.6	12.5	6.4
Urban	24.2	15.2	24.5

Source:1994-1998 Vital Statistics

IDS 33. Safety Equipment Non-Use Age 0-15

Detailed Data Report

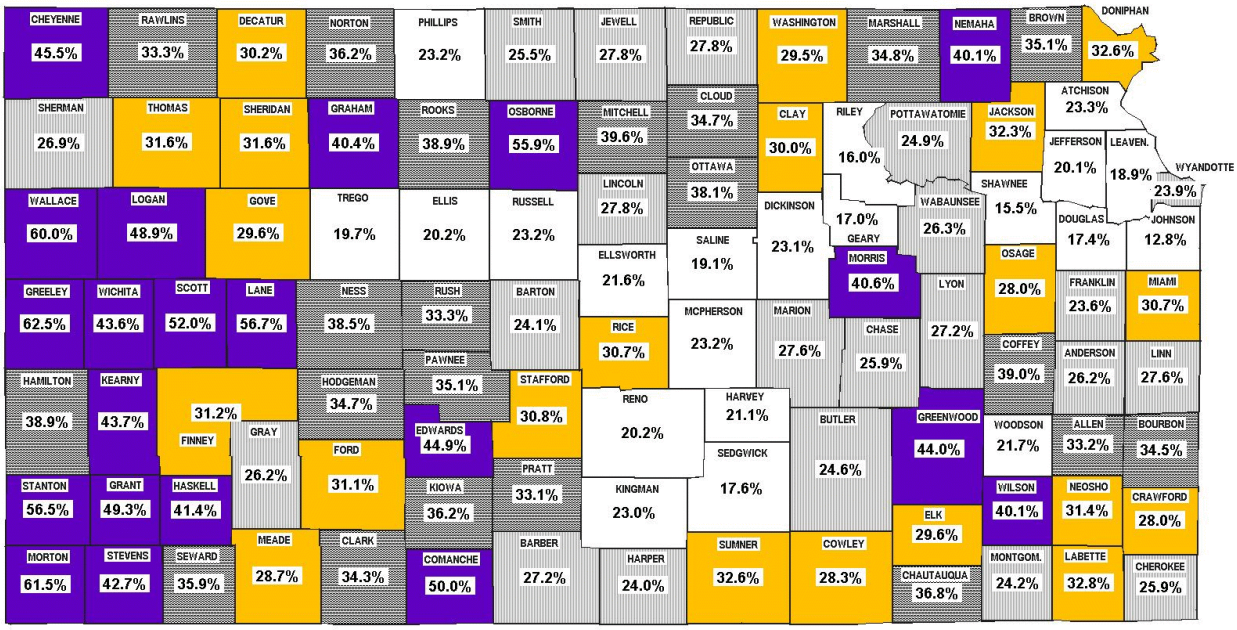
Title V Indicator: SPM 10 **Related Priority Need**: #5 Unintentional Injuries

Index: Child Health

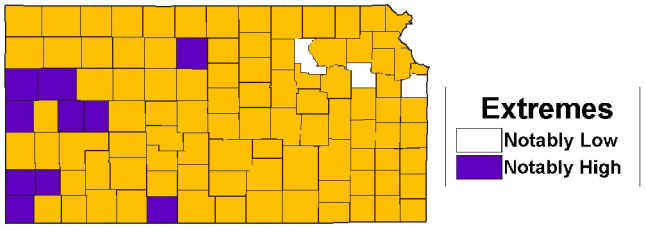
Age Group	% Not Wearing Safety Eq.
< 4	30.0%
4-15	12.4%
16-18	15.8%
19-25	13.7%

According to the Kansas Department of Transportation accident data (1995-1998), the age group least likely to be using proper safety equipment was children under age 4 (see table to left for usage by younger age groups). For children under 4, proper safety equipment is a child safety seat and is required by Kansas law. (Children wearing lap or shoulder belts only were counted as *"Not* wearing safety equipment".) Children *not* using proper safety equipment are more likely to be injured. For ages 4-15 involved in motor vehicle crashes, 37.3% of those not wearing safety equipment were injured versus 11.5% of those using a seatbelt or child safety seat.

For ages 0-15, statewide 21.8% involved in MV crashes were *not* using safety equipment. Children in Urban Counties were more than twice as likely to be using safety equipment as children in Frontier Counties (35.5% versus 16.7%). Children involved in accidents in Shawnee (Topeka), Johnson (KC suburbs), and Riley (university) were most likely to be using proper safety equipment. Children in Western KS were least likely.



Data Source: 1995-1998 Kansas Department of Transportation



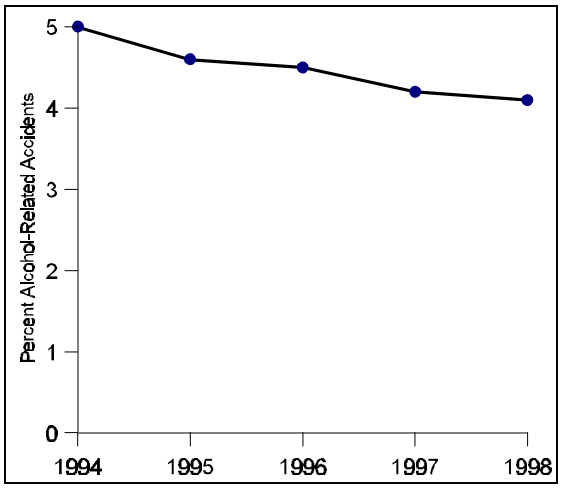
IDS 34. Alcohol-Related Accident Rate Age 15-24

Detailed Data Report

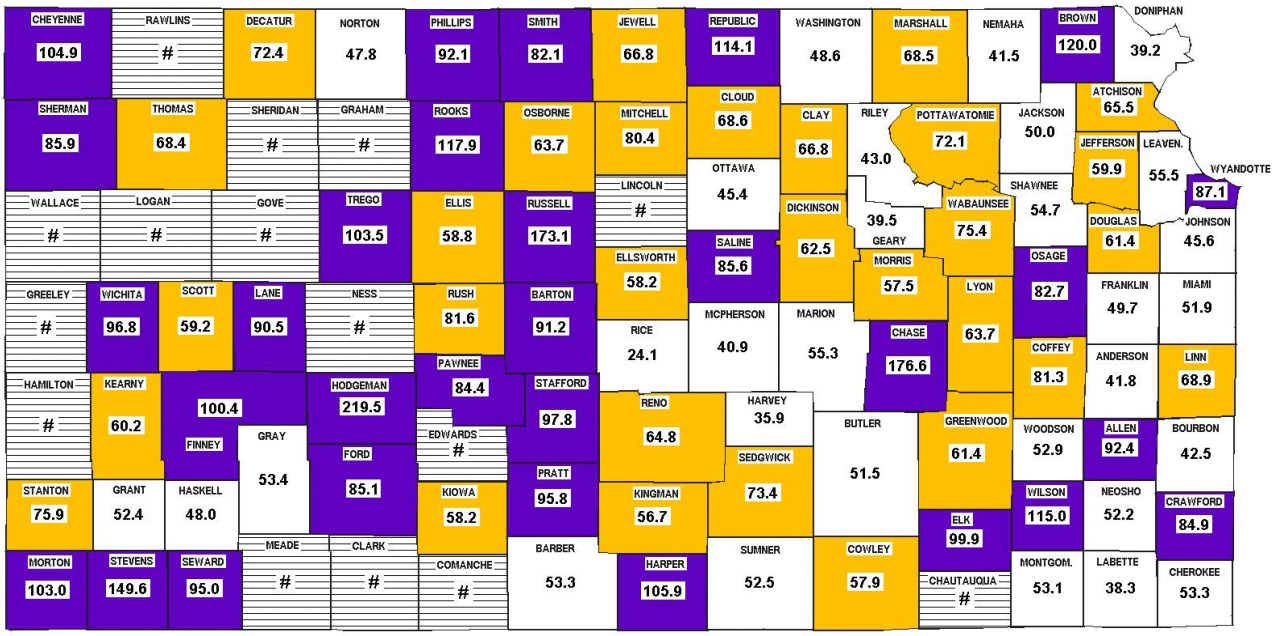
Title V Indicator: No specific indicator **Related Priority Need**: #5 Unintentional Injuries

Index: Adolescent Health

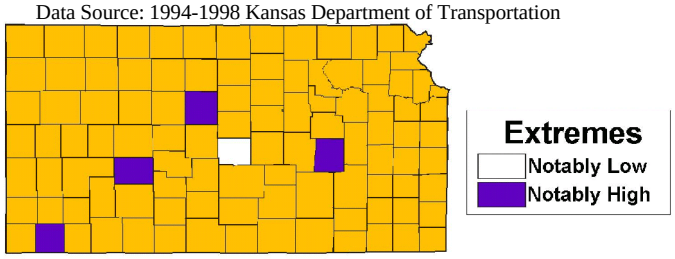
The table to the right shows that the trend in the **percentage of alcohol-related accidents for all ages** has been decreasing since 1994. The 15-24 age group is more likely to have an alcohol-related accident than other age groups, and the involvement of alcohol increases the likelihood of injury or death. Data from 1994-1998 shows that alcohol is involved in 4.5% of all accidents, 8.3% of all injury accidents, and 18.6% of all fatal accidents.



The map below shows the alcohol-related **accident rate per 10,000 people age 15-24** by county for the years 1994-1998**.** The Kansas rate is 63.1.



Data Source: 1994-1998 Kansas Department of Transportation



Frontier and Rural Caution: Even though the percentages based on less than 10 accidents have not been mapped, some "extremes" may be the result of small numbers producing an erratic rate rather than a truly high or low

alcohol-related accident rate.

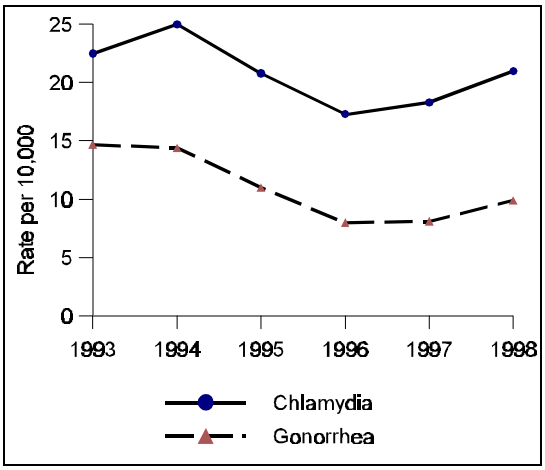
IDS 35. Reported STD Rate Age 15-19

Detailed Data Report

Title V Indicator: DHSI 03A (Related) **Related Priority Need**: No specific priority need

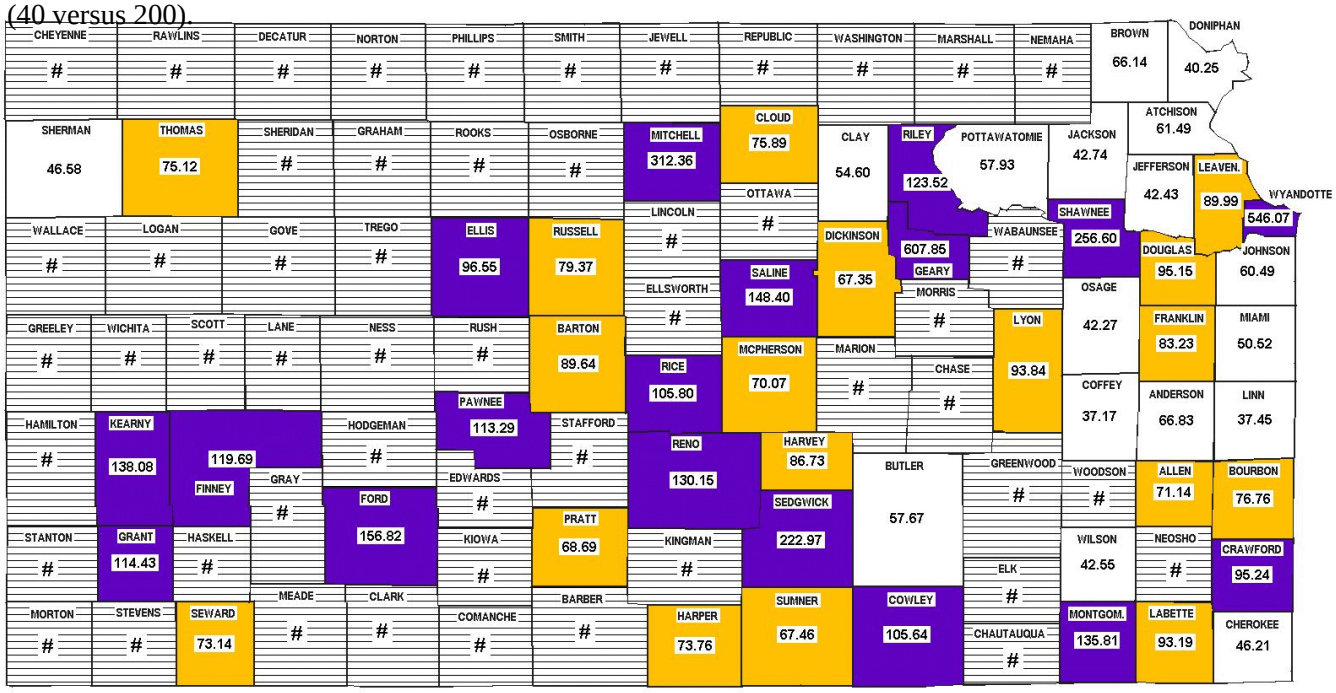
Index: Adolescent Health

Data Notes. The Reported STD rate in the Adolescent Health Index is reported cases of chlamydia and gonorrhea per 10,000 persons aged 15 to 19 years. This is *not* directly comparable to DHSI 03A, which reports chlamydia cases per *1,000 females* aged 15 to 19.



Recent Trend. Rates per 10,000 for Chlamydia and Gonorrhea are shown in the table to the right. The rates have begun to start creeping back up after reaching a low in 1996.

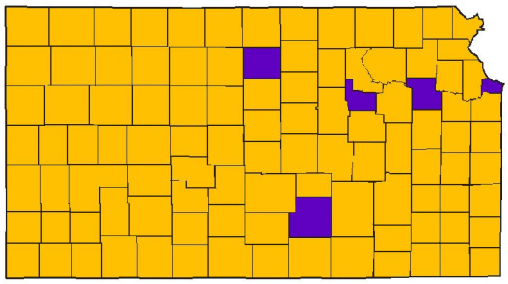
Geographic Disparities. Rates based on fewer than 10 cases are not shown in the map below. Geary and Wyandotte counties have the largest rates by far in the state with 608 and 546, four times the state rate of 147 (1995-1998). By PDG, frontier counties have a rate one-fifth that of urban counties (40 versus 200).



Data Source: 1995-1998 Bureau of Epidemiology and Disease Prevention

Reported STD Rate (Age 15-19)

- Low (37.17 to 66.83)
- Medium (67.35 to 95.15)
- High (95.24 to 607.85)
- Not Shown (<10 STDs)



Extremes

- Notably High

Frontier and Rural Caution: Even though counties with less than 10 cases are excluded, some "extremes" may still be the result of relatively small numbers producing an erratic rate rather than a truly

high incidence of sexually transmitted diseases.

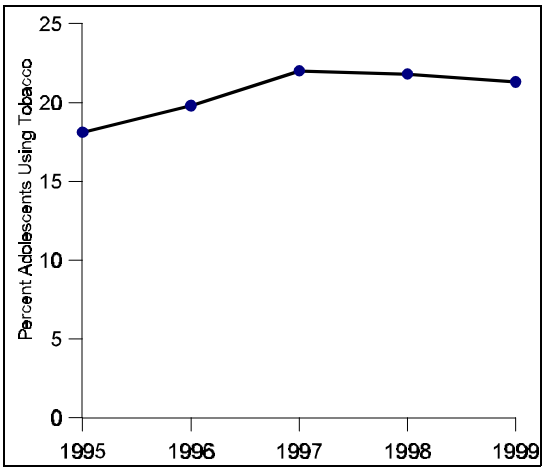
IDS 36. Adolescent Tobacco Use

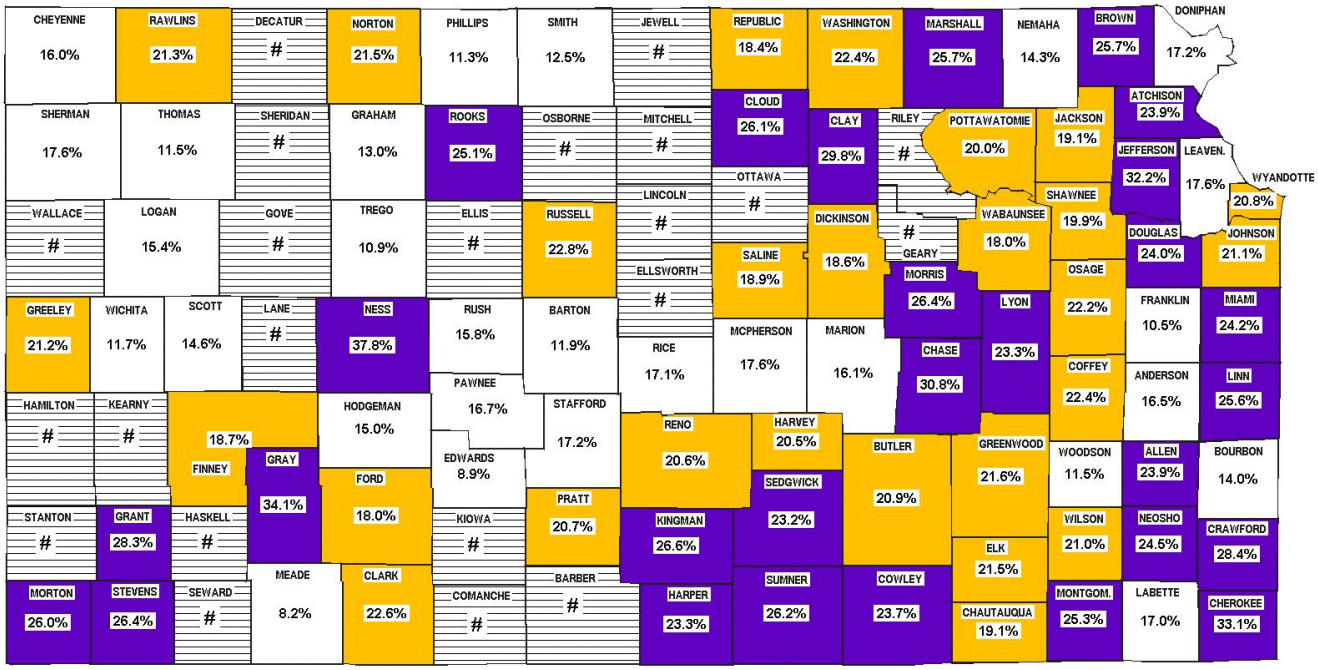
Detailed Data Report

Title V Indicator: DHSI 05 (Related) **Related Priority Need**: No specific priority need

Index: Adolescent Health

Recent Trends. Youth in 6th, 8th, 10th, and 12th grades were surveyed to determine the incidence of tobacco use and other risky behaviors. In 1999, 21.3% of students surveyed replied that they had smoked cigarettes in the past 30 days. According to the same survey, 46.0% confirmed that they had tried a cigarette at least once in their lifetime. The recent trend shows tobacco use has increased from 18.1% in 1995 to 22.0% in 1997, then decreased slightly in 1998 and 1999. Additionally, when asked if they had ever used smokeless tobacco, 21% responded "yes" in 1999.

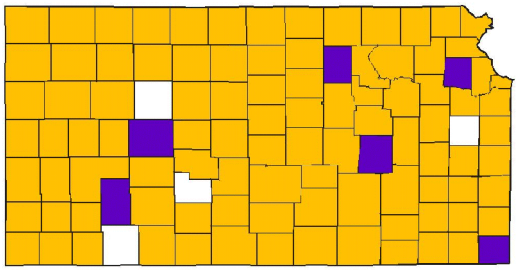




Data Source: 1999 Kansas Communities that Care Survey

Adolescent Tobacco Use

- Low (8.2% to 17.6%)
- Medium (18.0% to 22.8%)
- High (23.2% to 37.8%)
- Not Shown (no data or data prior to 1999)



Extremes

- Notably Low
- Notably High

Cautions: Some "extremes" may be the result of surveying issues, such as differences in grades surveyed (representative samples from all four grades were not surveyed in every county), rather than a truly high incidence of tobacco use.

IDS 37. Adolescent Alcohol Use

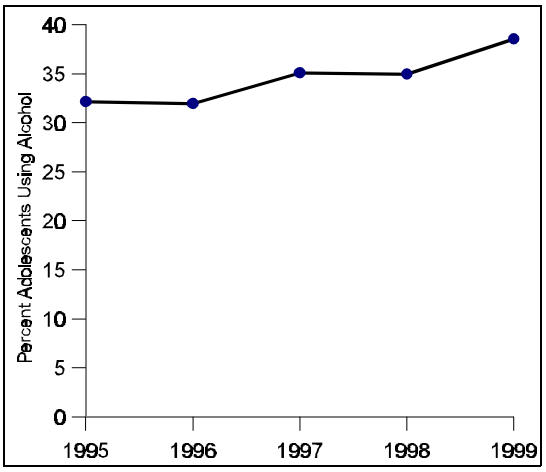
Detailed Data Report

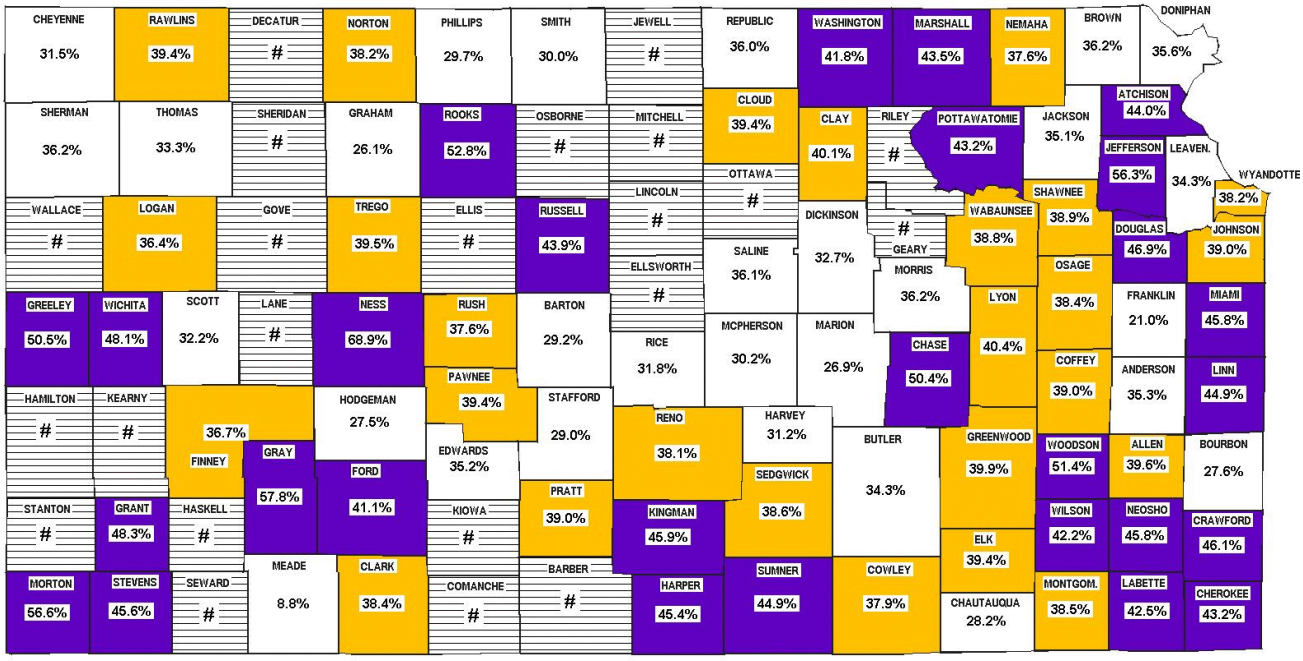
Title V Indicator: None

Related Priority Need: No specific priority need

Index: Adolescent Health

Youths in 6th, 8th, 10th, and 12th grades were surveyed to determine the incidence of alcohol use and other risky behaviors. In 1999, 38.6% of adolescents surveyed replied that they had used alcohol in the past 30 days. According to the same survey, 60% confirmed that they had tried alcohol at least once in their lifetime. The recent trend shows alcohol use has steadily increased in Kansas, up from 32.2% in 1995 to 38.6% in 1999. In addition, 21% of those surveyed stated that they had consumed 5 or more drinks in a row in the past 2 weeks, making them at risk for binge drinking.

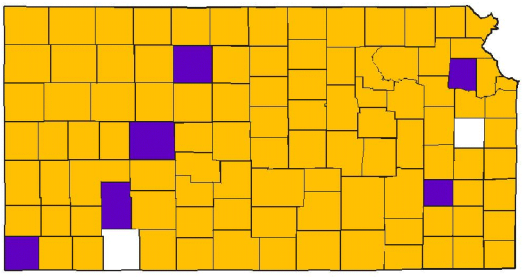




Data Source: 1999 Kansas Communities that Care Survey

Adolescent Alcohol Use

- Low (8.8% to 36.2%)
- Middle (36.4% to 40.4%)
- High (41.1% to 68.9%)
- Not Shown (no data or data prior to 1999)



Extremes

- Notably Low
- Notably High

Cautions: Some "extremes" may be the result of surveying issues, such as differences in grades surveyed (representative samples from all four grades were not surveyed in every county), rather than a truly high incidence of

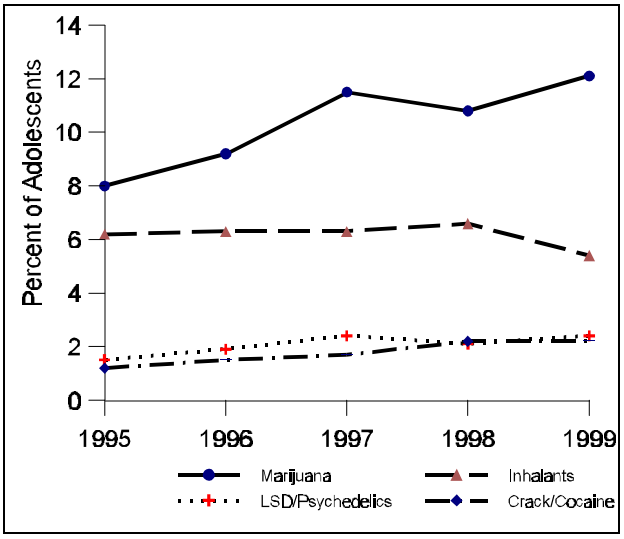
alcohol use.

IDS 38. Adolescent Drug Use

Detailed Data Report

Title V Indicator: None **Related Priority Need**: No specific priority need

Index: Adolescent



Recent Trends. Youth in 6th, 8th, 10th, and 12th grades were surveyed to determine the incidence of drug use and other risky behaviors. The results for four of the behaviors are listed in the table below and graphed to the left. In each instance the respondent was asked if he/she had used the illicit substance in the last 30 days. For 1999, the resulting proportion of students who tried the substance at least once in their lifetime are also reported. The use of LSD and Crack/Cocaine has increased slightly in the past 5 years while the use of inhalants decreased in the past year, from 6.6% in 1998 to 5.4% in 1999. Marijuana use in the past four years has shown a disturbing trend: a 51% increase from 1995 to 1999. According to the survey, recent marijuana use is twice as common as inhalant use and five time as common as LSD or crack/cocaine use.

Moreover, nearly one in four teens reported using marijuana at least once in their lifetime.

Year	Percent Using Marijuana	Percent Using Inhalants	Percent Using LSD/Psychedelics	Percent Using Crack/Cocaine
Used in past 30 days				
1995	8.0%	6.2%	1.5%	1.2%
1996	9.2%	6.3%	1.9%	1.5%
1997	11.5%	6.3%	2.4%	1.7%
1998	10.8%	6.6%	2.1%	2.2%
1999	12.1%	5.4%	2.4%	2.2%
Used at least once in lifetime				
1999	23.5%	14.3%	5.7%	5.3%

Data Source: 1999 Kansas Communities that Care Survey

Geographic Disparities. Marijuana use increases as we move across the rural/urban continuum. For Frontier Counties, an estimated 5.8% had used marijuana in the past 30 days compared to an estimated 13.5% in Urban Counties. Wyandotte had the highest reported marijuana usage at 18.4%.

IDS 39. Preventable Hospitalization Rate

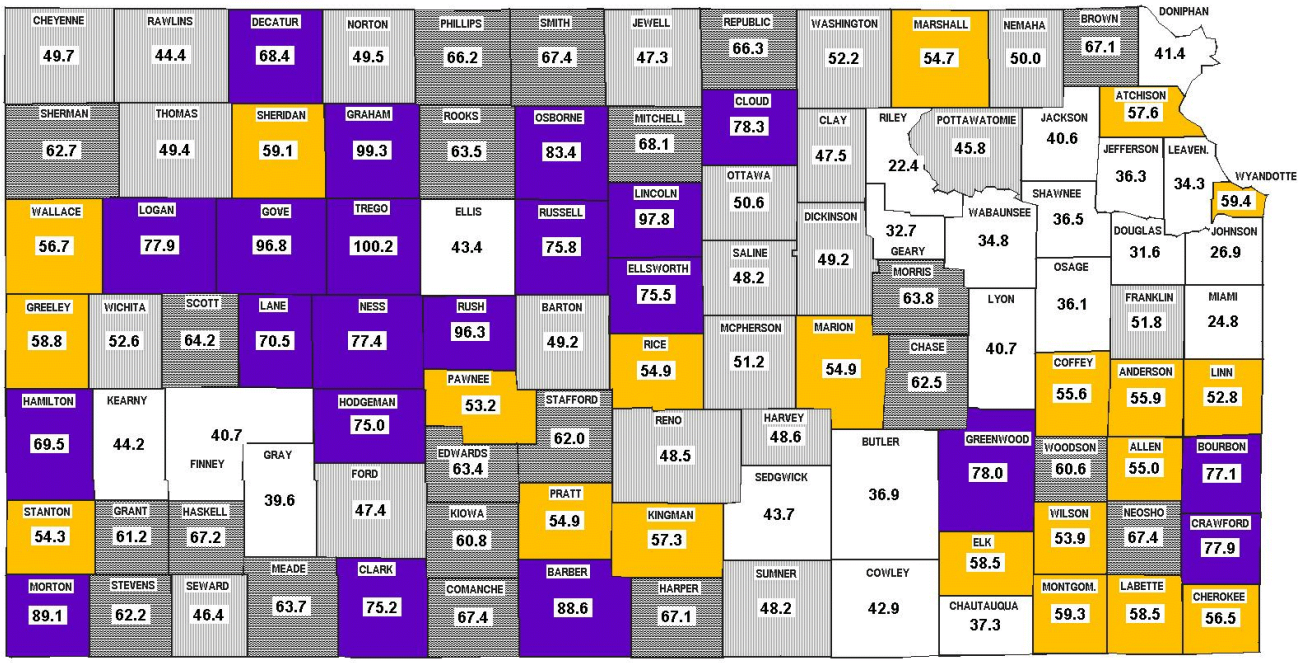
Detailed Data Report

Title V Indicator: No specific indicator **Related Priority Need**:#1 Access

Index: Primary Care

The below map shows the rate of "preventable" hospitalizations by county of residence based on DRG data. The selected hospitalizations do not conform exactly to a national standard; rather, they were selected for use in Kansas. They are a set of DRGs of hospitalizations representing preventable disease and injury. Statewide, the top five conditions are pneumonia and other respiratory infections, heart failure, psychosis, delivery with complicating diagnosis, and newborn with other significant problems.

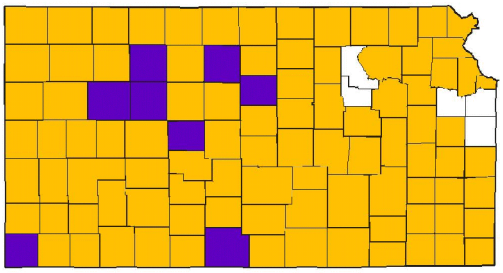
Rates were lowest in Urban Counties and highest in Frontier Counties, understandable since this is a measure of general morbidity and Frontier Counties tend to have older populations. However, it may also indicate an access issue as counties with particularly high rates tend to be in the more remote parts of the state.



Data Source: 1993-1997 Kansas Hospital Association

Preventable Hospitalization Rate

- Low (22.4 - 44.2)
- Lower Middle (44.4 - 52.6)
- Middle (52.8 - 59.4)
- Upper Middle (60.6 - 68.1)
- High (68.4 - 100.2)



Extremes

- Notably Low
- Notably High

Frontier and Rural Caution: Some "extremes" may be the result of small numbers producing an erratic rate rather than a truly high incidence of hospitalizations.

IDS 40. Percent Early Cancer Detection

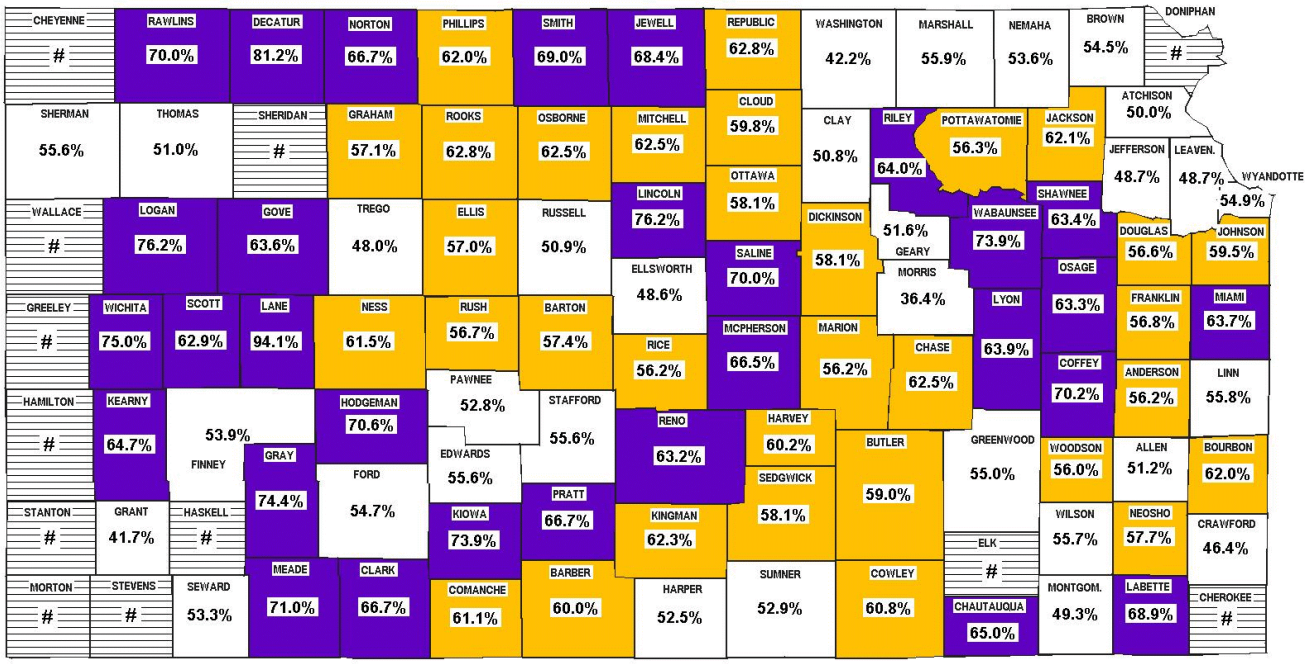
Detailed Data Report

Title V Indicator: No specific indicator **Related Priority Need**: #1 Access
Index: Primary Care

The percent of "preventable" cancers detected in the *in situ* or local stage is shown on the map below. Cancers included are breast, cervical, colorectal, lung and bronchus, prostate, and skin melanoma.

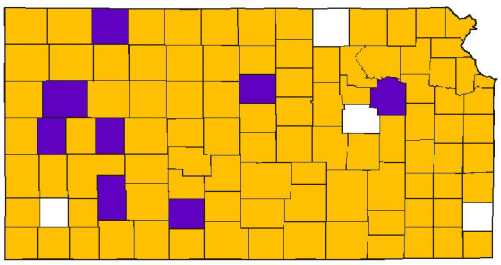
Based on 1996 and 1997 combined data, 58.5% of preventable cancers in Kansas were detected early. Geographic disparities do not show a clear rural/urban trend. Frontier Counties have the highest early detection rate (63.0%) while Rural Counties have the lowest (56.9%). However, this may be a function of small numbers rather than a true picture of geographic disparities. Additional analysis on more years of data is needed.

Of the preventable cancers, skin melanoma cancer is most likely to be detected early (93.9%) while lung and bronchus cancer is least likely (25.8%). Breast cancer in females was detected at the *in situ* or local stages 69.4% of the time while cervical cancer was detected early in 62.2% of cases.



Data Source: 1996-1997 Kansas Cancer Registry

Percent Cancers Staged In Situ or Local
- Low (36.4% - 55.9%)
- Middle (56.0% - 62.8%)
- High (62.9% - 81.2%)
- Not Shown (<10 Cancer Occurrences)



Extremes
- Notably Low
- Notably High

Frontier and Rural Caution: Even though counties with less than ten occurrences are not mapped, some "extremes" may be the result of small numbers producing an erratic rate rather than a truly high or low proportion of cancers detected early.

IDS 41. Respiratory Inpatient Hospitalizations

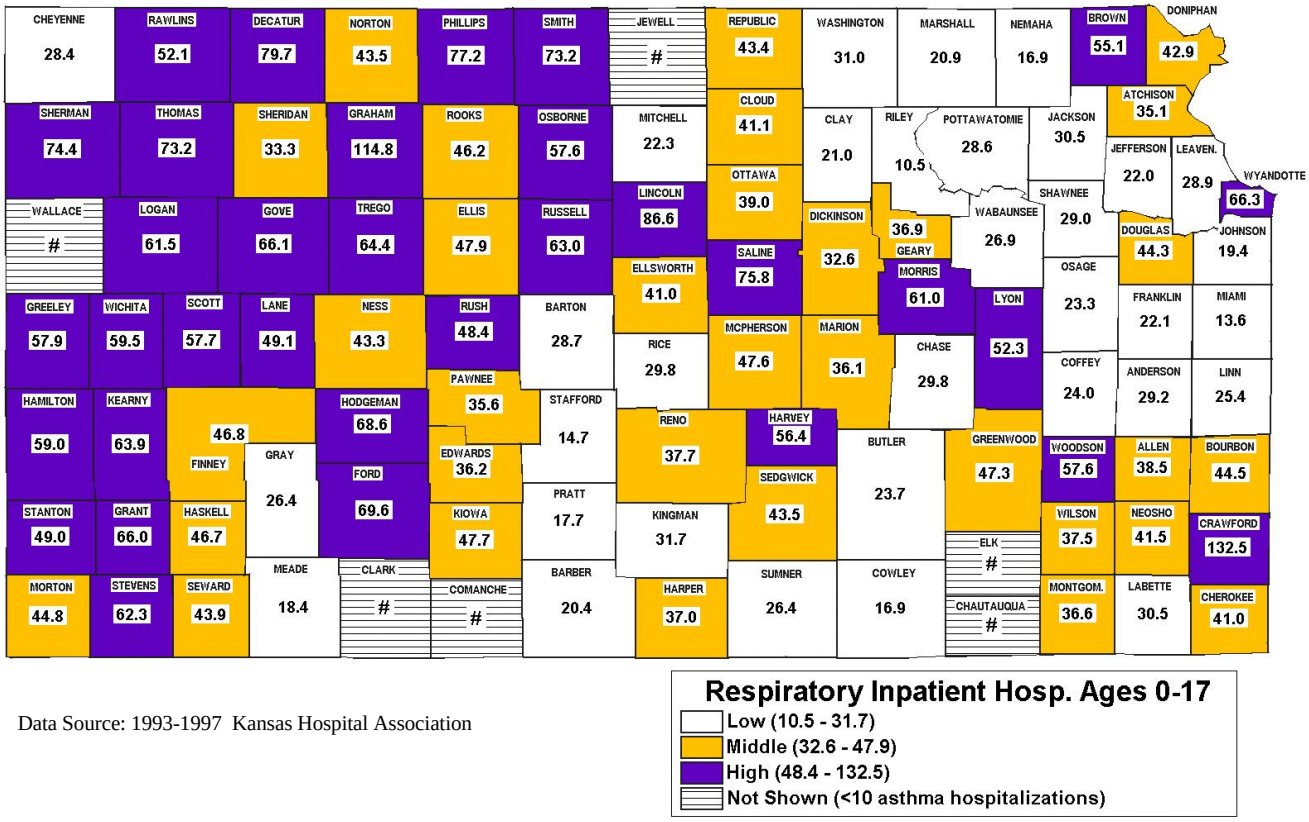
Detailed Data Report

Title V Indicator: CHSI 01 (related) **Related Priority Need**: #1 Access

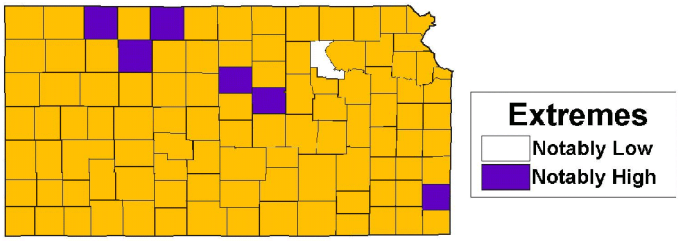
Index: Child Health

Although we are in the process of obtaining county-level ICD-9 coded hospital discharge data, this was not readily available throughout most of the JSNA. Thus, the rate of inpatient hospitalizations for bronchitis and asthma for children aged 0 to 17 years, based on 1993-1997 DRG data, was used.

State-wide, there were 38.7 inpatient hospitalizations per 10,000 children. The rate was highest for Frontier Counties (48.9) and lowest for Urban Counties (36.5). In general, rates tend to increase from east to west across the state. Crawford County (Semi-Urban, small university) in Southeast Kansas had a particularly high rate. Further investigation of asthma and other respiratory problems is needed and will be performed with increased access to hospital discharge data.



Data Source: 1993-1997 Kansas Hospital Association



Frontier and Rural Caution: Even though counties with less than ten hospitalizations are not mapped, some "extremes" may be the result of small numbers producing an erratic rate rather than a truly high

incidence of respiratory hospitalizations.

IDS 42. Crude Death Rate

Detailed Data Report

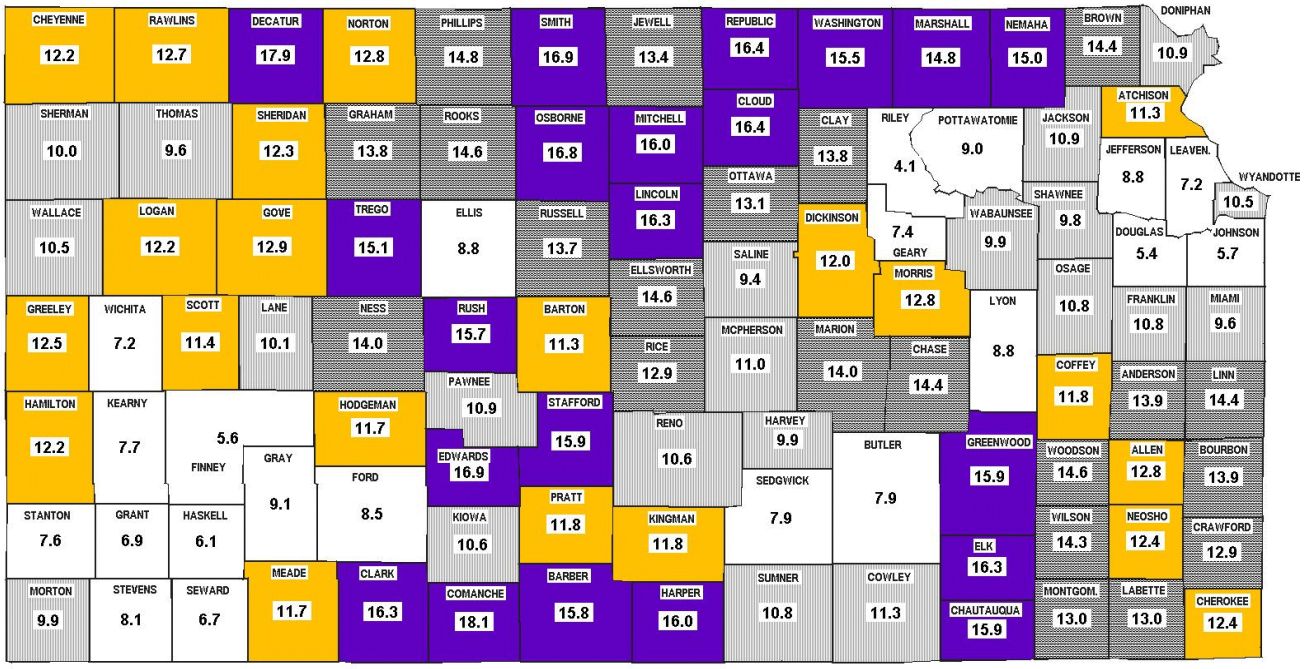
Title V Indicator: No specific indicator
Index: Primary Care

Related Priority Need: No specific need, but all are indirectly related

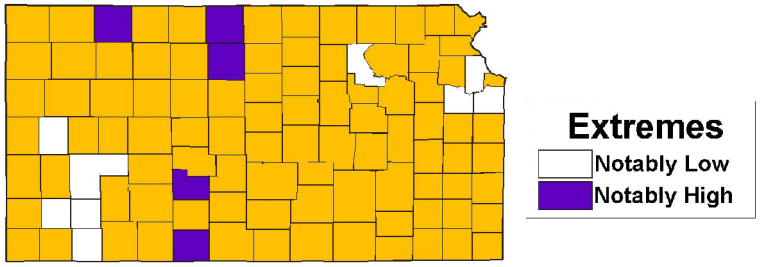
The total deaths per 1,000 persons in Kansas for 1994-1998 was 9.1.

By PDG, the Frontier Counties, with a higher proportion of people age 65 and over, had a higher crude death rate (13.5). Urban Counties had the lowest rate of 7.6.

Crude death rates by county are mapped below. Counties in the Northern part of the state tend to have high crude death rates. Again, this is due to an aging population in that region. Southwest Counties and counties such as Douglas and Riley, which have universities and a high proportion of young people, have the lowest crude death rates in the state.



Data Source: 1994-1998 Kansas Vital Statistics



IDS 43. Unintentional Injury Death Rate

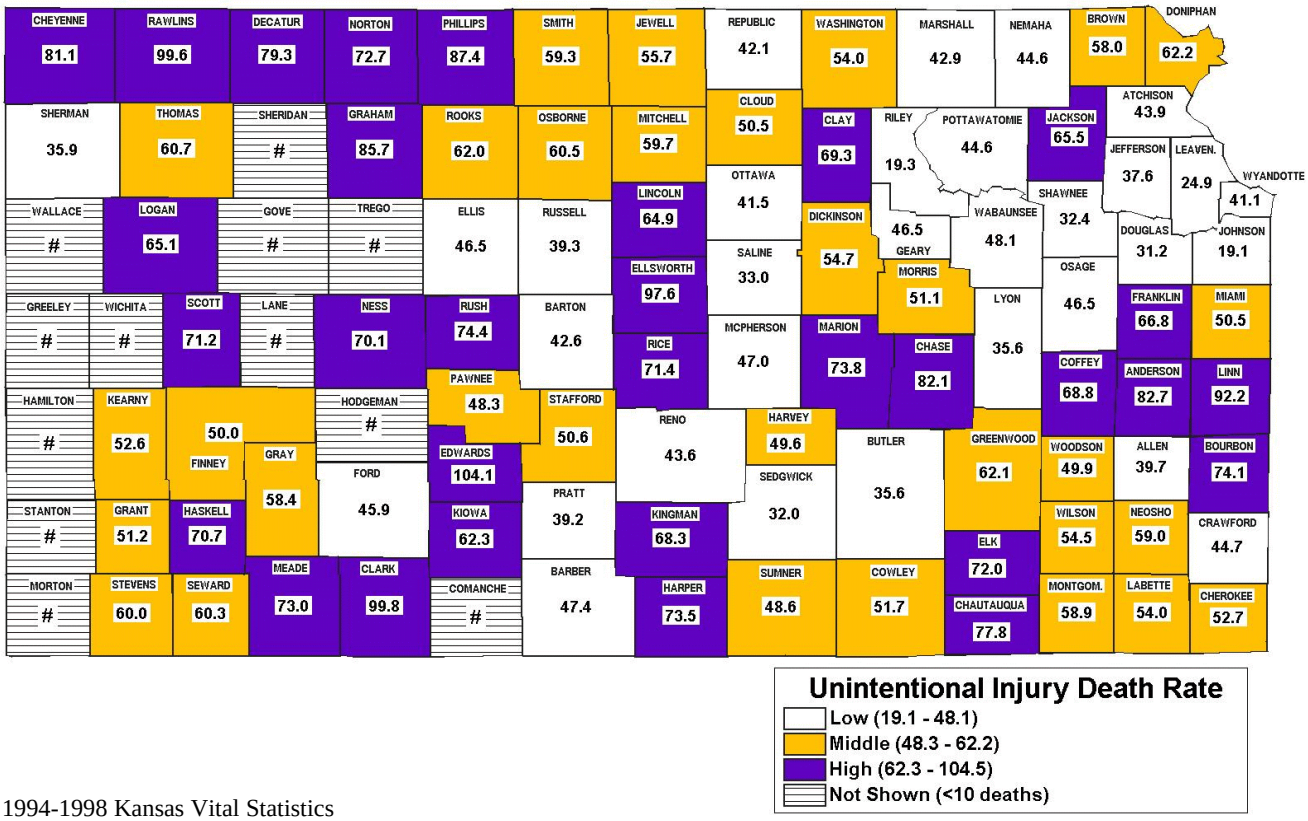
Detailed Data Report

Title V Indicator: DHSI 01 and 02 (related) **Related Priority Need**: #5 Unintentional Injuries

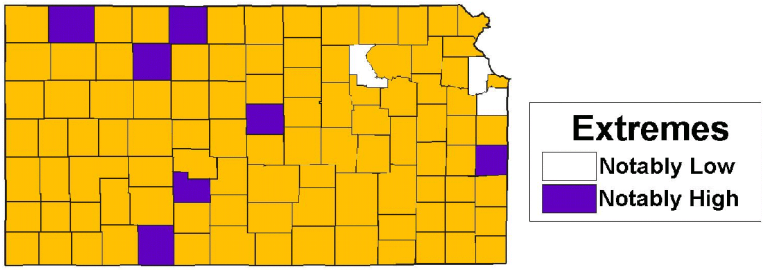
Index: Primary Care

Five years of data, 1994-1998, was analyzed. Statewide, unintentional injuries is the fifth leading cause of death; there are 39.3 unintentional injury deaths per 100,000 population. Nearly half of these unintentional injury deaths are due to motor vehicle accidents.

The rates increase as we move across the rural/urban continuum from urban to rural. Frontier Counties have an unintentional injury death rate over twice that of Urban Counties (66.4 versus 28.7). In the below map, counties with notably high rates are Frontier and Rural while those with low rates are Urban Counties in the Northeast part of the state.



1994-1998 Kansas Vital Statistics



Frontier and Rural Caution: Even though rates for counties with less than 10 deaths are not shown, some "extremes" may still be the result of small numbers producing an erratic rate rather than a truly high incidence of unintentional injury deaths.

IDS 44. Unintentional Injury Years Potential Life Lost Rate

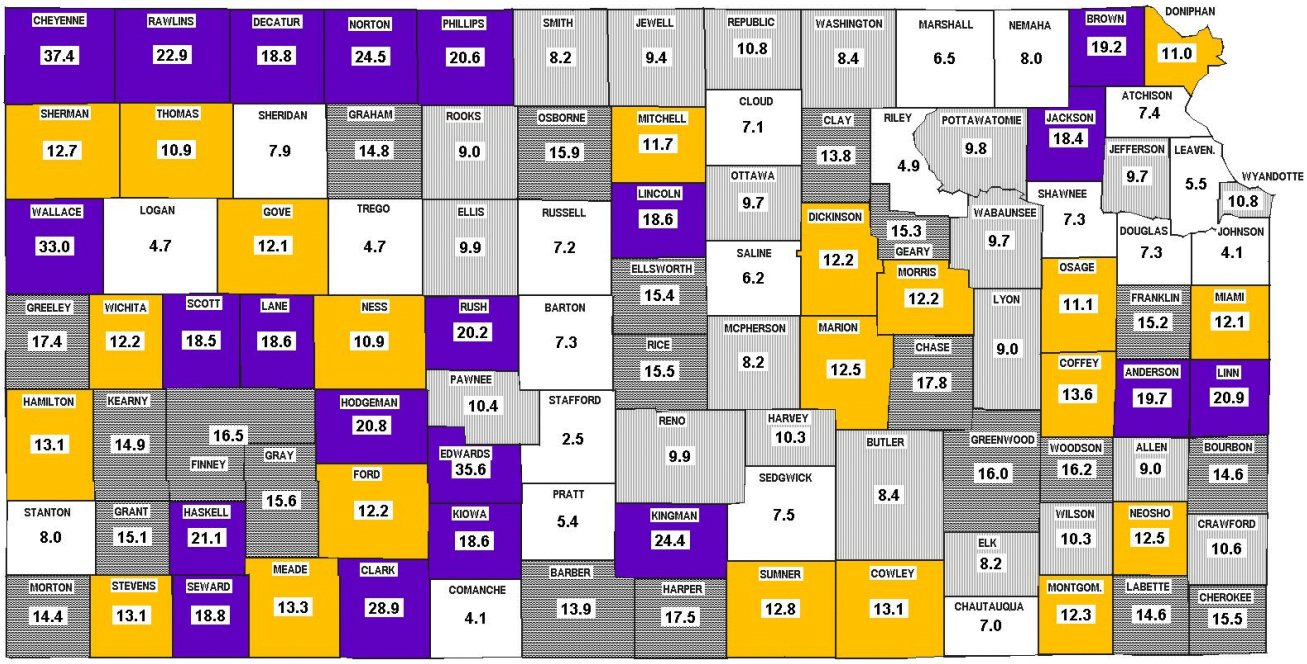
Detailed Data Report

Title V Indicator: No specific indicator **Related Priority Need**: #5 Unintentional Injuries

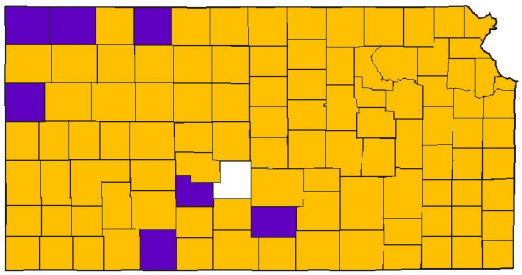
Index: Primary Care

Five years of data, 1994-1998, was analyzed. The crude unintentional injuries death rate is the fifth leading cause of death. However, unintentional injuries is the number one cause of death based on years of potential life lost before age 65. Statewide, of all years of life lost before age 65, 20.5% are due to unintentional injuries. Within unintentional injuries, 65% of years lost are due to motor vehicle accidents.

Similar to unintentional injury crude death rates, the YPLL rates increase as we move across the rural/urban continuum from urban to rural. Frontier Counties have an unintentional injury YPLL rate over twice that of Urban Counties (15.7 versus 6.7). In the below map, counties with notably high rates are Frontier and Rural Counties, particularly those along the Northwestern Kansas border.



1994-1998 Kansas Vital Statistics



Extremes

Notably Low

Notably High

Frontier and Rural Caution: Some "extremes" may be the result of small numbers producing an erratic rate rather than a truly high or low rate of years potential life lost.

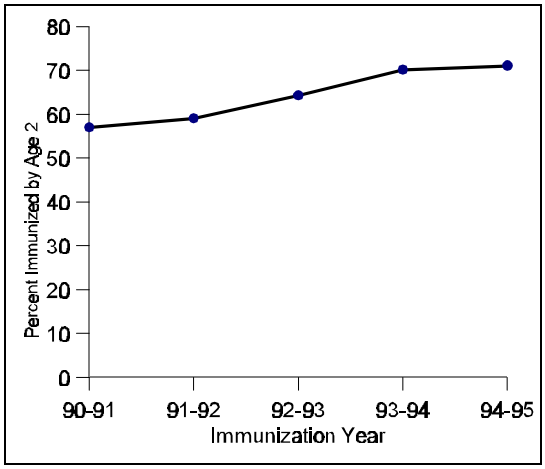
IDS 45. Percent Immunized by Age 2

Detailed Data Report

Title V Indicator: CPM 05 **Related Priority Need**: No specific priority need

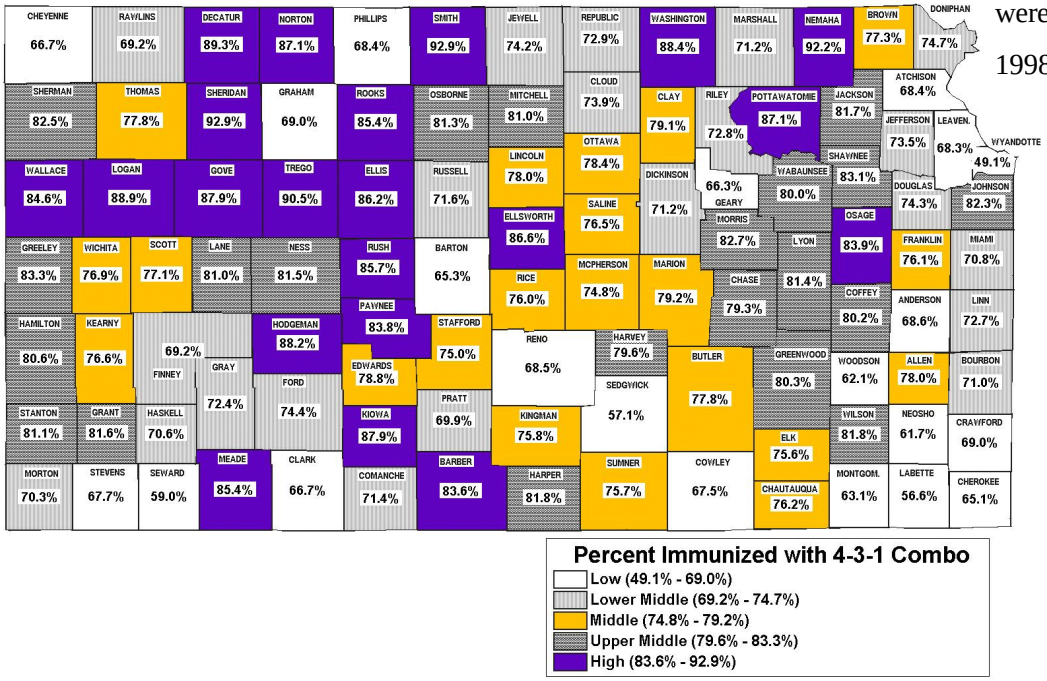
Index: Child Health

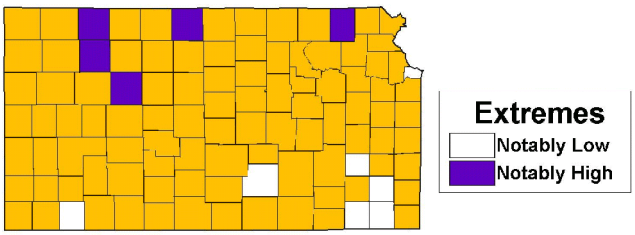
Data Note: Data is based on the immunization histories of five-year-old children enrolled in Kansas public school kindergarten classes during the 1994-95 through the 1998-99 school years, corresponding to 1990-91 through 1994-95 immunization coverage years.



Recent Trend. The graph to the right shows that the percentage of 2-year olds being immunized has been increasing steadily from 57% in 1990-91 to 71% in 1994-95. The 1994-95 immunization rates for individual antigens are DTP4 – 73.3%, Polio3 – 85.3%, and MMR1 – 84.9%.

Geographic Disparities. County. The map below shows the percentage of 2-year olds immunized with 4-3-1 Combo in 1994-1995 which were surveyed during the 1998-1999 school year. The Kansas immunization percentage for the same time period was 71.1%. The Healthy People 2010 target is 90%. The immunization percentage varies across the state with urban areas and southeast Kansas having the lowest rates.





PDG. Frontier counties have the highest immunization percentage (81%),

while Urban counties have the lowest percentage (69%).

IDS 46. Population Per Primary Care Physician FTE

Detailed Data Report

Title V Indicator: None

Related Priority Need: #1 Access

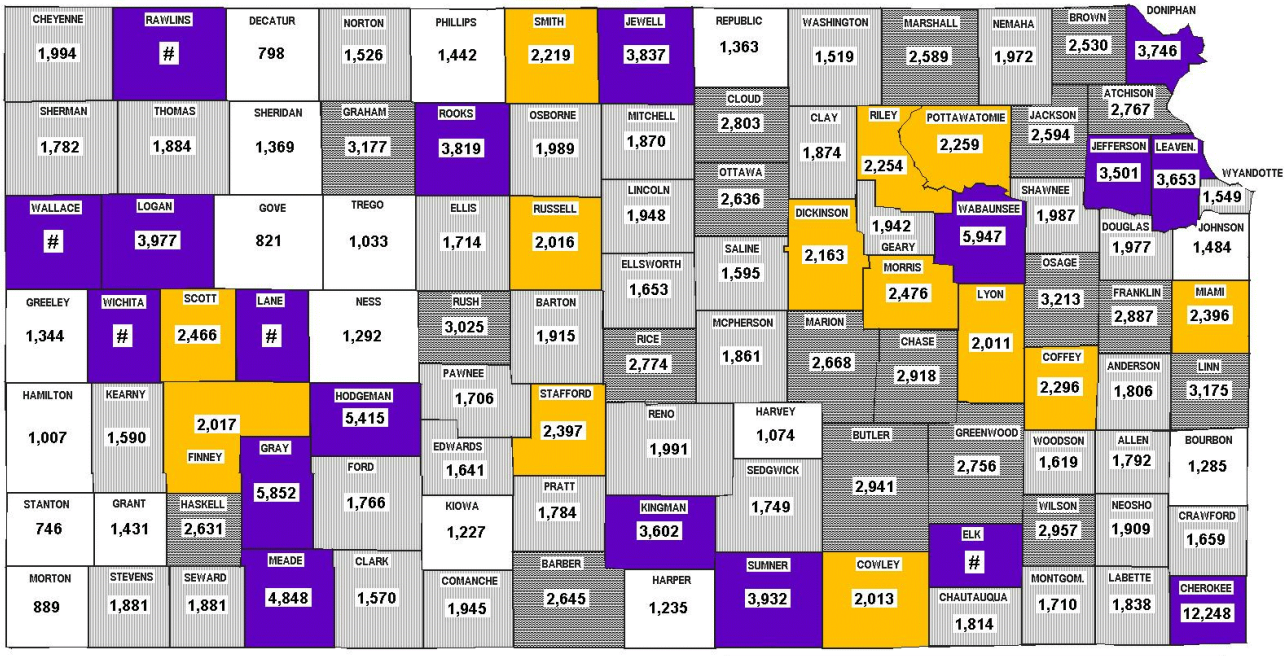
Index: Primary Care

#2 CSHCN Access

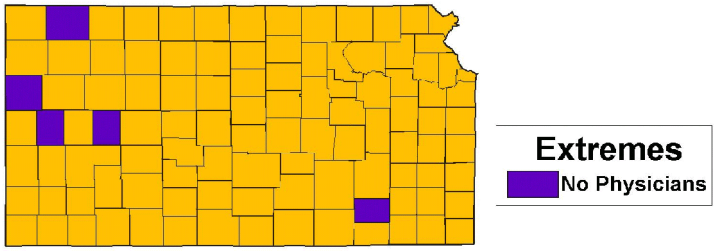
The below data is based on 1998 physician licensure data. Primary Care physicians include Mds and Dos with the following specialities: Family Practice, General Practice, Pediatrics, Obstetrics/Gynecology, and Internal Medicine. Physicians may list up to three specialities and up to three practice locations. Full-time equivalents (FTEs) were calculated in accordance with Health Professional Shortage Area guidelines.

At the time of 1998 licensure, five counties did not have a physician. However, physician distribution tends to fluctuate and one physician can make a large difference in the ratio for small counties. Ratios by PDG are given in the table to the right.

PDG	Ratio
Frontier	1,879
Rural	2,166
D.S. Rural	2,160
Semi-Urban	1,912
Urban	1,705
Kansas	**1,854**



1998 Kansas Board of Healing Arts and Office of Health Care Information



IDS 47. Dental Providers

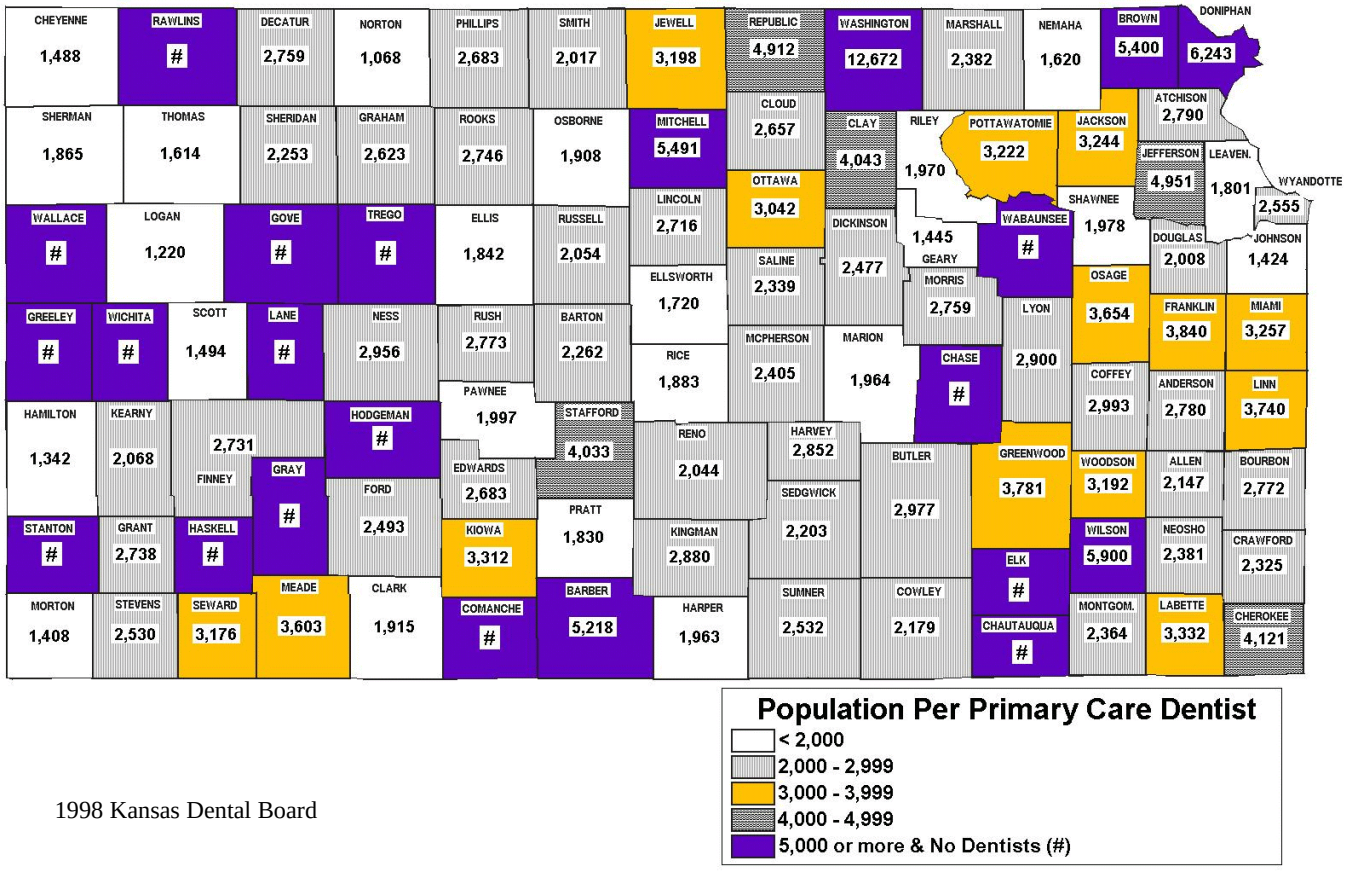
Detailed Data Report

Title V Indicator: None **Related Priority Need**: #8 Oral Health

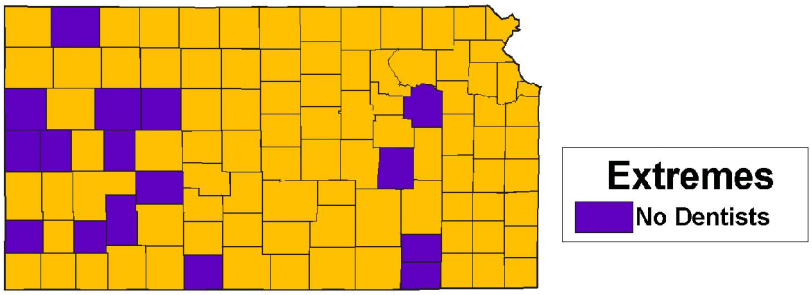
Index: None

Oral health capacity was identified as a need by the Joint State Needs Assessment. The availability of dental providers in rural areas, particularly Medicaid providers, was an identified need.

The population per primary care dentist ratio is shown on the map below. This includes all practicing licensed dentists by county of practice. According to 1998 licensure data, sixteen counties have no dentists.



1998 Kansas Dental Board



IDS 47. Dental Providers (continued)

Detailed Data Report

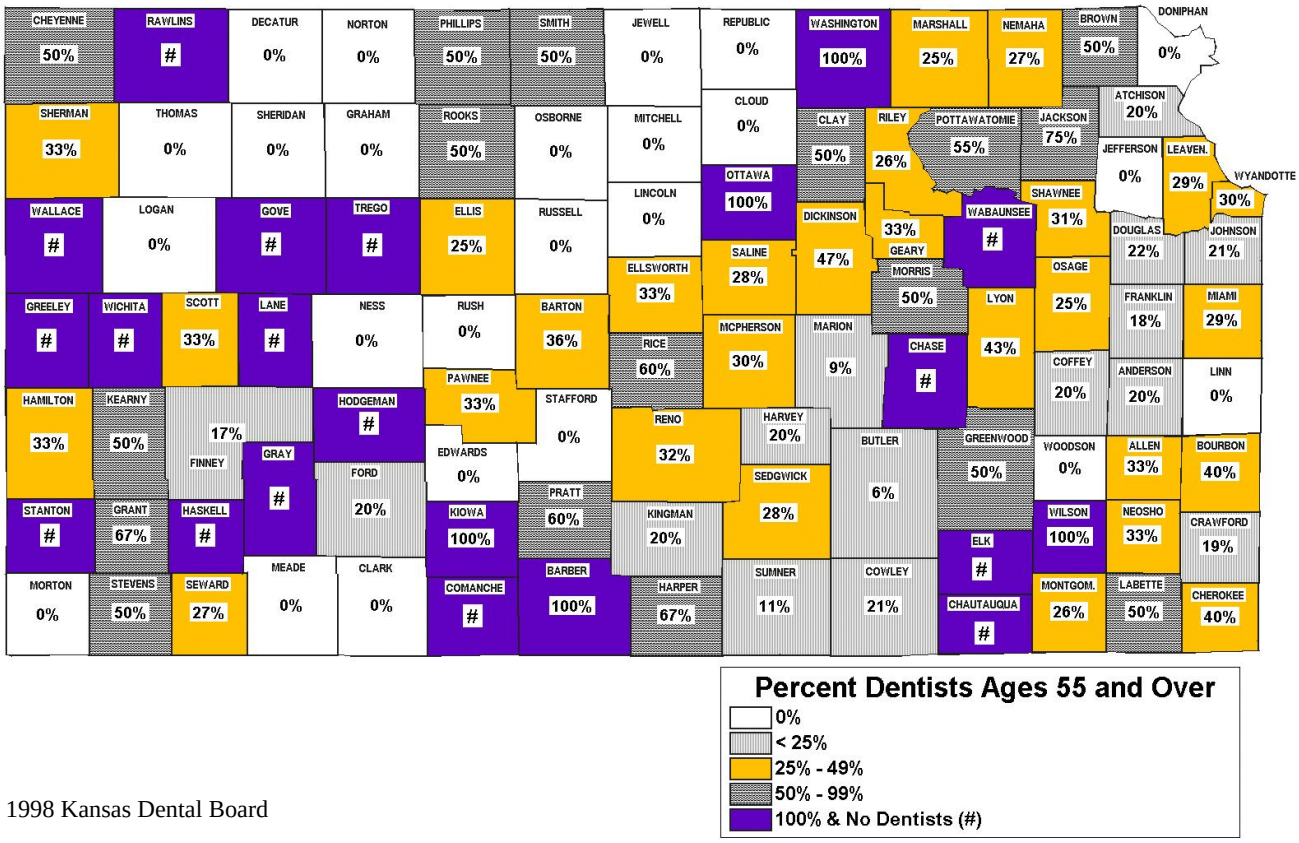
Title V Indicator: None

Related Priority Need: #8 Oral Health

Index: None

To help determine possible problems in future dental capacity, the percent of dentists aged 55 and older was analyzed. See the results by Population Density Group in the table, which shows the overall population to dentist ratio as well as the percent of dentists in each group age 55 and older.

PDG	Ratio	Percent Age 55+
Frontier	3,300	21.6%
Rural	2,741	35.5%
D.S. Rural	2,687	29.5%
Semi-Urban	2,353	24.6%
Urban	1,850	25.4%
Kansas	**2,151**	**26.7%**



1998 Kansas Dental Board

IDS 47. Dental Providers (continued)

Detailed Data Report

Title V Indicator: None

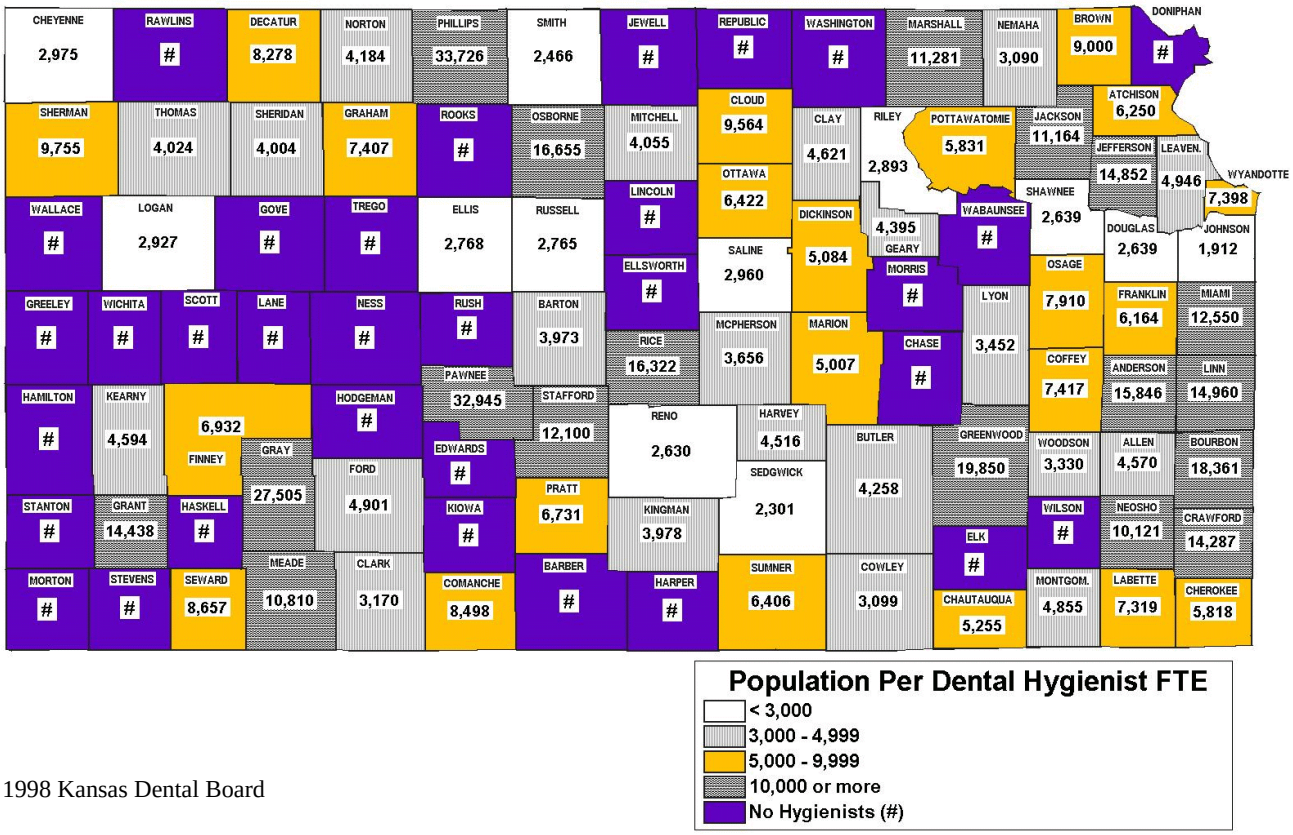
Related Priority Need: #8 Oral Health

Index: None

Based on 1998 dental licensure data, the population per dental hygienist FTE is shown in the map below. Thirty-two of the 105 counties in Kansas do not have a dental hygienist. Rural and Frontier Counties have fewer dental hygienists and a corresponding high population per dental hygienist ratio (see table). Frontier Counties have a ratio close to four times higher than the state.

During the JSNA, a need for more "dental extenders", including hygienists and dental assistants, was identified.

PDG	Ratio
Frontier	12,198
Rural	8,884
D.S. Rural	5,100
Semi-Urban	3,973
Urban	2,454
Kansas	**3,310**



1998 Kansas Dental Board

IDS 48. First Trimester Prenatal Care

Detailed Data Report

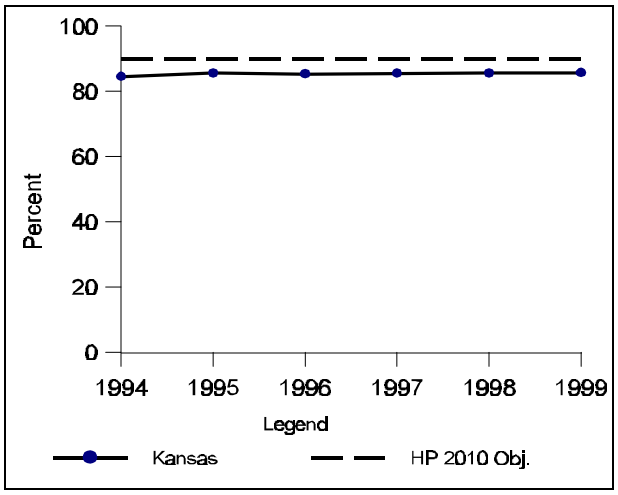
Title V Indicator: NPM 18 **Related Priority Need**: #3 Disparities

Index: None.

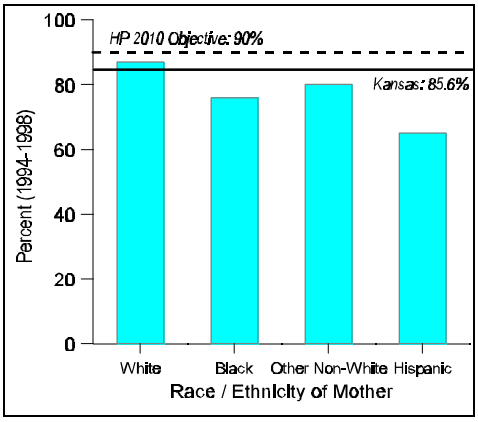
Recent Trend

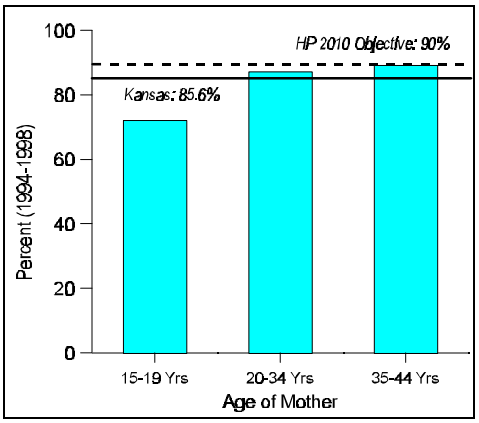
The proportion of women beginning care in the first trimester increased slightly from 1994 to 1999. However, the 1999 statistic of 85.8% is still below the Health People 2010 objective of 90%.

Year	Number	Percent
1994	31,461	84.6%
1995	31,651	85.7%
1996	31,101	85.4%
1997	31,667	85.6%
1998	32,691	85.7%
1999	33,062	85.8%



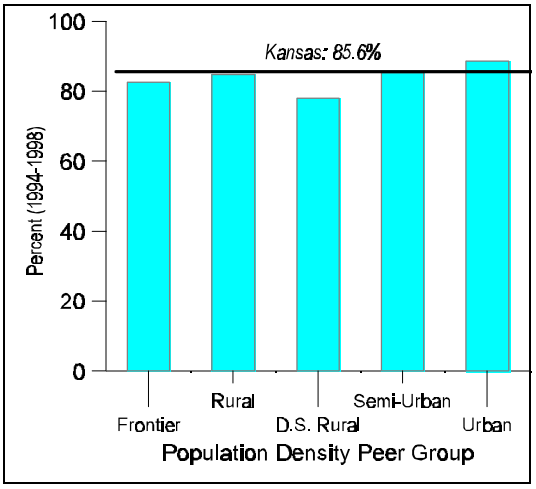
Demographic Disparities. *Hispanic* and *teen* mothers show the lowest rate of early entry into prenatal care.





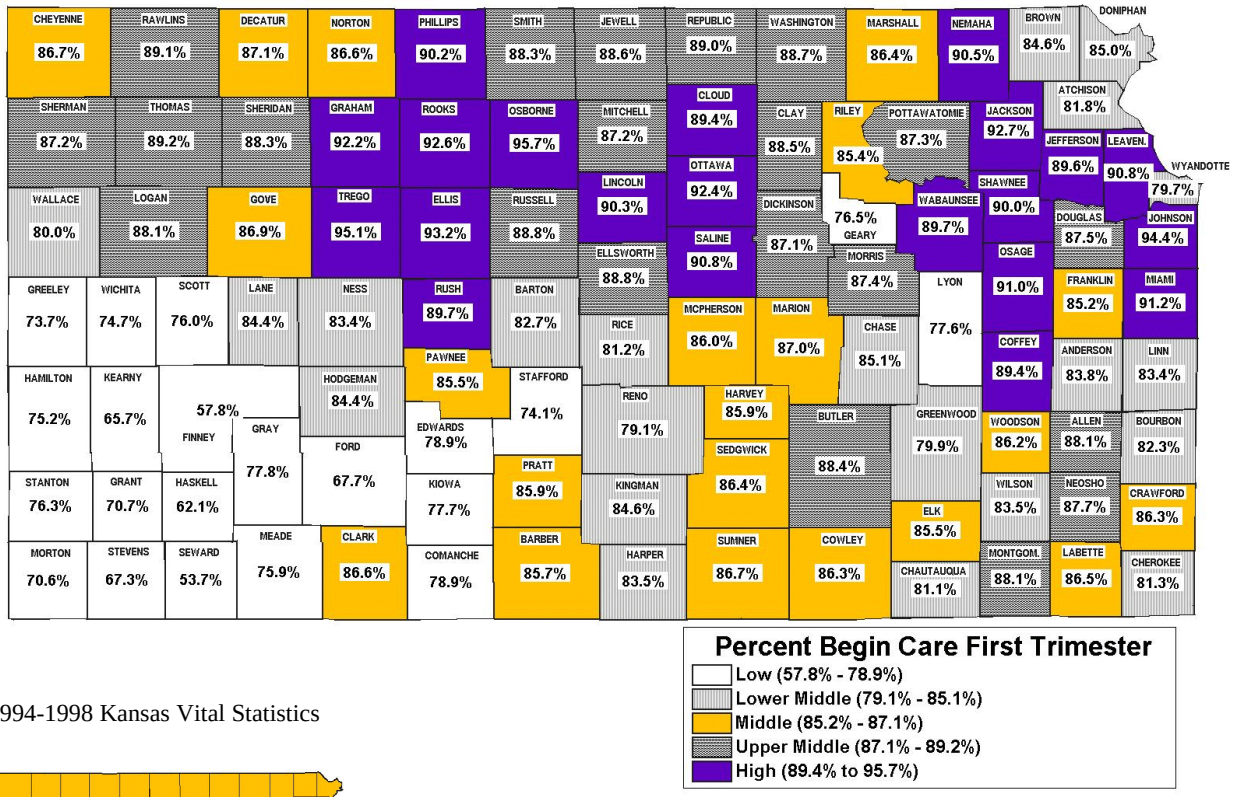
None of the age or race/ethnicity groups reached the Healthy People 2010 objective. Based on 1994-1998 data, the proportion of Hispanic women with early entry to prenatal care was one-third below the percentage of White females (65% versus 87%). Adolescents age 15-19 also performed well below the state average.

Geographic Disparities

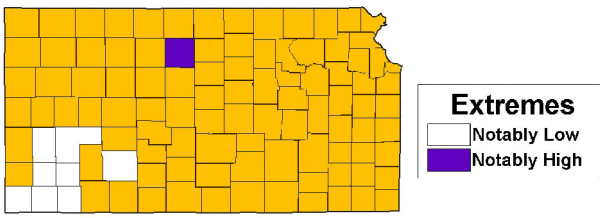


By Population Density Peer Group. By population density peer group, urban counties have the highest percent of early entry while Densely-Settled Rural Counties have the lowest early entry percentage.

By County. By county, geographic disparities are evident. Percentages are higher in North Central and Northeast Kansas, while a cluster in Southwest Kansas has disturbingly low rates of early entry to prenatal care.



1994-1998 Kansas Vital Statistics



IDS 48. First Trimester Prenatal Care

Detailed Data Report

Title V Indicator: NPM 18 **Related Priority Need**: #3 Disparities

Index: None.

Recent Trend

The proportion of women beginning care in the first trimester increased slightly from 1994 to 1999. However, the 1999 statistic of 85.8% is still below the Health People 2010 objective of 90%.

Year	Number	Percent
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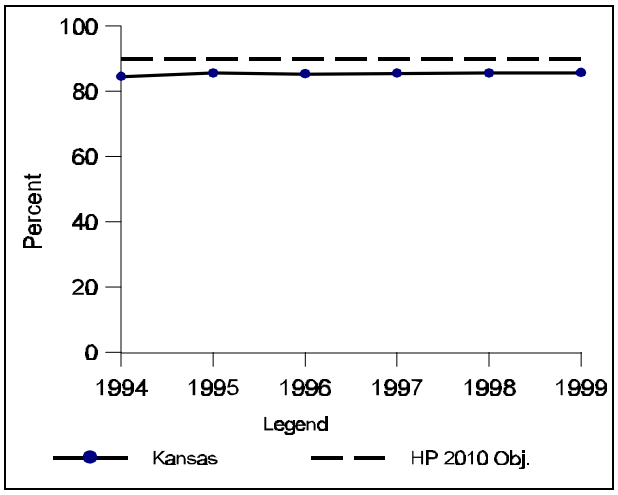
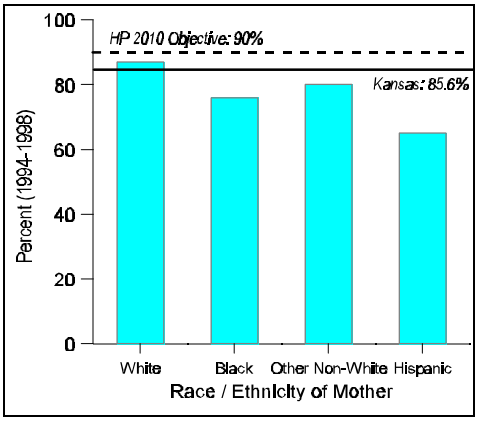
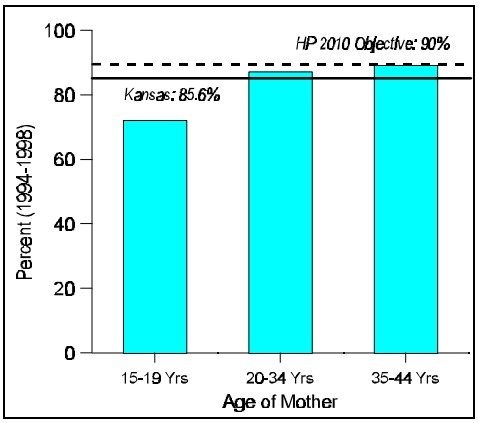


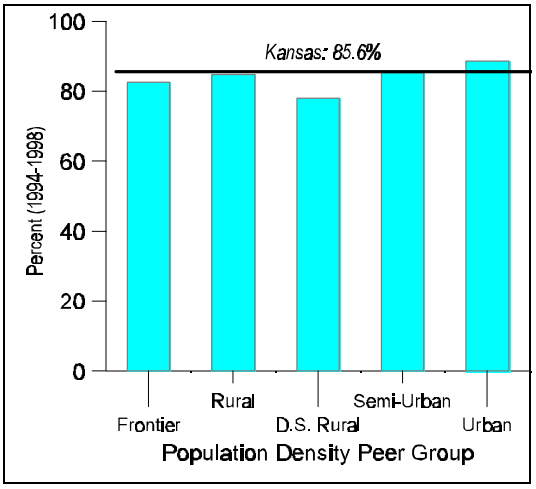
Demographic Disparities. *Hispanic* and *teen* mothers show the lowest rate of early entry into prenatal care.





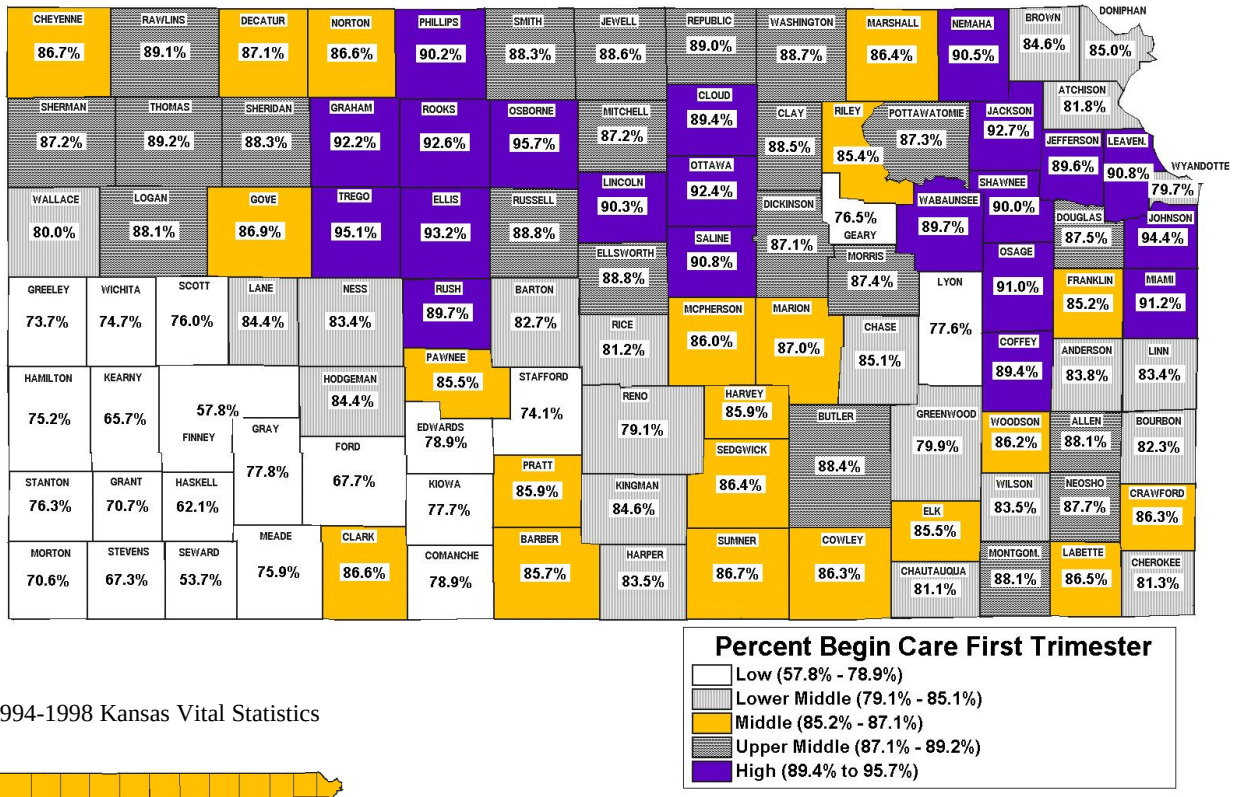
None of the age or race/ethnicity groups reached the Healthy People 2010 objective. Based on 1994-1998 data, the proportion of Hispanic women with early entry to prenatal care was one-third below the percentage of White females (65% versus 87%). Adolescents age 15-19 also performed well below the state average.

Geographic Disparities

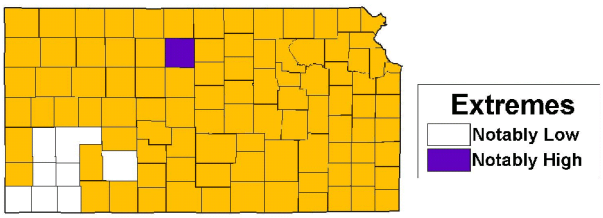


By Population Density Peer Group. By population density peer group, urban counties have the highest percent of early entry while Densely-Settled Rural Counties have the lowest early entry percentage.

By County. By county, geographic disparities are evident. Percentages are higher in North Central and Northeast Kansas, while a cluster in Southwest Kansas has disturbingly low rates of early entry to prenatal care.



1994-1998 Kansas Vital Statistics



IDS 49. Percent Adequate Prenatal Care

Detailed Data Report

Indicator: CHSI 03, SPM 08 **Related Priority Needs**: #3 Disparities

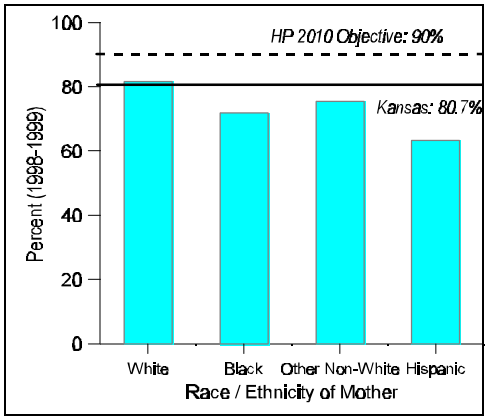
Indexes: Perinatal, Primary Care #1 Access

Recent Trend. *No real trend established due to lack of data.*

Year	Number	Percent
1998	30,647	80.7%
1999	30,746	80.3%

Kansas has only recently begun to use the Adequacy of Prenatal Care Utilization (Kotelchuck) Index (APNCU Index). Thus, a trend has not yet been established. However, Kansas performs above the U.S. 1997 average of 74% but well below the Healthy People 2010 objective of 90% with adequate or better prenatal care.

Demographic Disparities. ***Hispanic*** *women and* ***Medicaid*** *consumers have the lowest adequate prenatal care percentages.*



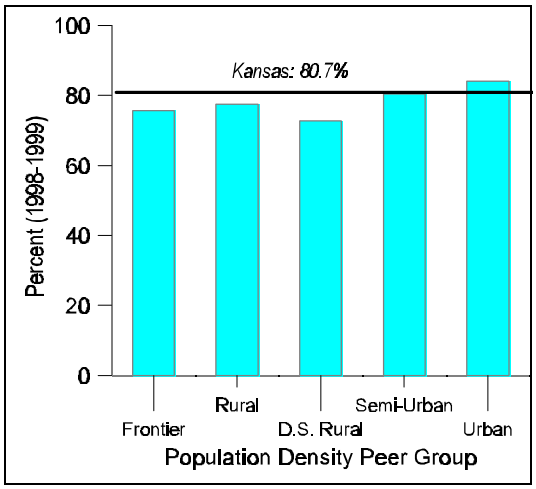
	Percent
Medicaid*	70.0%
Non-Medicaid*	83.3%

*Based on in-process partial match of Medicaid claims data and birth records (1999).

Disparities are evident both when comparing the Medicaid to the non-Medicaid population as well as when comparing across racial/ethnic groups. Based on preliminary 1999 birth-Medicaid matching, mothers with Medicaid-reimbursed births have an APNCU Index which is 19% below the non-Medicaid population.

By race and ethnicity, Hispanic women have the lowest APNCU index, only 63.3%.

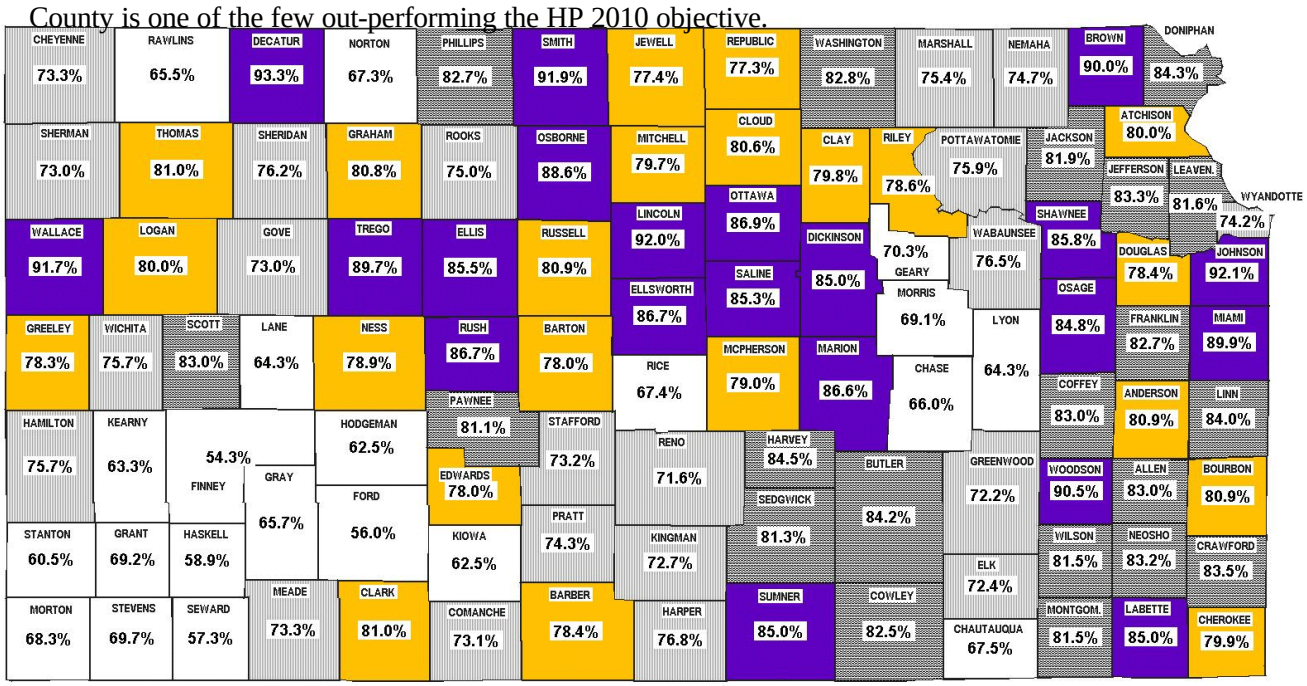
Geographic Disparities



By Population Density Peer Group. *Densely-Settled Rural counties have the lowest rate.*

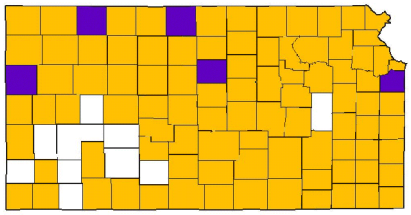
By PDG, D.S. Rural counties have the lowest rate of adequate prenatal care while urban counties have the highest. Disparities by PRE group are more striking. Rural and Frontier Black rates are very low (33% and 50%, respectively), but this may be a function of small numbers. The D.S.-Rural and Frontier Hispanic groups as well as the D.S.-Rural Black group all have percentages below 60%. The Urban White group performs the best (86%).

By County. Most notable is the cluster of counties in SW Kansas with particularly low percentages. Johnson County is one of the few out-performing the HP 2010 objective.



1994-1998 Kansas Vital Statistics

Percent Adequate or Better APNCU Score
- Low (54.3% - 70.3%)
- Lower Middle (71.6% - 76.8%)
- Middle (77.3% - 81.0%)
- Upper Middle (81.1% - 84.5%)
- High (84.8% - 93.3%)



Extremes
- Notably Low
- Notably High

IDS 50. Percent Linguistically Isolated

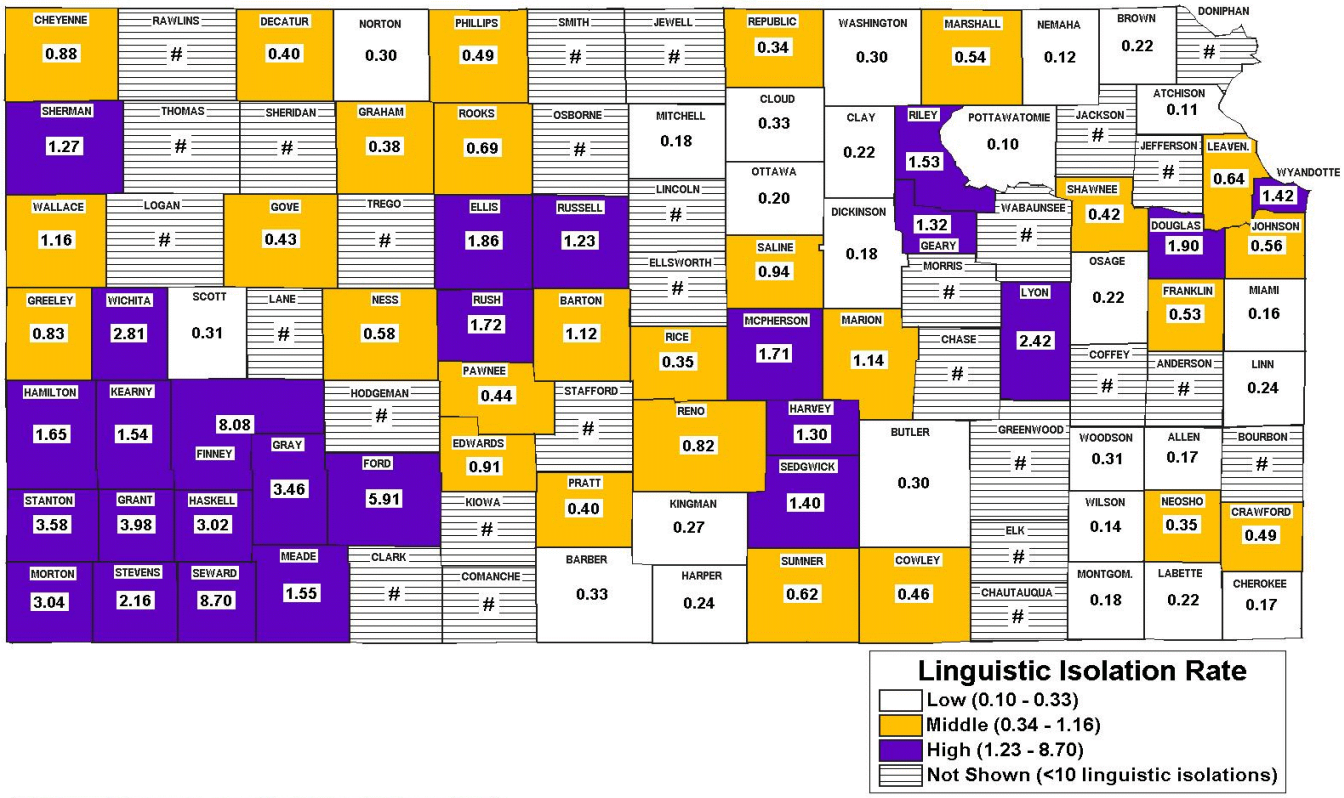
Detailed Data Report

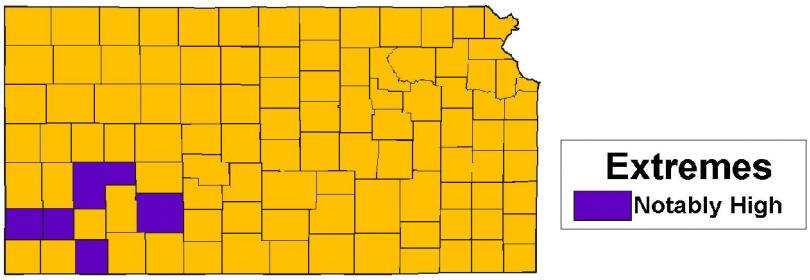
Title V Indicator: No specific indicator **Related Priority Need**: #1 Access

Index: Primary Care

The limited English proficiency population and, related, Spanish-speaking immigrants are two target population groups that have been identified by the Joint State Needs Assessment. The proportion of the population which is linguistically isolated has been used as a proxy measure to capture these populations. Linguistically isolated persons live in households in which there are no persons aged 14 and older who speak English well.

Statewide, 1% of the population is linguistically isolated (1998 Claritas, Inc. estimate). D.S.-Rural Counties have the highest percentage at 2%. Looking at the below map, a cluster of counties in Southwest Kansas have the highest percentage.





Data Source: Claritas Inc., (1998)

IDS 51. Childcare Availability

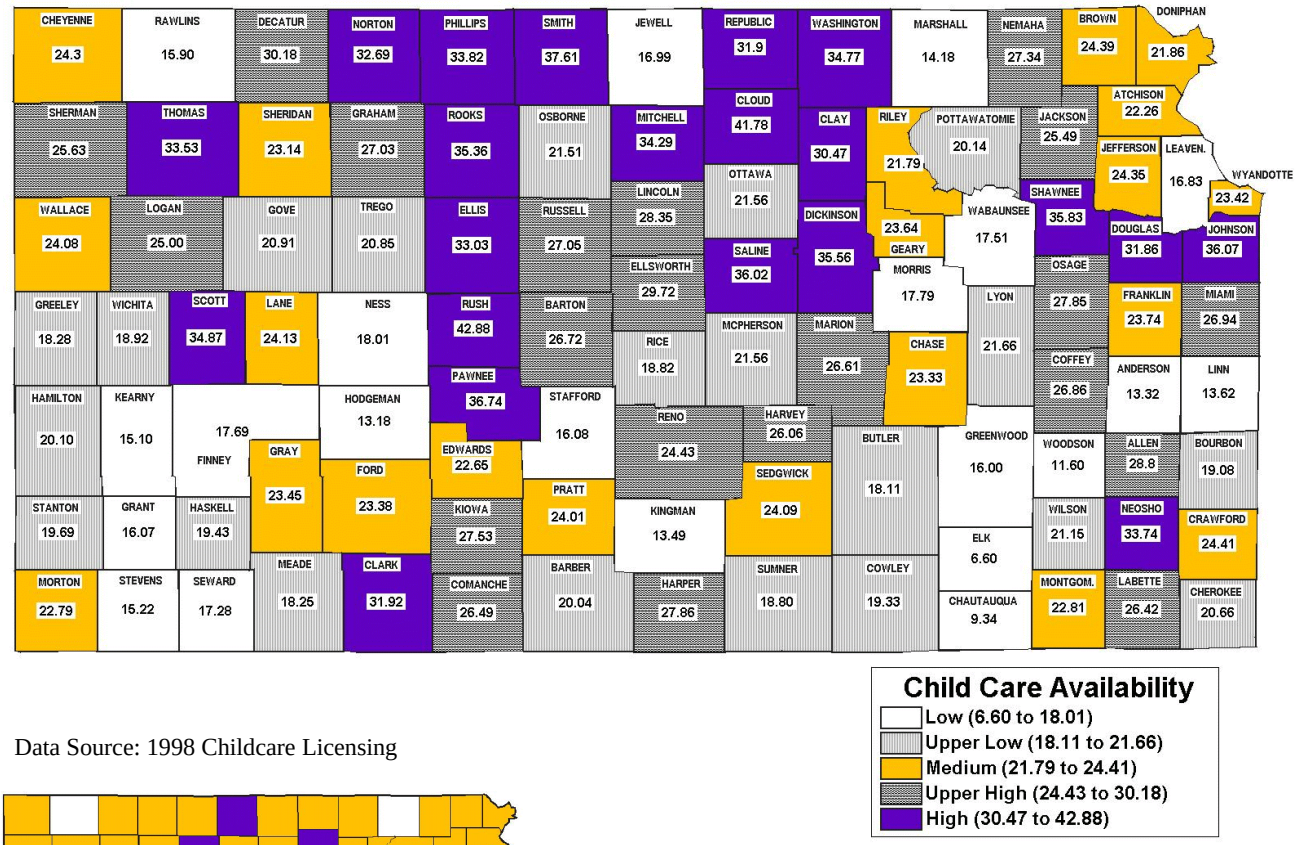
Detailed Data Report

Title V Indicator: None **Related Priority Need**: No specific priority need

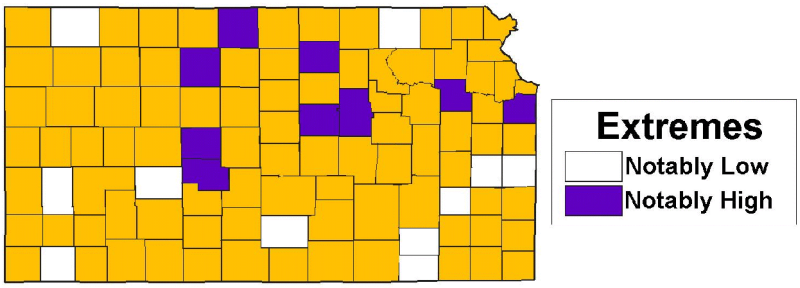
Index: Child Health

The Map below shows the rate of childcare availability per 100 children ages 0-12. The rate for Kansas is 27. In general Urban Counties have more childcare available (rate of 29) while Frontier Counties have the lowest rate at 23. However, Rush, a Frontier County has the highest rate in the state at 43. Elk county in Southeast Kansas has the lowest childcare availability with a rate of 6.

The utility of this indicator is questionable, however. The rate is based on the number of licensed slots. There is no indication of whether or not these slots are filled or if the provider chooses to fill all of the slots. Furthermore, it does not provide information related to the quality of childcare. Comments from JSNA participants indicated that child care availability itself is not a problem, but the availability of ***quality*** child care is.



Data Source: 1998 Childcare Licensing



IDS 52. Child Participation in Medicaid

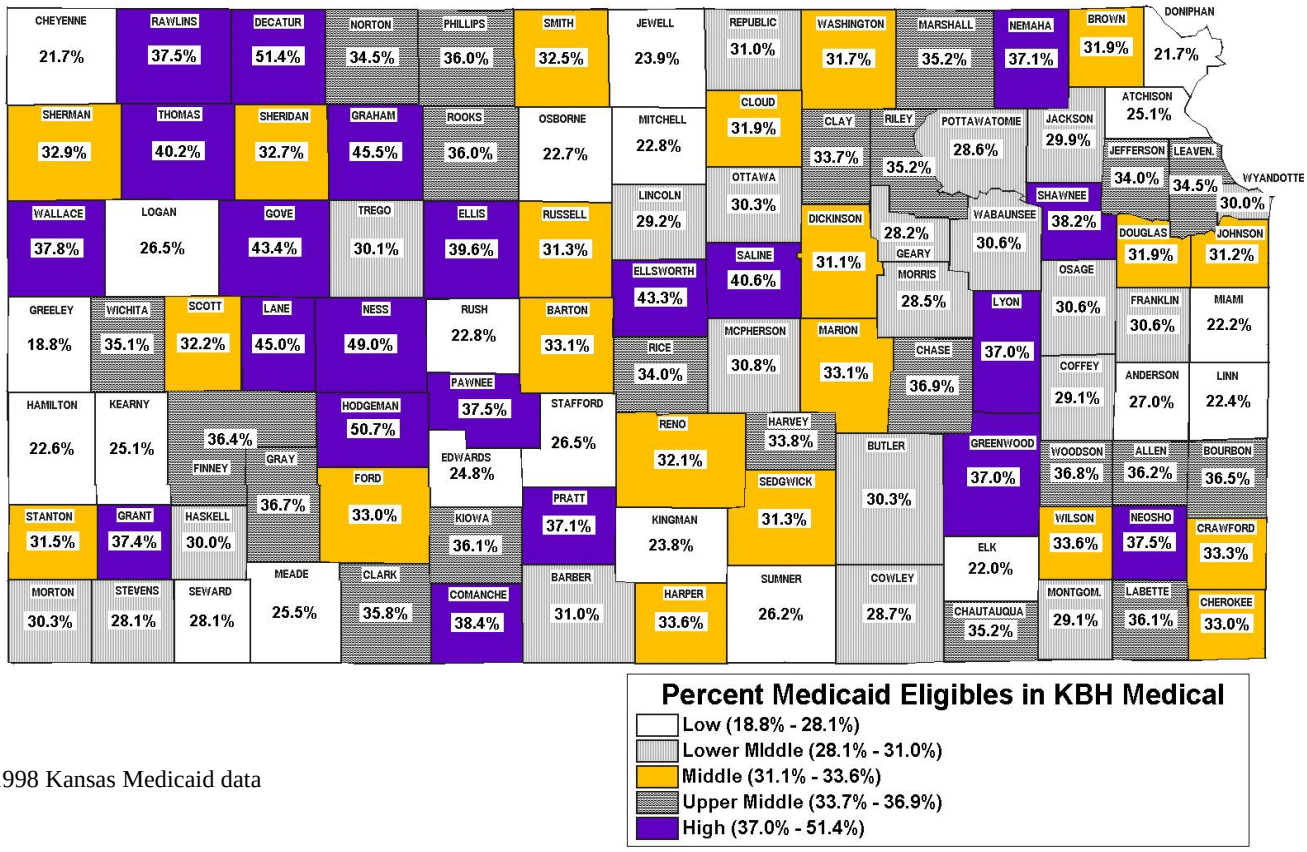
Detailed Data Report

Indicator: DHSI 04, SPM 13, 15 **Related Priority Needs**: #1 Access

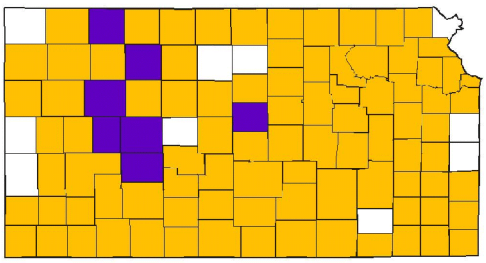
Indexes: Child Health, Adolescent Health #10 Coordinated Systems of Care

Data Note: Throughout the JSNA, an effort was made to work with SRS to develop consistent and accurate data reports. Preliminary results are reported here, but efforts are continuing to improve and update this data. In fact, the statistics reported for DHSI 04 and SPM 03 are from a later adhoc data report, and then was used for the Child Health Index and the information reported in this detail sheet.

Geographic Disparities. The below map displays the percent of children age 0 to 21 who have received at least one Kan Be Healthy (EPSDT) medical screen. Counties with particularly low screening rates are scattered across the state. Counties with particularly high rates are clustered in an area in Western Kansas.



1998 Kansas Medicaid data



Extremes
- Notably Low
- Notably High

Note: This is preliminary data.

Geographic and Demographic Disparities. Selected results from the Child and Adolescent Health Index are presented below. The percentage of children with at least one screen during the year is reported. The data is from a preliminary 1998 adhoc report developed for the JSNA.

Population Density Group	Adolescent (Age 10-21) KBH Medical Participation	Child (Age 0-9) KBH Medical Participation
Frontier	23.2%	36.6%
Rural	23.2%	39.1%
D.S. Rural	23.5%	38.7%
Semi-Urban	23.2%	38.1%
Urban	21.7%	38.8%
Kansas	**22.5%**	**38.4%**

There is relatively little variation in KBH Medical screening rates by population density group. However, there is a notable difference by age group. Children are more likely than adolescents to have had a medical screen in the last year. Percentages for both are disappointing low, although this may be a function of the way the data is captured and reported. Medicaid data issues are still being investigated.

The below table shows participation in the KBH Dental program by PDG.

Population Density Group	Adolescent (Age 10-21) KBH Dental Participation	Child (Age 5-9) KBH Dental Participation
Frontier	21.8%	23.1%
Rural	22.1%	24.5%
D.S. Rural	21.8%	27.4%
Semi-Urban	22.9%	26.8%
Urban	24.0%	31.3%
Kansas	**23.0%**	**28.7%**

Again, there are not large disparities by PDG. Children in Urban Counties tend to have higher screening percentages than children in Frontier Counties (31.3% versus 23.1%). Similarly, the Adolescent rate is slightly higher for Urban Counties.

Section 3.1.2.1. Overview of the Maternal and Child Health Population's Status

B. JSNA Indexes

B1. Index Summary: Summary results of all JSNA Indexes for Counties and Population Density Peer Groups.

B2. Primary Care Index: Includes County, PDG, and PRE results.

B3. Family Planning Index: Includes County, PDG, and PRE results.

B4. Perinatal Index: Includes County and PDG results.

B5. Child Health Index: Includes County and PDG results.

B6. Adolescent Health Index: Includes County and PDG results.

JSNA Index Summary

	Primary Care			Family Planning			Perinatal			Child Health			Adolescent Health		
COUNTY	**Index**	**Rank**	**Need**	**Index**	**Rank**	**Need**	**Index**	**Rank**	**Need**	**Index**	**Rank**	**Need**	**Index**	**Rank**	**Need**
ALLEN	-2.20	77	Lower Middle	1.47	32	Upper Middle	1.56	37	Upper Middle	-0.90	57	Middle	5.81	25	Upper Middle
ANDERSON	0.69	46	Middle	2.13	24	Upper Middle	-1.14	60	Middle	**8.63**	**8**	**Very High**	-0.76	54	Middle
ATCHISON	-1.12	62	Middle	2.34	22	Upper Middle	0.98	40	Upper Middle	2.96	34	Upper Middle	**8.35**	**10**	**Very High**
BARBER	1.90	31	Upper Middle	-3.66	91	Low	-1.87	67	Lower Middle	0.98	48	Middle	4.85	29	Upper Middle
BARTON	0.99	44	Middle	2.19	23	Upper Middle	4.68	20	High	1.18	46	Middle	-0.25	50	Middle
BOURBON	3.85	13	High	3.18	17	High	3.41	26	Upper Middle	**10.74**	**2**	**Very High**	2.29	41	Upper Middle
BROWN	1.24	37	Upper Middle	-0.29	49	Middle	1.15	39	Upper Middle	2.20	39	Upper Middle	4.32	33	Upper Middle
BUTLER	-6.81	101	Low	-1.72	68	Lower Middle	-2.54	72	Lower Middle	-2.00	67	Lower Middle	-2.13	65	Lower Middle
CHASE	**5.73**	**6**	**Very High**	**9.11**	**5**	**Very High**	3.85	23	Upper Middle	-1.34	63	Middle	7.04	17	High
CHAUTAUQUA	2.75	22	Upper Middle	-1.15	60	Middle	**10.20**	**6**	**Very High**	4.13	21	High	6.27	20	High
CHEROKEE	3.05	18	High	3.44	15	High	5.67	13	High	3.97	23	Upper Middle	**11.41**	**6**	**Very High**
CHEYENNE	-0.76	57	Middle	-4.09	93	Low	-5.49	92	Low	3.14	31	Upper Middle	-2.66	69	Lower Middle
CLARK	1.25	35	Upper Middle	-4.26	96	Low	-4.74	90	Low	1.16	47	Middle	-11.63	103	Low
CLAY	-3.52	85	Low	-2.22	76	Lower Middle	-2.46	71	Lower Middle	-3.75	85	Low	0.98	46	Middle
CLOUD	2.22	26	Upper Middle	-2.86	84	Lower Middle	-0.17	50	Middle	-4.75	91	Low	3.16	35	Upper Middle
COFFEY	-1.55	66	Lower Middle	-0.28	48	Middle	-3.71	78	Lower Middle	-3.29	78	Lower Middle	-3.12	75	Lower Middle
COMANCHE	3.20	17	High	0.28	46	Middle	0.28	45	Middle	0.08	53	Middle	-10.34	100	Low
COWLEY	-0.21	52	Middle	1.49	30	Upper Middle	2.29	31	Upper Middle	3.28	28	Upper Middle	6.38	19	High
CRAWFORD	1.11	41	Upper Middle	1.05	35	Upper Middle	3.53	25	Upper Middle	**9.18**	**5**	**Very High**	**12.67**	**3**	**Very High**
DECATUR	-1.67	70	Lower Middle	-2.02	73	Lower Middle	-10.21	104	Low	-7.05	102	Low	-9.03	96	Low
DICKINSON	-1.86	74	Lower Middle	-1.27	61	Middle	-1.16	61	Middle	-5.11	95	Low	1.83	44	Middle
DONIPHAN	-0.37	54	Middle	0.28	45	Middle	0.71	42	Upper Middle	0.39	49	Middle	-0.57	53	Middle
DOUGLAS	-4.22	92	Low	-2.99	86	Low	1.19	38	Upper Middle	-6.09	98	Low	4.59	30	Upper Middle
EDWARDS	**5.34**	**10**	**Very High**	-0.80	56	Middle	-0.17	51	Middle	4.94	19	High	-0.84	55	Middle
ELK	**5.66**	**8**	**Very High**	0.45	42	Upper Middle	5.83	12	High	**14.88**	**1**	**Very High**	7.05	16	High
ELLIS	-6.00	99	Low	-5.75	99	Low	-2.02	68	Lower Middle	-6.57	100	Low	-2.54	68	Lower Middle
ELLSWORTH	-1.12	61	Middle	-2.03	74	Lower Middle	-2.98	73	Lower Middle	-6.95	101	Low	-1.51	62	Middle
FINNEY	**11.54**	**3**	**Very High**	**13.14**	**2**	**Very High**	**12.00**	**3**	**Very High**	5.74	16	High	**9.58**	**7**	**Very High**
FORD	**8.91**	**5**	**Very High**	**9.34**	**4**	**Very High**	**11.62**	**4**	**Very High**	3.80	24	Upper Middle	**9.10**	**8**	**Very High**
FRANKLIN	-0.80	58	Middle	4.04	11	High	2.17	32	Upper Middle	0.23	51	Middle	-2.82	70	Lower Middle

JSNA Index Summary

	Primary Care			Family Planning			Perinatal			Child Health			Adolescent Health		
COUNTY	Index	Rank	Need	Index	Rank	Need	Index	Rank	Need	Index	Rank	Need	Index	Rank	Need
GEARY	**11.22**	**4**	**Very High**	**12.04**	**3**	**Very High**	**10.01**	**7**	**Very High**	6.07	14	High	**13.51**	**2**	**Very High**
GOVE	-2.40	79	Lower Middle	2.12	25	Upper Middle	-3.79	80	Lower Middle	-3.51	81	Lower Middle	-17.75	105	Low
GRAHAM	3.47	15	High	-6.53	103	Low	0.04	48	Middle	1.41	43	Middle	-17.64	104	Low
GRANT	2.14	27	Upper Middle	**7.30**	**7**	**Very High**	**11.48**	**5**	**Very High**	6.65	12	High	8.04	11	High
GRAY	1.72	32	Upper Middle	2.63	20	High	0.48	44	Middle	-4.36	89	Low	-0.85	56	Middle
GREELEY	-3.88	87	Low	-2.73	82	Lower Middle	-4.41	88	Low	**8.08**	**9**	**Very High**	5.88	24	Upper Middle
GREENWOOD	3.66	14	High	**4.31**	**10**	**Very High**	5.05	17	High	2.71	36	Upper Middle	3.79	34	Upper Middle
HAMILTON	-0.71	56	Middle	-0.83	58	Middle	3.13	27	Upper Middle	1.39	44	Middle	-6.22	84	Lower Middle
HARPER	-1.56	67	Lower Middle	-1.68	67	Lower Middle	-0.20	52	Middle	-1.31	62	Middle	6.54	18	High
HARVEY	-6.28	100	Low	-2.62	81	Lower Middle	-3.97	82	Lower Middle	-4.81	92	Low	-2.10	64	Lower Middle
HASKELL	**5.38**	**9**	**Very High**	**5.46**	**9**	**Very High**	**7.82**	**8**	**Very High**	3.44	27	Upper Middle	0.20	49	Middle
HODGEMAN	2.77	21	High	-6.36	102	Low	-1.13	59	Middle	-2.65	75	Lower Middle	-8.75	95	Low
JACKSON	-2.82	81	Lower Middle	0.85	39	Upper Middle	-4.46	89	Low	-0.75	57	Middle	-1.33	60	Middle
JEFFERSON	-7.05	103	Low	-1.78	71	Lower Middle	-1.74	64	Lower Middle	-5.81	97	Low	2.96	37	Upper Middle
JEWELL	-1.64	69	Lower Middle	-4.12	94	Low	-6.56	94	Low	-3.71	84	Lower Middle	-7.34	88	Low
JOHNSON	-13.07	105	Low	-7.06	104	Low	-9.22	103	Low	-8.50	104	Low	-5.38	81	Lower Middle
KEARNY	1.24	36	Upper Middle	2.97	19	High	5.20	15	High	3.02	33	Upper Middle	6.05	22	Upper Middle
KINGMAN	1.23	38	Upper Middle	-0.68	55	Middle	0.09	47	Middle	2.29	38	Upper Middle	-1.13	58	Middle
KIOWA	-0.32	53	Middle	-2.52	79	Lower Middle	2.43	29	Upper Middle	2.62	37	Upper Middle	-2.91	72	Lower Middle
LABETTE	3.46	16	High	1.79	29	Upper Middle	4.20	21	High	7.04	11	High	7.05	15	High
LANE	2.89	20	High	-3.94	92	Low	-5.94	93	Low	-1.37	64	Lower Middle	-9.89	98	Low
LEAVENWORTH	-5.31	96	Low	0.43	43	Middle	-0.69	56	Middle	-0.94	59	Middle	-1.08	57	Middle
LINCOLN	0.66	47	Middle	-6.15	101	Low	-11.28	105	Low	-2.49	72	Lower Middle	-2.48	66	Lower Middle
LINN	1.35	34	Upper Middle	**6.88**	**8**	**Very High**	-0.04	49	Middle	3.24	30	Upper Middle	5.95	23	Upper Middle
LOGAN	-1.55	65	Lower Middle	-5.96	100	Low	-6.83	96	Low	1.74	41	Upper Middle	-6.97	87	Low
LYON	1.02	43	Middle	0.88	37	Upper Middle	**7.44**	**9**	**Very High**	3.03	32	Upper Middle	3.13	36	Upper Middle
MCPHERSON	-3.65	86	Low	-2.52	80	Lower Middle	-3.15	74	Lower Middle	-4.68	90	Low	-7.87	89	Low
MARION	-2.40	78	Lower Middle	-2.27	77	Lower Middle	-7.10	98	Low	-4.06	88	Low	-9.68	97	Low
MARSHALL	-1.69	71	Lower Middle	-4.13	95	Low	-2.19	69	Lower Middle	-0.02	54	Middle	-3.15	76	Lower Middle
MEADE	1.20	39	Upper Middle	3.92	12	High	0.69	43	Middle	-1.71	65	Lower Middle	-10.99	102	Low

JSNA Index Summary

	Primary Care			Family Planning			Perinatal			Child Health			Adolescent Health		
COUNTY	**Index**	**Rank**	**Need**	**Index**	**Rank**	**Need**	**Index**	**Rank**	**Need**	**Index**	**Rank**	**Need**	**Index**	**Rank**	**Need**
MIAMI	-5.79	98	Low	-0.33	50	Middle	-3.73	79	Lower Middle	1.23	45	Middle	2.45	40	Upper Middle
MITCHELL	-1.81	73	Lower Middle	-1.75	70	Lower Middle	-3.98	83	Lower Middle	-2.62	74	Lower Middle	1.55	45	Middle
MONTGOMERY	2.65	24	Upper Middle	2.00	26	Upper Middle	6.44	11	High	**8.72**	**7**	**Very High**	**11.80**	**4**	**Very High**
MORRIS	-2.43	80	Lower Middle	1.90	28	Upper Middle	-0.48	54	Middle	5.28	17	High	-1.80	63	Middle
MORTON	2.56	25	Upper Middle	0.65	40	Upper Middle	1.99	34	Upper Middle	**9.10**	**6**	**Very High**	5.72	26	Upper Middle
NEMAHA	-4.56	93	Low	0.59	41	Upper Middle	-3.67	77	Lower Middle	-6.29	99	Low	-8.22	91	Low
NEOSHO	1.96	30	Upper Middle	-1.75	69	Lower Middle	2.06	33	Upper Middle	3.74	25	Upper Middle	5.43	28	Upper Middle
NESS	-2.14	76	Lower Middle	-3.52	89	Low	-4.03	85	Low	-2.98	76	Lower Middle	-8.27	92	Low
NORTON	-0.19	51	Middle	-1.54	65	Lower Middle	-1.35	62	Middle	-5.19	96	Low	-1.39	61	Middle
OSAGE	-5.10	95	Low	0.25	47	Middle	-1.75	65	Lower Middle	-3.57	82	Lower Middle	2.50	39	Upper Middle
OSBORNE	1.71	33	Upper Middle	-1.49	63	Middle	-4.38	87	Low	**7.81**	**10**	**Very High**	-3.35	77	Lower Middle
OTTAWA	-3.03	83	Lower Middle	1.34	33	Upper Middle	-3.51	76	Lower Middle	3.98	22	Upper Middle	-2.53	67	Lower Middle
PAWNEE	-4.11	90	Low	-0.44	51	Middle	0.85	41	Upper Middle	-2.52	73	Lower Middle	2.14	43	Middle
PHILLIPS	-1.62	68	Lower Middle	-3.25	87	Low	-8.03	101	Low	-4.86	93	Low	-8.70	94	Low
POTTAWATOMIE	-5.62	97	Low	1.48	31	Upper Middle	-4.10	86	Low	-2.34	71	Lower Middle	0.83	47	Middle
PRATT	-1.02	60	Middle	-0.55	54	Middle	0.14	46	Middle	-2.12	69	Lower Middle	-0.34	51	Middle
RAWLINS	5.34	11	High	-4.97	97	Low	-0.67	55	Middle	0.12	52	Middle	-9.99	99	Low
RENO	2.02	29	Upper Middle	1.12	34	Upper Middle	4.72	19	High	-1.75	66	Lower Middle	6.22	21	High
REPUBLIC	-1.24	63	Middle	-3.36	88	Low	-3.98	84	Lower Middle	-3.34	79	Lower Middle	-5.58	82	Lower Middle
RICE	3.93	12	High	3.52	13	High	4.94	18	High	3.50	26	Upper Middle	-2.90	71	Lower Middle
RILEY	-4.01	89	Low	-1.67	66	Lower Middle	-0.82	57	Middle	-3.78	86	Low	0.22	48	Middle
ROOKS	0.97	45	Middle	-5.33	98	Low	-2.38	70	Lower Middle	-2.25	70	Lower Middle	-1.15	59	Middle
RUSH	2.06	28	Upper Middle	-3.58	90	Low	-7.40	99	Low	-3.10	77	Lower Middle	-0.41	52	Middle
RUSSELL	1.03	42	Upper Middle	0.36	44	Middle	-1.80	66	Lower Middle	0.31	50	Middle	2.75	38	Upper Middle
SALINE	-1.77	72	Lower Middle	-1.51	64	Lower Middle	1.81	35	Upper Middle	-2.08	68	Lower Middle	5.45	27	Upper Middle
SCOTT	-1.34	64	Lower Middle	-1.13	59	Middle	-1.11	58	Middle	-3.59	83	Lower Middle	-6.76	86	Low
SEDGWICK	2.68	23	Upper Middle	3.09	18	High	3.99	22	Upper Middle	2.83	35	Upper Middle	**11.44**	**5**	**Very High**
SEWARD	**15.13**	**2**	**Very High**	**8.94**	**6**	**Very High**	**13.90**	**2**	**Very High**	**9.64**	**4**	**Very High**	7.86	13	High
SHAWNEE	0.51	48	Middle	1.92	27	Upper Middle	2.73	28	Upper Middle	-3.35	80	Lower Middle	**8.54**	**9**	**Very High**
SHERIDAN	-8.28	104	Low	-8.50	105	Low	-8.70	102	Low	-4.99	94	Low	-8.62	93	Low

JSNA Index Summary

	Primary Care			Family Planning			Perinatal			Child Health			Adolescent Health		
COUNTY	**Index**	**Rank**	**Need**	**Index**	**Rank**	**Need**	**Index**	**Rank**	**Need**	**Index**	**Rank**	**Need**	**Index**	**Rank**	**Need**
SHERMAN	-0.09	50	Middle	-1.33	62	Middle	5.18	16	High	4.51	20	High	7.13	14	High
SMITH	-2.83	82	Lower Middle	-0.46	53	Middle	-6.63	95	Low	-9.51	105	Low	-10.60	101	Low
STAFFORD	2.96	19	High	0.86	38	Upper Middle	5.53	14	High	1.84	40	Upper Middle	-3.08	74	Lower Middle
STANTON	-2.06	75	Lower Middle	-2.29	78	Lower Middle	1.62	36	Upper Middle	3.25	29	Upper Middle	-4.51	79	Lower Middle
STEVENS	0.08	49	Middle	1.05	36	Upper Middle	**7.24**	**10**	**Very High**	6.05	15	High	4.49	31	Upper Middle
SUMNER	-3.34	84	Lower Middle	-0.46	52	Middle	-3.23	75	Lower Middle	-0.42	56	Middle	4.46	32	Upper Middle
THOMAS	-4.22	91	Low	-0.81	57	Middle	-0.32	53	Middle	-1.11	60	Middle	-4.05	78	Lower Middle
TREGO	-7.04	102	Low	-2.84	83	Lower Middle	-7.00	97	Low	-3.87	87	Low	-6.55	85	Low
WABAUNSEE	-4.00	88	Low	-1.97	72	Lower Middle	-4.75	91	Low	-1.13	61	Middle	-6.22	83	Lower Middle
WALLACE	-0.59	55	Middle	3.37	16	High	-3.81	81	Lower Middle	1.45	42	Upper Middle	-8.20	90	Low
WASHINGTON	-4.84	94	Low	-2.97	85	Low	-7.89	100	Low	-8.41	103	Low	-5.01	80	Lower Middle
WICHITA	**5.72**	**7**	**Very High**	-2.17	75	Lower Middle	2.35	30	Upper Middle	6.49	13	High	-2.92	73	Lower Middle
WILSON	-0.99	59	Middle	2.38	21	High	3.65	24	Upper Middle	5.04	18	High	7.92	12	High
WOODSON	1.12	40	Upper Middle	3.52	14	High	-1.47	63	Middle	-0.21	55	Middle	2.15	42	Upper Middle
WYANDOTTE	**15.34**	**1**	**Very High**	**13.40**	**1**	**Very High**	**13.97**	**1**	**Very High**	**10.30**	**3**	**Very High**	**29.75**	**1**	**Very High**
FRONTIER	0.72	2	Upper Middle	-1.57	5	Low	-6.91	5	Low	**5.76**	**1**	**High**	-11.52	5	Low
RURAL	-1.23	4	Lower Middle	0.12	4	Lower Middle	-1.54	4	Lower Middle	-1.67	3	Middle	-2.71	4	Lower Middle
DENSELY-SETTLED RURAL	**4.58**	**1**	**High**	**2.84**	**1**	**High**	**7.11**	**1**	**High**	3.66	2	Upper Middle	5.78	2	Upper Middle
SEMI-URBAN	-0.76	3	Middle	0.39	3	Middle	2.34	2	Upper Middle	-1.86	4	Lower Middle	**-0.29**	**3**	**Middle**
URBAN	-3.31	5	Low	0.79	2	Upper Middle	-1.00	3	Middle	-7.50	5	Low	**8.73653**	**1**	High

Notes:

1. Top 10 most "in need" counties are bolded for each index.
Top population density peer group most "in need" is bolded for each index.

2. The z-score standardizes the indicators so they may be combined for the final index.

3.1.2.1. Overview of the Maternal and Child Health Population's Health Status

Since the MCH needs assessment has been conducted within the context of the JSNA, the materials here are not limited to MCH Health Status.

Section 3.1.2.1(A) provided detail for selected JSNA indicators. Most of these key indicators are in the five JSNA Indexes. Section 3.1.2.1(B) provided detail for each of the Indexes.

Additional health status information was been provided in Section 3.1.2. In particular, some health status information is contained within the following sections:

3.1.2 (A.2) Overview of Primary Care Results

3.1.2 (A.3) Overview of Results for Pregnant Women, Mothers, and Infants

3.1.2 (A.4) Overview of Results for Children and Adolescents

3.1.2 (A.5) Overview of Results for CSHCN

3.1.2 (A.6) Overview of Results for Cross-Cutting Issues

3.1.2.2 & 3.1.2.3 Direct Health Care and Enabling Services

In addition to the materials provided here, information pertaining to Direct Health Care and Enabling Services is in the following sections:

- Section 1.4. Overview of the State, including a description of Kansas' geographic characteristics, population, per capita income and poverty, and health care delivery environment.
- Section 1.5.1. State Agency Capacity.
- Section 1.5.2. State Agency Coordination.
- Section 2.4. Progress of Annual Performance Measures. In particular, refer to NPM 1 through 3 and SPM 02, 03, and 01.
- Section 3.1.2 and 3.1.2.1(A). In particular, refer to the Access /Resource Indicator Detail Sheets (IDS) in Section 3.1.2.1(A).
- Section 4.1. Program Activities Related to Performance Measures. In particular, refer to NPM 1 through NPM 3 and SPM 08, 13, and 15.
- Section 4.2. Refer to Direct Health Care and Enabling Services discussions.

3.1.2.2(A) Context: Barriers to Service. Several barriers which inhibit the provision of direct health care and enabling services are discussed: geographic, transportation, financial, cultural and linguistic, and categorical. All are addressed with the access priority need (#1).

3.1.2.2(A.1) Geographic. Kansas geography limits the provision of services. This is particularly a problem for persons living in rural and frontier areas across the state, especially Western Kansas.

3.1.2.2(A.2) Transportation. Transportation was identified as a problem by local agencies and case managers. The transportation is not limited to rural areas; the Kansas City public transportation system was also identified as inadequate. Specific examples were given:

- It is difficult for a mother to travel with small children on a bus.
- If a car is available, families usually only have one car and it is reserved for transportation to work.
- In many of the Spanish-speaking immigrant families, the women do not drive.

CSHCN does have the ability to provide up-front mileage or reimbursement for families traveling to authorized providers more than 50 mile from their home.

3.1.2.2(A.3) Financial. There are financial barriers for the low income, including the uninsured and underinsured. Even if services are available, an appointment usually means taking time off work and losing income.

3.1.2.2(A.4) Cultural and Linguistic. There are many cultural and linguistic barriers for the Spanish-speaking immigrant population in Kansas. Cultural and linguistic barriers are not limited to the Hispanic population, however. Other populations include refugees and the German Mennonite population. Specific examples of cultural and linguistic barriers are given:

"For many Spanish-speaking immigrants, preventive care simply isn't very high on their hierarchy of needs."

- Farmworker Case Manager, explaining that there are daily struggles and formidable barriers which prevent the population she serves from seeking and receiving preventive care.

- Nationally, 34% of foreign-born versus 14% of native born persons do not have health insurance.
- HealthWave (CHIP) and Medicaid programs do not provide services (other than emergency) for those with no legal status.
- Even for those who qualify for Medicaid or HealthWave, the forms may be hard to understand by certain populations.
- Many countries (including Mexico) do not have health insurance, as we know it. Even after a person applies for and receives a medical card, they may continue to pay out-of-pocket for services.
- Quality interpreters are needed. In many situations, children are used as interpreters. In

other situations, persons in the clinic or facility who happen to speak Spanish must be used, whether or not they have clinical training or speak the same dialect of Spanish. If an interpreter is provided, they may not have much experience. While some clinics provide an interpreter, specialists do not. However, CSHCN does reimburse language interpreters used for outpatient office visits.

- Some providers may not understand or respond respectfully to clients' beliefs in folk medicine.
- Some local and state policies are not culturally responsive. For example, state statute requires that those applying for CSHCN assistance record all persons living in the house and all income received by those persons. It is not uncommon for two or three Spanish-speaking families to live in the same house. Some living in the house may be single persons who are working here to support families in Mexico, resulting in the entire household being above the income limit. CSHCN is working to resolve this issue.

3.1.2.2(A.5) Categorical Barriers. Finally, categorical barriers to direct and enabling services have been identified. Local health departments described the difficulty of coordinating state and federal programs at the local level to provide services while navigating the Medicaid, HeathWave, and insurance payment systems. One local mental health provider commented, while explaining difficulties arising from categorical barriers, "We just need to let a kid in Kansas be a kid in Kansas, instead of a Medicaid kid or a foster kid or an uninsured kid."

3.1.2.2(B) Resources

3.1.2.2(B.1) Provider Availability.

3.1.2.2(B.1.a) Primary Care. Thirty-one (out of 105) counties are currently wholly or partially designated as a Primary Care Health Professional Shortage Area (HPSA). See IDS 46 in Section 3.1.2.1(A) for a map of the Population to Primary Care Physician FTE.

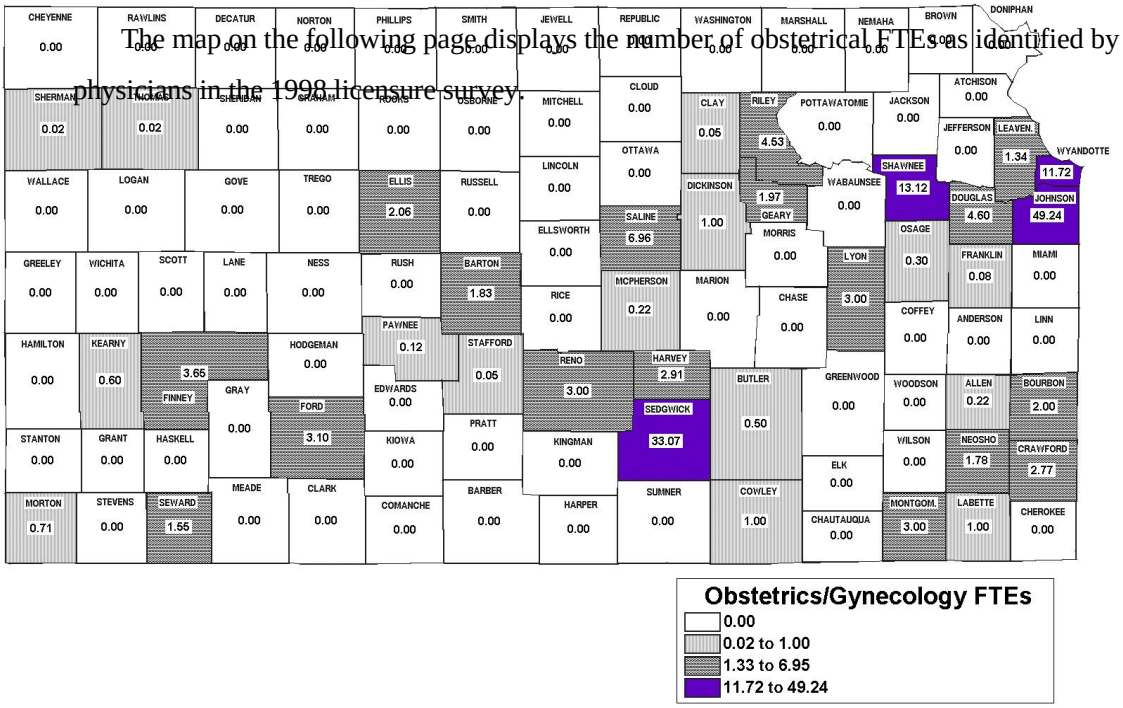
3.1.2.2(B.1.b) Obstetrical Services. Because some family and general practitioners in rural and frontier areas provide obstetrical care, it is difficult to quantify the availability of obstetrical services across the state. According to the 1998 physician licensure survey, 69 counties have 0.0 obstetrical physician FTEs. For the most part, OB and OB/GYN physicians are limited to Urban, Semi-Urban, and some Densely-Settled Rural counties.

Related to perinatal issues, subspecialists have worked to develop linkages with other groups, and larger hospitals are developing better linkages with smaller hospitals. Larger

hospitals are providing consultation for smaller hospitals, and the referral patterns are becoming better developed.

There are only five hospitals in the state which would qualify "Level III" facilities (there is no official designation system in Kansas) equipped for high-risk deliveries and neonates: two in Wichita, one in Topeka, and two in the Kansas City area. Thus, there are no high-risk facilities in North Central Kansas or the western half of the state.

The map on the following page displays the number of obstetrical FTEs as identified by physicians in the 1998 licensure survey.



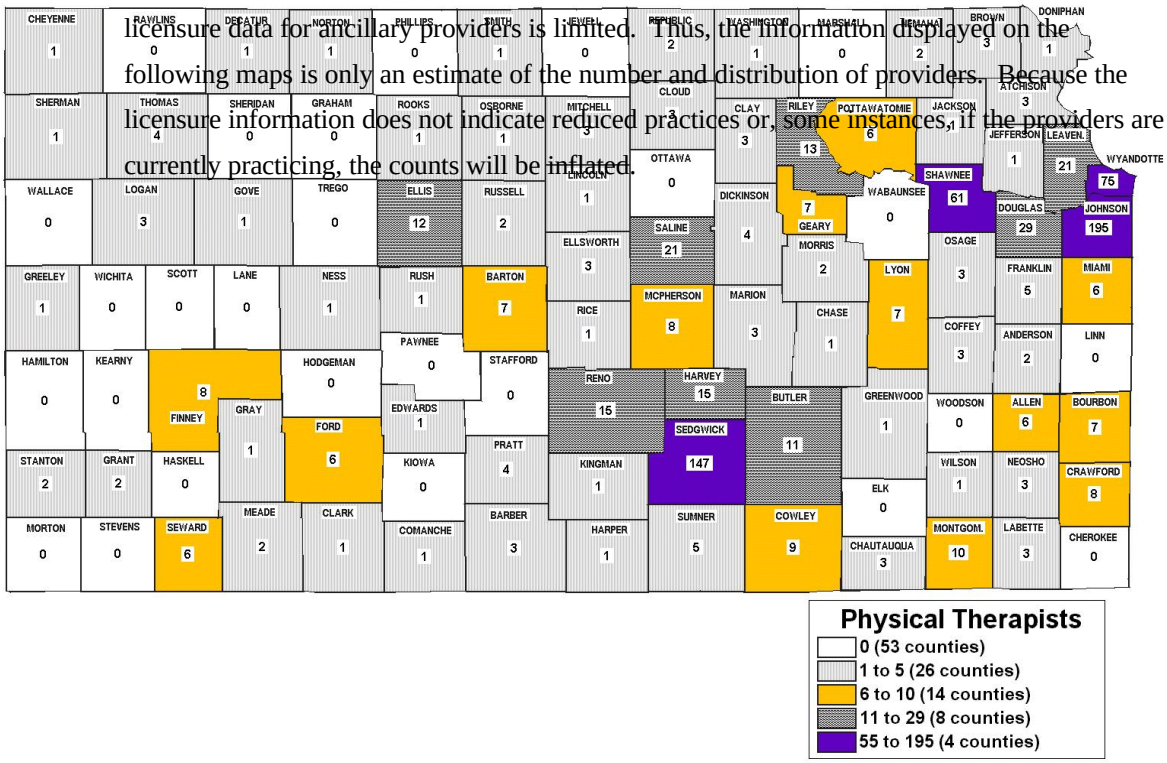
3.1.2.2(B.1.c) **Dental Providers**. Twenty of 105 counties are wholly or partially designated as Dental HPSAs. Refer to IDS 47 in Section 3.1.2.1(A).

3.1.2.2(B.1.d) **Mental Health**. Eighty-six of 105 counties are designated as Mental Health HPSAs. A more in-depth analysis of mental health providers and services will be performed through JSNA follow-up activities.

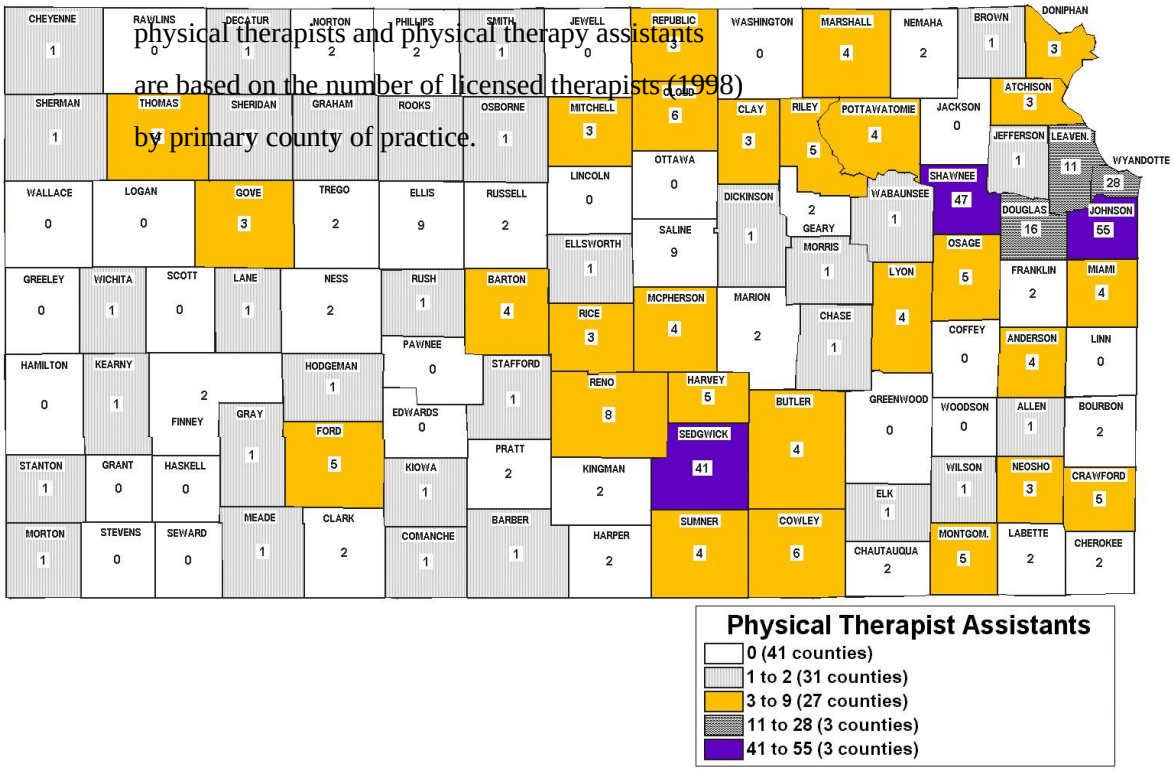
3.1.2.2(B.1.e) **Ancillary Providers**. See the following maps for the availability of ancillary providers. The same patterns appear in all maps, emphasizing geographic barriers: providers are concentrated in urban counties and in the eastern portion of the state.

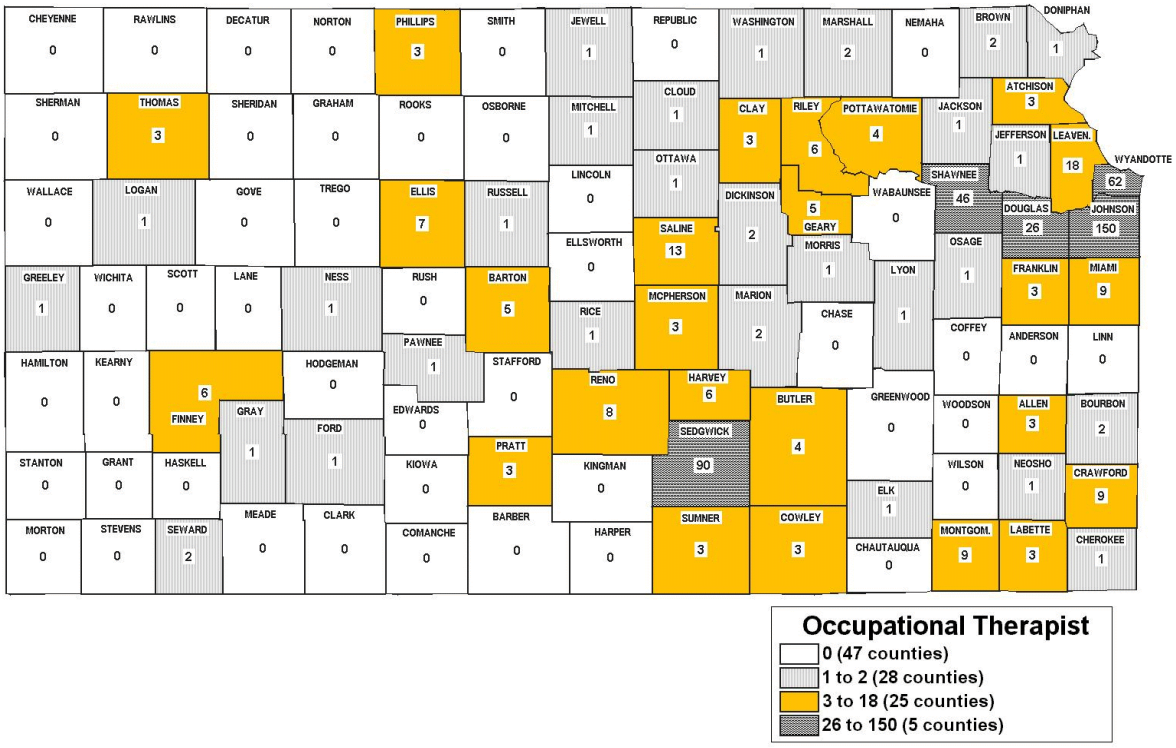
Map Cautions: In general, counts are based on licensure data. Practice information from

licensure data for ancillary providers is limited. Thus, the information displayed on the following maps is only an estimate of the number and distribution of providers. Because the licensure information does not indicate reduced practices or, some instances, if the providers are currently practicing, the counts will be inflated.

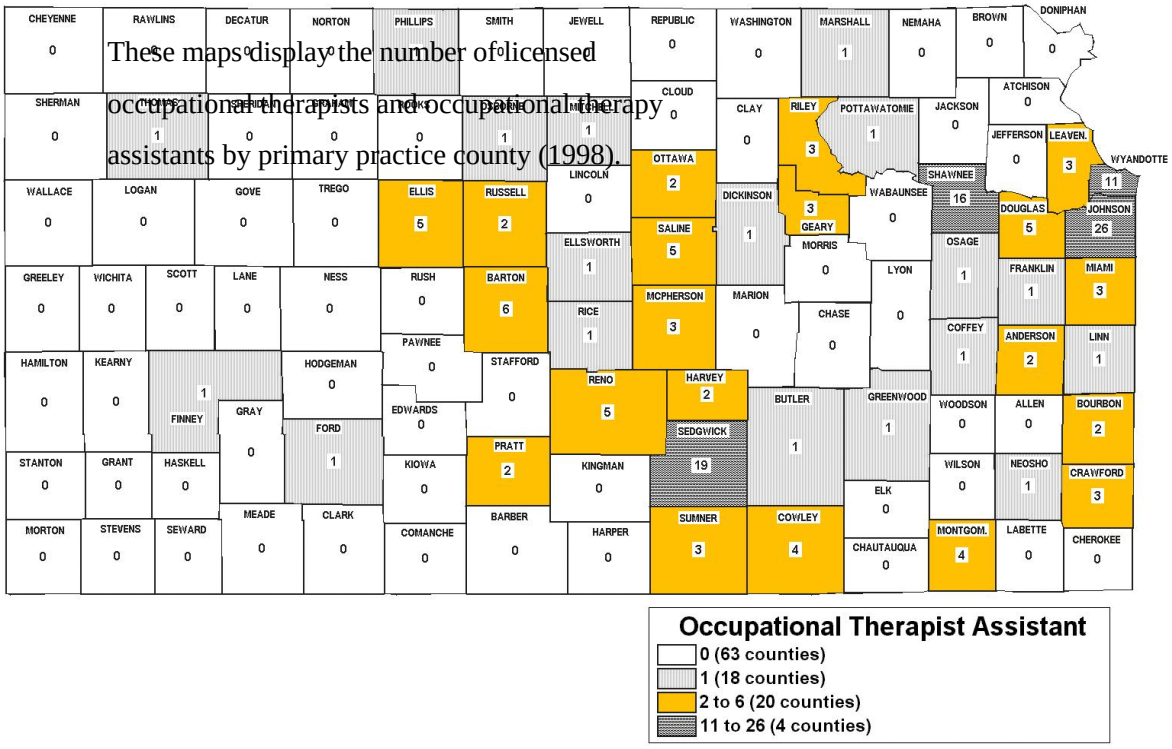


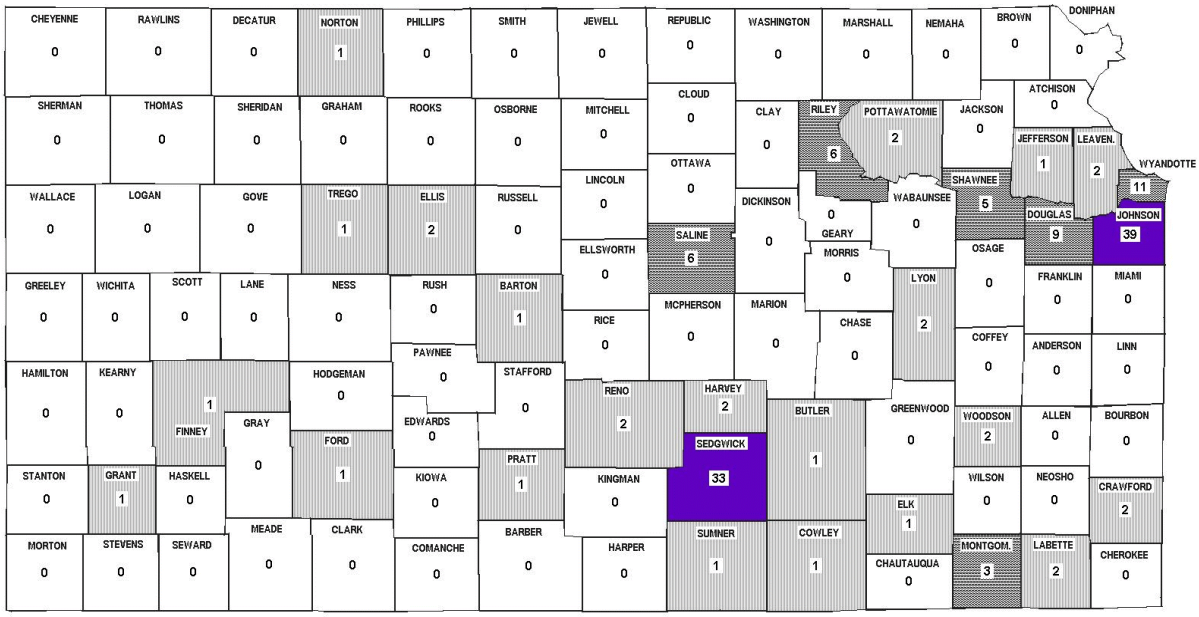
The maps displaying the distribution of physical therapists and physical therapy assistants are based on the number of licensed therapists (1998) by primary county of practice.



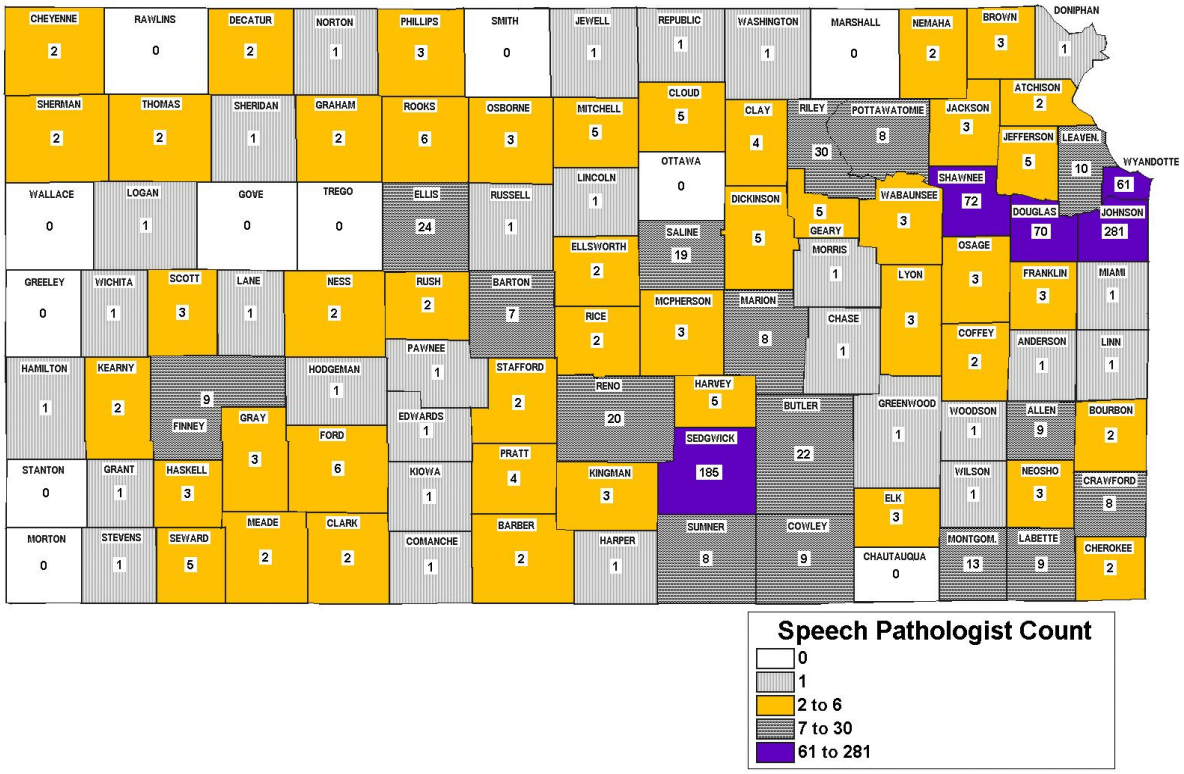


These maps display the number of licensed occupational therapists and occupational therapy assistants by primary practice county (1998).





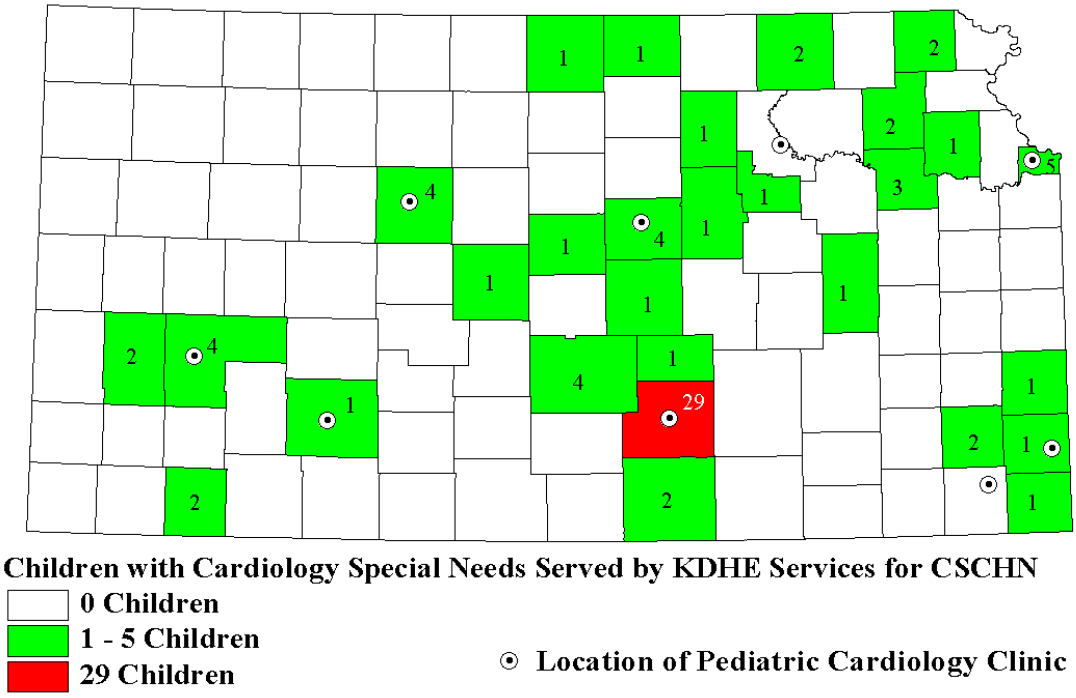
These maps show the number of audiologists and speech pathologists by county of mailing address (1998). No information is available on the licensure form regarding their practice location or if they are currently practicing.



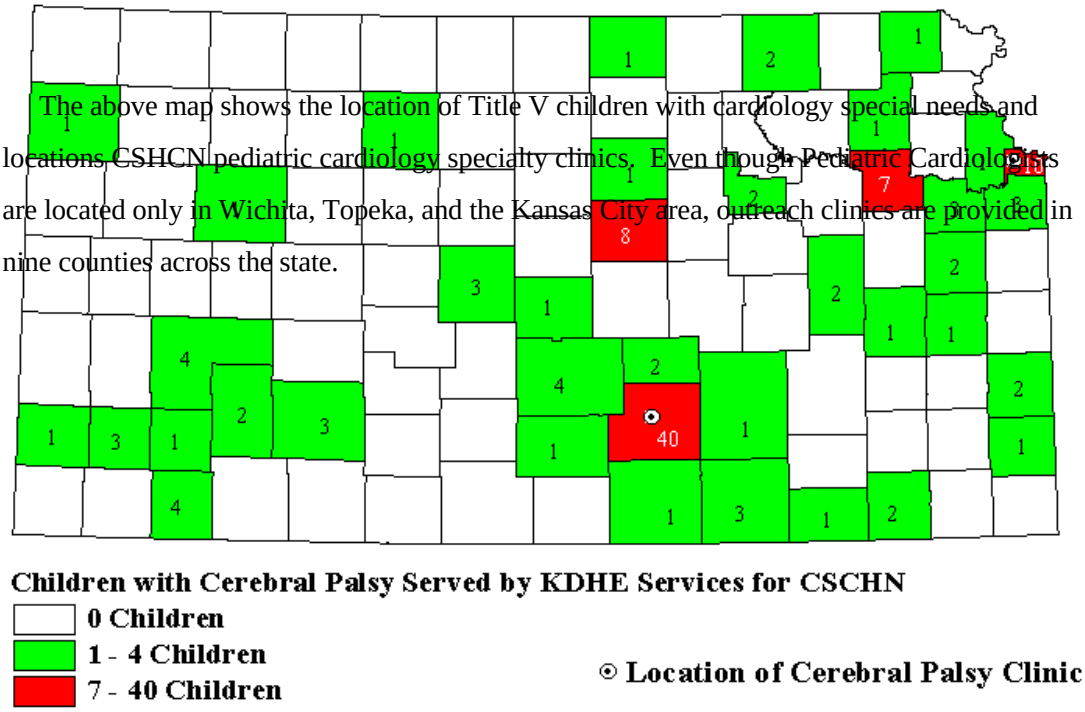
3.1.2.2(B.2) Safety-Net Providers. Although the extent of providers offering sliding fee scales is not known, there are 31 clinics (operating in 21 counties) which are members of Kansas Association of the Medically Underserved (KAMU, the state Primary Care Association) and are dedicated to providing primary care services to the medically indigent. Eleven of these clinic locations are federally-qualified health centers (some FQHCs have multiple locations) .

3.1.2.2(B.3) CSHCN. Refer to Section 3.1.2(A.5) additional information on Direct and Enabling Services for CSHCN.

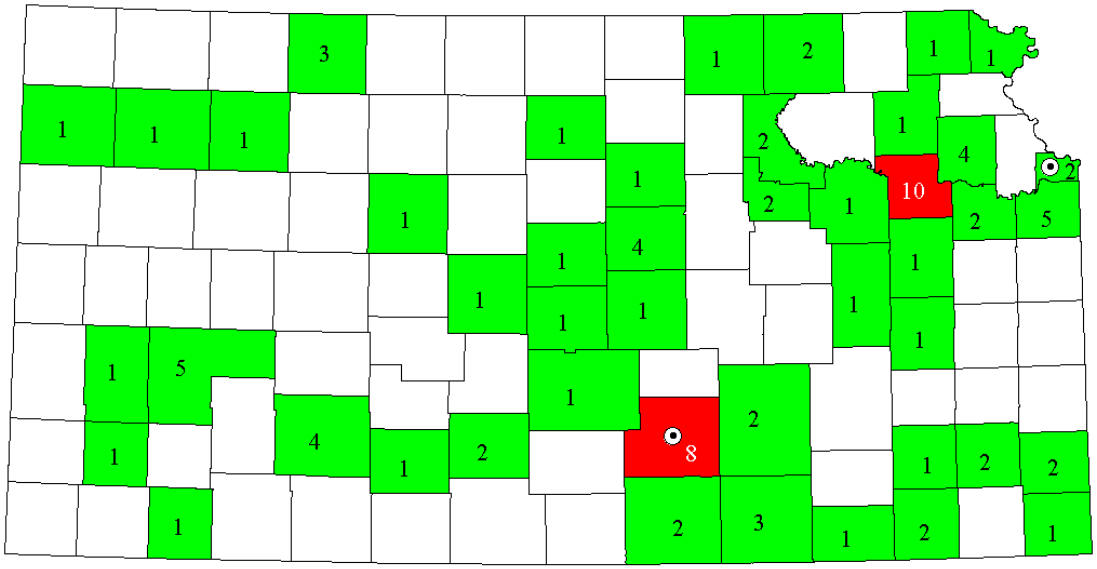
The CSHCN program offers periodic specialty clinics at locations around the state. In particular, four types of clinics are offered: Cerebral Palsy, Cleft Lip/Cleft Palate, Spina Bifida, and Cardiac. The following maps identify the location of the clinics as well as the location of children with related diagnoses enrolled in the CSHCN



The above map shows the location of Title V children with cardiology special needs and locations CSHCN pediatric cardiology specialty clinics. Even though Pediatric Cardiologists are located only in Wichita, Topeka, and the Kansas City area, outreach clinics are provided in nine counties across the state.



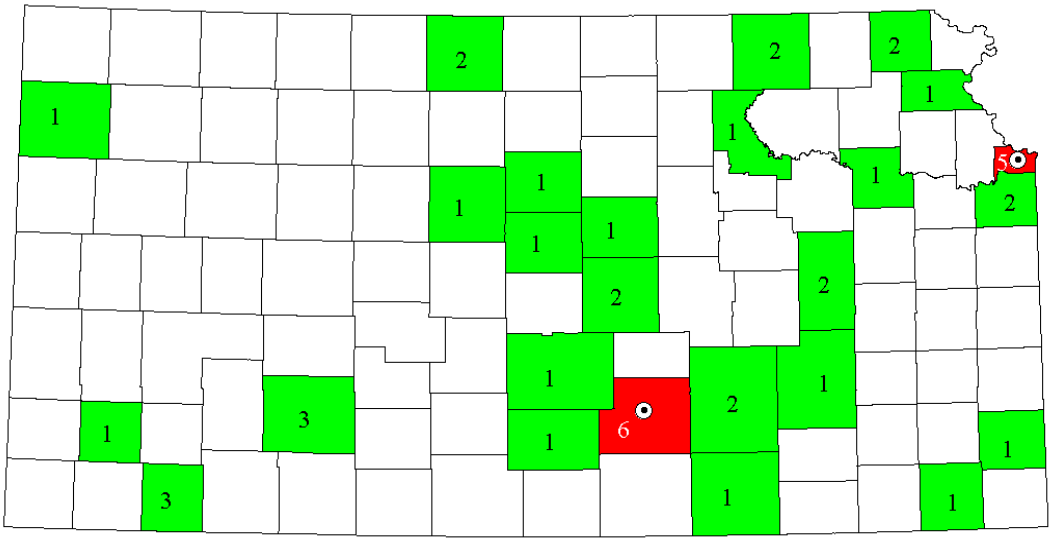
Children with CP are scattered across the state, but clinics are available only in Wichita and Kansas City. The situation for children with spina bifida is similar.



Children with Cleft Lip/Cleft Palate Served by KDHE Services for CSCHN

- 0 Children
- 1 - 5 Children
- 8 - 10 Children

⊙ Location of Cleft Lip/Cleft Palate Clinic



Children with Spina Bifida Served by KDHE Services for CSCHN

- 0 Children
- 1 - 3 Children
- 5 - 6 Children

⊙ Location of Spina Bifida Clinic

Title V children with a Cleft Lip/Cleft Palate diagnosis, too, live across the state while clinics are available only in Wichita and Kansas city.

3.1.2.2(C) Service Availability and Delivery

3.1.2.2(C.1) Local Heath Departments. Nearly all of the local health departments are county-level. LHD are autonomous and receive aid-to-local funds for Title V programs. On average, each of the following sources provide about 1/3 of LHD funding: grants and contracts, local tax revenue, and fees generated.

3.1.2.2(C.2) Health Wave (Kansas CHIP). In 1999, 16,735 children were enrolled in CHIP. See Section 1.4, for an overview of HealthWave. There are problems with Health Wave provider availability, particularly in Southwest Kansas. Also see discussion in Section 1.4.

3.1.2.2(C.3) Medicaid. The number of children enrolled in Medicaid at least one month during 1999 was 152,676. This was up 6% from 1998, presumably due to the opportunity to capture more Medicaid children through HealthWave outreach.

Local representatives identified problems related to provider availability for primary care and dental services. A study by United Methodist Health Ministry Fund on Medicaid Access to Dental Services found that

- The primary dental access issue in Kansas is the distribution of dentists throughout the state rather than the number of dentists.
- Frontier and rural areas of the state are underserved and undersupplied, and dental specialists (e.g., pediatric dentists) are particularly scarce.
- Of Kansas dentists, fewer than 27% participate in Medicaid. Of those who participate, an even smaller number of dentists serve a disproportionate number of beneficiaries. Thirty-five dentists provide services to half of the beneficiaries in the state.
- The overwhelming service need is primary dental care (cleaning and checkup).
- In a survey of Medicaid beneficiaries, over half of the respondents thought their child currently needed dental care.

See discussion in Section 1.4 for more information related to Medicaid.

3.1.2.2(C.4) Managed Care. The JSNA identified unintended consequences of the shift to managed care, particularly in the Medicaid population. Three problems identified through families, local health departments (LHD), and program staff are

(1) Families are not able to obtain appointments to see Medicaid managed care providers in a timely manner.

(2) Local health departments can provide EPSDT screenings, if needed, but must have a referral from the Primary Care Provider. In many areas of the state, LHD say that referrals are not being made.

(3) Pregnant women may not be receiving the non-medical case management they need.

LHD representatives anticipate a decline in EPSDT screening ratios and related indicators. Based on their input, the state-negotiated priority measure chosen to track priority need #10 (coordinated systems of care) is the observed to expected Kan Be Healthy (EPSDT) screening ratio.

Also see Managed Care discussion in Section 1.4.

3.1.2.2(C5) Welfare Reform. See discussion in Section 1.4

3.1.2.2(C6) SSI. See Section 1.5.2.

3.1.2.7(C7) Telemedicine. Telemedicine brings specialty care to communities. There are 31 telemedicine sites at medical facilities in Kansas and ten Tele-KidCare project sites in Kansas City schools. Educational modules are available for physician education through telemedicine. Refer to Section 4.1 (NPM 10) and discussion in Section 4.2.

3.1.2.4. Population-Based Services. Information relating to Population-Based Services is in the following Sections:

- Section 1.5.1.1. State Agency Capacity: Organizational Structure. Note the listing of federal and state statutes relevant to BCYF program authority. Several of the state statutes related to population-based services.
- Section 1.5.1.2. State Agency Capacity: Program Capacity. This description of BCYF programs includes some population-based services.
- Section 1.5.2. State Agency Coordination. The description of coordination efforts includes listing and description of coordination activities related to population-based services.
- Section 2.4. Progress of Annual Performance Measures. In particular, refer to NPM 4 through 10 and SPM 04.
- Section 4.1. Program Activities Related to Performance Measures. In particular, refer to NPM 4 through NPM 10 and SPM 10 through 12.

- Section 4.2. Refer to Population-Based Services discussions.

Here is a topical reference of selected population-based services.

- Newborn Screening: Section 1.5.1, Sections 2.4 and 4.1 (NPM 04 and 10), Section 4.2.
- Immunization: Sections 2.4 and 4.1 (NPM 05).
- Lead Screening: Section 1.5.1, Section 4.2
- Injury Prevention: Section 1.5.1, Sections 2.4 (NPM 08 and SPM 04), Section 4.1 (NPM 08) and Section 4.2.

3.1.2.5 Infrastructure-Building Services.

In addition to the materials provided here, information pertaining to Infrastructure-Building Services is in the following sections:

- Section 1.4. Overview of the State provides the context for infrastructure-building services.
- Section 1.5.1. State Agency Capacity. This section gives a description of statutes (Section 1.5.1.1) and programs (1.5.1.2), including several which are related to infrastructure-building.
- Section 1.5.2. State Agency Coordination. This section is directly applicable to infrastructure-building services.
- Section 2.4. Progress of Annual Performance Measures. In particular, refer to NPM 11 through NPM 18 and SPM 05 through 07.
- Section 3.1.1. Needs Assessment Process. The JSNA process is described in detail.

- Section 4.1. Program Activities Related to Performance Measures. In particular, refer to NPM 11 through NPM 18 and SPM 09 and 14.
- Section 4.2. Refer to Infrastructure-Building Services discussions.

3.1.2.5(A) Needs Assessment

3.1.2.5(A.1) Joint State Needs Assessment. The JSNA has provided *many* opportunities for collaboration and infrastructure-building. See discussion in Section 3.1.1.

3.1.2.5(A.2) Community Health Assessment. The Office of Local and Rural Health provides technical assistance to communities conducting health assessments. The JSNA can provide further opportunities for MCH and HIV/AIDS to provide technical assistance related to communities and to OLRH as community resources are developed.

3.1.2.5(B) Data Analysis and Capacity

3.1.2.5(B.1) MCH Epidemiologist. The need for an MCH Epidemiologist has been highlighted again by

the JSNA. Plans are underway to hire an MCH Epidemiologist through the SSDI Project.

3.1.2.5(B.2) **County Health Profile**. As part of the collaborative JSNA effort, JSNA data has been incorporated into the Kansas County Health Profiles, community-based planning tools developed in a project led by Primary Care (OLRH). See Section 3.1.2.1(C.1) for example pages.

3.1.2.5(B.3) **Kansas Information for Communities**. As part of JSNA follow-up activities, MCH is supporting the Office of Health Care Information in the development of KIC, a query-based Internet data system modeled after Missouri's MICA Internet site.

3.1.2.5(B.4) **Birth Defects Reporting System**. At this point, Kansas does not have a birth defects surveillance system, only a reporting system. This is one of the criteria in the new state-negotiated performance measure (SPM 09, MCH Data Capacity).

3.1.2.5(B.5) **General MCH Capacity**. MCH Data Capacity, in general is addressed by SPM 09.

3.1.2.5(B.6) **Coordination with Data Resources**. The JSNA has provided several opportunities to coordinate with data resources to improve data capacity. Highlights are listed below:

- Using a common contractor for MCH, PC, and common data analysis tasks between all three JSNA programs saved resources, improved communication, and allowed the JSNA to request common data once from data resources.
- Through the assistance of the Office of Health Care Information (OHCI) and the Bureau of Health Promotion, the JSNA negotiated the use of Kansas Hospital Association's (KHA) ICD-9 level hospital discharge data set for Title V monitoring.
- JSNA representatives worked with SRS to develop a detailed set of adhoc reports for Title V and JSNA monitoring of the Medicaid population.
- JSNA representatives worked with OHCI to help facilitate matching of Medicaid-birth files for Title V indicator requirements.
- Information was obtained from 30 other separate data resources for shared JSNA use.

Information was obtained from over 30 data resources for shared JSNA use.

3.1.2.5(C) **Coordination Efforts**. Refer to Section 1.5.2 for a listing of Title V coordination efforts.

3.1.2.5(D) **Standards of Care**. CSHCN has set standards for facilities and health care providers. These include hospitals, laboratory facilities, radiology and nuclear medicine facilities, ambulatory surgical facilities, prosthetics and orthodontics appliance facilities, pharmacies, home health

agencies, audiologists, dentists, hearing aid dealers, nurses, nutritionists, ocularists, occupational therapists, optometrists, oral surgeons, orthodontists, physical therapists, physicians, respiratory therapists, social workers, and speech therapists. Those who wish to be a provider of a service for children with special needs and wish to receive payment for these services must meet the standards. Private insurance and Medicaid are first payers over Title V, and CSHCN providers must accept CSHCN-established rates as payment in full.

All Title V programs have developed and implemented standards which are tracked through contract monitoring.

3.2 Health Status Indicators

Refer to Sections 5.4 through 5.7.

3.2.1 Priority Needs

Details of the Joint State Needs Assessment are found in Section 3.1 of this document. The priority needs identified through this process are listed below. Also, please see Form 14 in the Supporting Documents section.

I. Improve access to all aspects of primary health care for vulnerable population.
2. Improve access to all aspects of health care for CSHCN
3. Reduce reproductive health demographic and geographic disparities.
4. Increase data infrastructure, epidemiology capacity and products of analysis for improved state and community problem solving.
5. Reduce unintentional injuries.
6. Reduce intentional injuries.
7. Increase proper nutrition and physical activity, particularly among children and adolescents.
8. Develop oral health capacity.
9. Develop behavioral health infrastructure.
10. Improve systems coordination and remove barriers caused by categorical programs and funding.

State negotiated performance measures were identified for eight of the ten of the priority needs. State negotiated performance measures were not written for priority 1 and 2 as these are related to NPM1, NPM2, NPM 3, NPM 4, NPM 5, NPM 7, NPM 10, NPM 11, 12, NPM 13, NPM 14, NPM 15, and NPM 18 and to many of the State Negotiated Performance Measures. See Section 3.4.2 for additional information.

3.3 Annual Budget and Budget Justification

3.3.1 Completion of Budget Forms

Please see Budget Forms 2, 3, 4 and 5 in Supporting Documents Section. Estimates have been used in providing some budget and expenditure details, particularly with regard to breakdowns by "types of individuals served" and "types of services." Also, it was necessary to estimate local and program budget and revenue data, since this information is not routinely compiled for all MCH-related activities in Kansas.

3.3.2 Other Requirements

Maintenance of Effort Kansas is in compliance with maintenance of effort requirements described in Section 505(a)(4). Kansas has maintained and exceeded efforts of the 1989 program year.

Sources of All Dollars Sources of all funds (federal, state, local, other) under the direction of the Title V Director are indicated in the Annual Budget.

Justification Kansas attempts to match funding to the level of unmet need, and to address the four levels of the MCH pyramid and the four target populations. Since funded programs often take more than one structural approach to targeted needs and populations, program funds are allocated to reflect percentage of effort in infrastructure-building, population-based services, enabling services and direct health care services. Program allocations also take into account the "30-30-10" requirements of Title V.

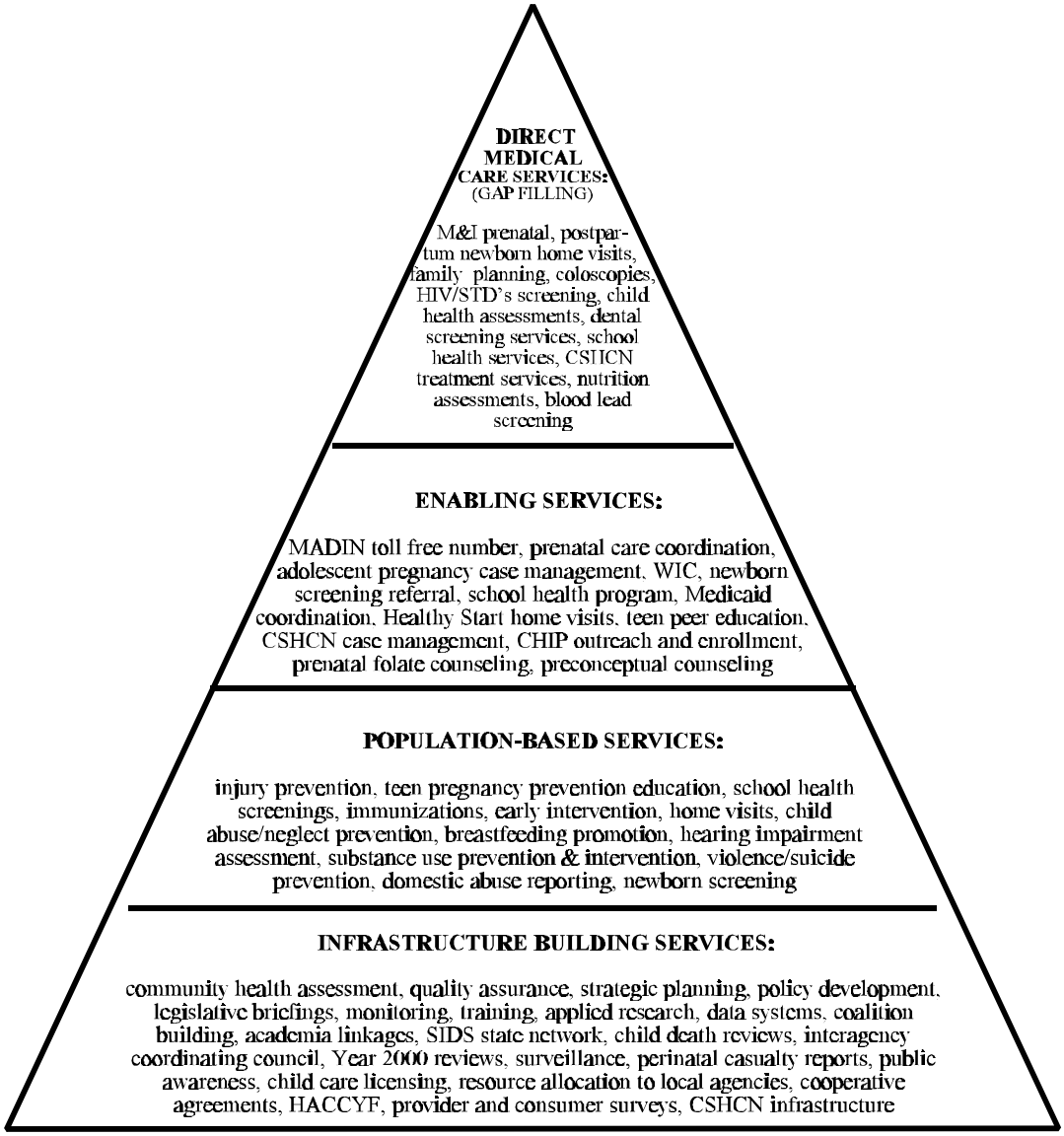
Kansas uses a fair method to allocate Title V funds among areas of the state identified as having unmet needs for maternal and child health services. The State uses its MCH funds for the purposes outlined in Title V, Section 505 of the Social Security Act. See Section 3 for a description of the JSNA process used to identify priorities and needs. The methodology used to identify expenditures for MCH-related programs as presented in previous applications has not changed.

Budget Variations from Last Year The budget for FY 2001 remains consistent with the FY2000 budget even though there were movements in specific programs, the overall budget remains consistent. Funds within the programs may be refocused to address the newly identified state negotiated performance measures.

KANSAS CORE PUBLIC HEALTH SERVICES

DELIVERED WITH MCH BLOCK GRANT ASSISTNACE

BY LEVEL OF SERVICE



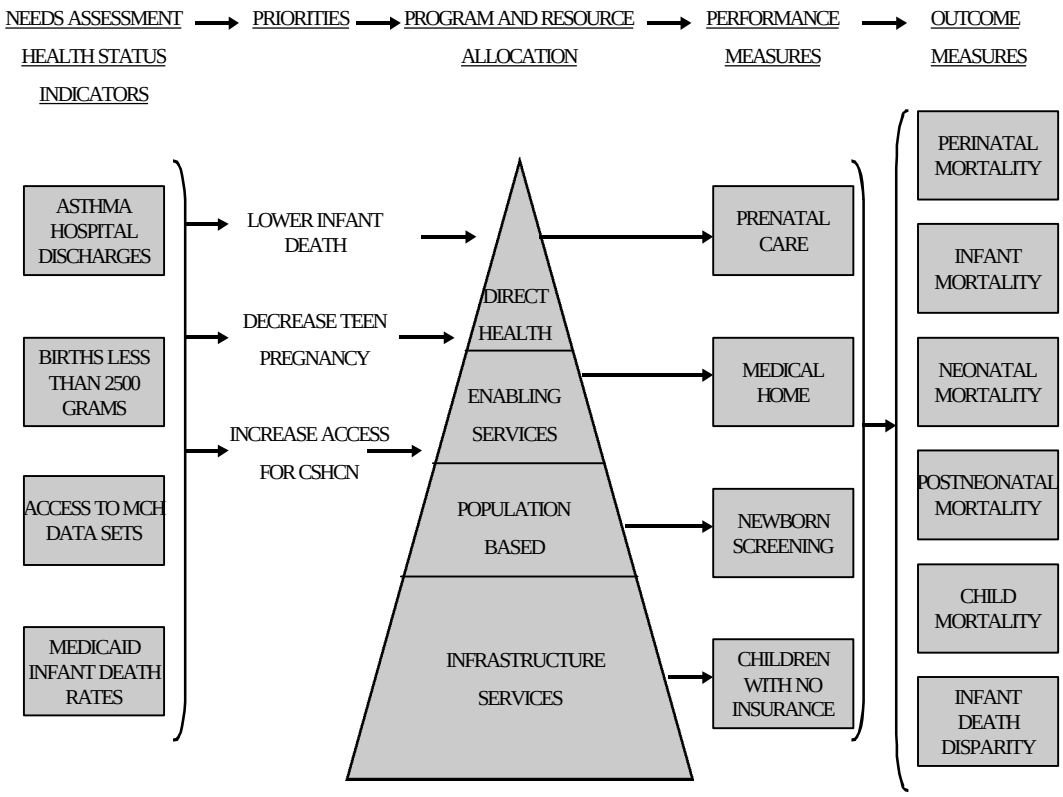
3.4 Performance Measures

In section 3.4.1, Kansas will report on the eighteen national performance measures and 6 national outcome measures. Section 3.4.2 outlines the additional state-selected performance measures on which Kansas chooses to report for the remainder of this block grant cycle.

Figure 3

TITLE V BLOCK GRANT

PERFORMANCE MEASUREMENT SYSTEM



3.4.1 National "Core" Five-Year Performance Measures

FIGURE 4

PERFORMANCE MEASURES SUMMARY SHEET

Performance Measure	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home?		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN program.				X		X	
15) Percent of very low birth weight live births.				X			X
16) Rate (per 100,000) of suicide deaths among youths 15-19.				X			X

Performance Measure	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
17) Percent of very low birth weight infants delivered at facilities for high risk deliveries and neonates.				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				X			X
SP #8 Rate of Densely-Settled Rural Kansas APNCU/ Hispanic APNCU	X	X					X
SP #9 Modified MCH Capacity Scoring System				X	X		
SP #10 Percent under age 4 children involved in motor vehicle crashes not properly using child safety equipment			X				X
SP #11 Violent acts per 100 children enroled 6TH through 9TH grades			X				X
SP #12 Percent Overweight WIC children aged 36 - 59 months			X				X
SP #13 Percent of KBH - eligible children aged 6-9 years who have received one dental screen	X	X				X	
SP #14 Behavioral Health Capacity Scoring System				X	X		
SP #15 Observed to Expected KBH screening ratio for infants < 1	X	X				X	

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

3.4.1.1 Five Year Performance Objectives

See Form 11 for Kansas' progress relative to the eighteen national performance measures and five-year objectives relative to each of these. See Form 12 for a report on Kansas' status relative to the national outcome measures. To compare the priority needs to the national performance and outcome measures, the following table may be helpful. This information is also summarized on forms 11 and 12.

Comparison of Priority Needs with National Performance and Outcome Measures

	Pyramid *				National "Core" Performance Measures																		Nat'l Outcome Measures					
Priority Needs*	D	E	P	I	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	01	02	03	04	05	06
Primary Care Access	T	T	T	T	T	T	T	T	T	T	T	T	T	T	T	T	T		T		T	T	T	T	T	T	T	T
CSHCN Access to Care	T	T	T	T	T	T	T		T		T	T		T	T	T	T	T	T	T	T							
Reproductive Health Disparities	T	T	T	T	T					T		T							T			T	T	T	T	T	T	
Data/ Epi/Analysis Capabilities				T	T	T	T	T	T	T	T	T	T	T	T	T	T	T	T	T	T	T	T	T	T	T	T	T
Unintentional Injury			T								T																	T
Intentional Injury			T																	T								T
Nutrition/Activity			T		T	T					T		T						T		T	T	T	T	T	T	T	
Oral Health Capacity	T	T	T	T							T	T																
Behavioral Health				T		T	T													T								T
Systems Coordination	T	T		T	T	T	T	T	T	T	T	T	T	T	T	T	T	T	T	T	T	T	T	T	T	T	T	T

* Priority Needs have been shortened to key words . See Section 3.2 and Form 14 for a complete rendering of the priority needs

D = Direct Services; E = Enabling; P = Population-Based; I = Infrastructure

3.4.2 State "Negotiated" Five-Year Performance Measures

3.4.2.1 Development of State Performance Measures

Why each measure was chosen. As a component of the Joint State Needs Assessment a list of ten state priorities for MCH/Title V were developed. See Section 3.1 for a description of the needs assessment process and the individuals involved in the process. MCH has chosen to develop performance measures for eight of the ten identified priorities. It was thought that these access priorities were addressed in the NPMs. Section 3.2.1 lists the priorities.

3.4.2.2 Discussion of State Performance Measures

The ten state priorities for the years 2001 through 2006 selected through the Joint State Needs Assessment process Form 14.

3.4.2.3 Five Year Performance Objectives

See Form 11 for State measures by level of pyramid. The annual performance objectives are completed for Kansas' five year targets for each State Objective. Five Year Performance Targets are based upon trend analyses completed through the SSDI program.

Relationship of Priority Needs to State Performance Measures

Kansas Performance Measures

Priority Needs*	SP08	SP09	SP10	SP11	SP12	SP13	SP14	SP15
Primary care access	X	X						
CSHCN access to care	X	X						
Reduce reproductive disparities	X	X						
Data/Epi/Anal capacity	X	X	X	X	X	X	X	X
Unintentional injuries		X	X					
Intentional injuries		X		X				
Nutrition/Activity		X			X			
Oral health capacity		X				X		
Behavioral health		X					X	
Systems Coordination	X	X						X

*Priority Needs have been shortened to key words. See Section 3.2 and Form 14 for complete rendering of the

priority needs.

3.4.2.4 Review of State Performance Measures

See Forms 11 and 12 and Detail Sheets in the appendix. Objectives added by the state are preceded with the prefix "SP#." Also included in this section are descriptions of the state-selected measures that includes their category on the pyramid, the Kansas goal, the measure used, how the measure is defined, the measure's relationship to Healthy People 2000 (if there is one), data sources and data issues, and the significance of the indicator or why this particular indicator was chosen.

Kansas "Negotiated" Performance Measures Summary Sheet

Kansas "Negotiated" Performance Measures*	Pyramid Level of Service				Type of Service			Population		
	DHC	ES	PBS	IB	C	P	RF	W&I	C&A	CSHCN
8. Rate Kansas APNCU/Hispanic APNCU	X						X	X		
9. MCH Scoring Capacity				X	X			X	X	X
10. Children under 4 using car safety equipment properly			X				X		X	X
11. School violence			X				X		X	X
12. Overweight children			X				X		X	X
13. Dental Sealants		X					X		X	X
14. Behavioral Health				X	X				X	X
15. KBH for infants		X				X		X		

* Performance Measures have been shortened to key words. See State Negotiated Performance Sheets for details.

CODES: DHC = Direct Health Care; ES = Enabling Services; PBS = Population-based Services; IB = Infrastructure Building; C = Capacity; P = Process; RF = Risk Factor; W&I = Women & Infants; C&A = Children & Adolescents; CSHCN = Children with Special Health Care Needs

<u>On Indicators Not Chosen</u> It was determined that the two access priorities were being addressed in the NPMs and the new State Negotiated Measures.

3.4.3 Outcome Measures

Details of the six national outcome measures are found in Forms 12. The annual outcome objective row for Kansas' five year targets are listed for each outcome measure. Outcome detail sheets are found in Forms 16.

IV REQUIREMENTS FOR THE ANNUAL PLAN [Section 505(a)(2)(A)]

01 National Performance Measure	The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program
Type: Capacity Category: Direct Health Services	

4.1 Program Activities Related to Performance Measures

Relationship to Priority Needs

Relates to the MCH priority need of access to care. Title V legislation mandates that rehabilitative services are provided to those individuals under the age of 16 when the services are not provided by Medicaid.

Capacity/Resource Capability

Kansas CSHCN program provides case management services for individuals up to age 21. Transmittals are received by the CSHCN program on a regular basis from Disability Determination Services and SHS program applications are mailed to each SSI eligible individual. When the application is returned to the CSHCN program both medical and financial eligibility are determined. Upon application, case management services are provided to all SSI recipients.

Program Activities

By providing rehabilitative services to SSI beneficiaries the CSHCN program is able to improve access to health care for CSHCN's in Kansas.

- Maintain current information sharing with Disability Determination Services.
- Continue the use of the shorter application for SSI referred children not medically eligible for SHS but who want case management services.
- Develop additional methods to capture those children receiving rehabilitative services from SHS that have not formally applied.

02 National Performance Measure	The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients
Type: Capacity Category: Direct Health Service	

4.1 Program Activities Related to Performance Measures

Relationship to Priority Needs

Relates to the MCH priority needs of access to care and quality standards. The CSHCN program is able to improve access to health care for CSHCN's in Kansas by providing specialty and subspecialty services to CSHCN's. Under OBRA '89 legislation, Title V programs are charged with providing and promoting family-centered, community based, coordinated care for CSHCN and to facilitate the development of community-based systems of services.

Capacity/Resource Capability

Kansas CSHCN program is currently providing all 9 areas of service for CSHCN. The SHS program has agreements with providers throughout the state to provide specialty and subspecialty services. Kansas regulations provide standards of care which must be met by individual providers throughout the state, thus assuring that providers are qualified. Care coordination is provided to numerous individuals attending specialty clinics supported by SHS who do not meet eligibility criteria.

Program Activities

- Continue to monitor for services not accessible or affordable to CSHCN and their families.
- A family survey will be sent to families with update applications biannually. The survey will be used to determine satisfaction with SHS program services.
- Continue and expand advocacy and planning activities directed at helping families obtain services for CSHCN.

03 National Performance Measure	The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home"
Type: Capacity Category: Enabling	

4.1 Program Activities Related to Performance Measures

Relationship to Priority Needs

This performance measure relates to the following priority needs: improve access to health care for mothers and children; community needs assessment; and promote quality standards for health care. CSHCN can have very complex needs requiring the care of numerous specialists and providers. The goal of the "medical home" concept is to ensure that all children have a "medical home" where health care services are accessible, family centered, continuous, comprehensive, coordinated and compassionate.

Capacity/Resource Capability

Kansas CSHCN program provides reimbursement to the local primary care physician in addition to the child's specialist in an effort to ensure all children receive and participate in a "medical home." Utilizing a variety of specialists the local primary care physician is appropriate to coordinate the CSHCN care. SHS encourages exchange of medical reports and information between local and specialty care.

Program Activities

- Continue to encourage and track the use of local primary care physicians for those children participating in the CSHCN program.
- A task force met in November, 1998 to discuss the Kansas' definition of CSHCN. The task force will meet in the future. At this time. Kansas has informally adopted the national definition.
- Continue to survey both families and providers regarding the criteria suggested in the definition of "medical home."
- Encourage the participation of the Kansas AAP chapter in the "medical home" project in order to identify those pediatricians who have expertise working with CSHCN.

04 National Performance Measure	Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies [(e.g., the sickle cell disease) (combined)]
Type: Risk Factor Category: Population Based	

4.1 Program Activities Related to Performance Measures

Relationship to Priority Needs

This performance measure relates to the following MCH Priority Needs: improving access to health care for mothers and children; ensuring healthy births through pre- and postnatal interventions; promoting quality standards for health care; promoting quality standards for health care; and assuring quality care through provider education.

Capacity/Resource Capability

In partnership with birthing hospitals, the Kansas Health and Environment Laboratory (KHEL), and medical specialty consultant teams in Kansas City and Wichita, a system has been developed that provides for the early identification and follow-up specialty care for newborns with specific metabolic/genetic conditions. Newborn blood spot screening tests are obtained by hospital personnel, analyzed by the KHEL, and the follow-up program is carried out by the BCYF staff and the medical consultant teams.

Program Activities

- Newborn screening personnel ensure ongoing follow-up activities are carried out in a timely manner.
- Medical specialty consultants meet periodically with newborn screening staff to assure current policy and procedure.
- The KHEL links with Vital Statistics to ensure that all newborns are screened.
- Newborn screening personnel are vigilant in locating newborns with failed screens to reduce the incidence of “lost to follow-up.”
- In response to the parent advocacy group, follow-up letters are sent to parents of newborns with presumptive positive screens, and the program has expanded access to foods medically necessary for treatment.
- Consultation and educational services are provided by the medical specialty consultants and the BCYF newborn screening personnel.

- Distribute Practitioners Manual for Newborn Screening and the revised Newborn Screening Brochure.

05 National Performance Measure	Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Haemophilus Influenza, Hepatitis B
Type: Risk Factor Category: Population Based	

4.1 Program Activities Related to Performance Measures

Relationship to Priority Needs

The State Title V agency is dedicated to the prevention of disease and disability in families with young children. Vaccine preventable disease efforts are among effective public health measures to accomplish the goal of prevention of disease and disability. The target age group of birth through age 2 receives particular attention since research clearly indicates that prevention efforts facilitate healthy growth and development during the most developmental stages of a human beings life cycle. This performance measure relates to MCH priority need of improving access to health care for mothers and children.

Capacity/Resource Capability

Title V staff work in close liaison with the KDHE Bureau for Disease Prevention and Epidemiological Services, local public health agencies, the Kansas State Department of Education and the Kansas Department of Social and Rehabilitation Services as well as the Kansas Medical Society and the Kansas State Nurses Association and volunteer organizations toward ensuring that all young children in Kansas are age appropriately immunized. This is accomplished through Title V staff actively participating on the Statewide Immunization Coalition and through liaisons with the state EPSDT State Advisory Council as well as the nurse liaison provided on a consultation and technical assistance basis directly to Local Education Agencies. Operation Immunize, a statewide public health initiative, changed ts focus from statewide campaigns two or three times per year to weekly or monthly free local immunization clinics. Most local public health agencies, in cooperation with other local community health care providers and volunteer organizations, participate in this ongoing effort. Further, a statewide centralized data base is currently being piloted in several local public health agencies with the goal of insuring accurate, accessible documentation for those who need to know in order to comply with state immunization laws.

Program Activities

- Strengthen collaboration with local public schools and public health agencies to engage in public education regarding the importance of age appropriate immunization levels for all children and youth.
- Support ongoing efforts through school nurses to maintain accurate records on the Kansas Certificate for young children and to measure progress toward the state and national goal of 98% age appropriate immunization levels.
- Provide immunization updates (in-service education and training) annually through regional workshops and the statewide school nurse conference.
- Provide ongoing technical assistance and consultation related to questions and problems on immunization levels.
- Work toward the development an implementation of a centralized statewide data base on immunization levels for children and youth.
- Continue strong interagency collaborative efforts that larger maintenance of high levels of immunization compliance for all children and youth.
- Continue to support funding for disease surveillance to determine outbreaks of vaccine preventable diseases.

06 National Performance Measure	The rate of births (per 1,000) for teenagers aged 15 through 17 years
Type: Risk Factor Category: Population Based	

4.1 Program Activities Related to Performance Measures

Relationship to Priority Needs

Relationship to Priority Needs: improve access to health care for mothers and children; ensure healthy births through pre- and postnatal interventions; strategies to reduce substance abuse; address the reproductive health needs of women and men; and assure quality care through provider education.

Capacity/Resource Capability

Since 1991, BCYF has been designated as the state agency responsible for administering the teen pregnancy prevention program. This includes both primary and secondary intervention programs. Currently, there are four Teen Pregnancy Reduction Projects (primary), four Peer Education Projects (primary), and seven Teen Pregnancy Case Management Projects (secondary). The focus of the primary programs is to assist youth age 10-17 in recognizing the value in postponing sexual intercourse through educational presentations in local school systems and to community groups. The purpose of the secondary program is to provide case management services to Medicaid teens under age 21 who are currently pregnant or parenting one child. The goals of the program are to reduce the number of second pregnancies and to reduce welfare dependence. In order to achieve these goals, case managers work with clients on eight life domains: family planning and health, finances, education/training, employment, parenting, key relationships, daily living and empowerment.

Program Activities

- Monitor service system to assess and assure that services are being provided to Medicaid teens and their children.
- Continue planning and strengths-based training activities directed at assisting project staff in obtaining services for youth and families.
- Disseminate monthly information packets to project staff and advocacy groups on issues relevant to decreasing teen pregnancy rates and improving pre-natal care.

07 National Performance Measure	Percent of third grade children who have received protective sealants on at least one permanent molar tooth
Type: Risk Factor Category: Population Based	

4.1 Program Activities Related to Performance Measures

Relationship to Priority Needs

This performance measure relates to the following MCH Priority Needs: improving access to health care for mothers and children; promote community health assessment to address priority needs; improve nutritional status of mothers and children; promote quality standards; and provider education.

Capacity/Resource Capability

Title V clinics provide dental services in three Kansas communities. In many areas of the state including rural areas, access to dental care is limited or non-existent especially for low-income children. This is due to a shortage of providers and/or the reluctance of providers to accept low reimbursement rates for dental services.

In Kansas there are no current mandates to fluoridate water systems. The largest municipality in Kansas does not fluoridate its water. Kansas' rural population relies primarily on private water wells which do not provide adequate fluoridation.

Program Activities

- The WIC program at the state health department is working with local health departments on a media campaign to increase the awareness of baby bottle tooth decay.
- Kansas has an active statewide dental association which works with health care providers in increasing the awareness of oral health.
- The state department of health and environment collects information regarding dental health on the statewide behavioral risk factor survey (BRFS).
- School nurses work with their local providers in promoting oral health in school-age children by sponsoring on-site dental inspections.
- Continue WIC staff participation on the National Work Group, focused on nutritional aspects of WIC and Head Start programs and to support distribution of white papers developed by this group.
- Work with Medicaid to obtain the Medicaid paid Dental Sealants services for children age 9.

08 National Performance Measure	The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.

Type: Risk Factor
Category: Population Based

4.1 Program Activities Related to Performance Measures

Relationship to Priority Needs

This performance measure relates to the following MCH Priority Needs: access to care; community health assessment; healthy births; reduce unintentional injury to children; and provider education. Reducing unintentional injury to children has been identified as a priority need by several organizations. The Kansas Child Death Review Board has documented that about two-thirds of all child deaths in Kansas are motor vehicle-related fatalities.

Capacity/Resource Capability

The Kansas Department of Health and Environment has a very active statewide Kansas SAFE Kids Coalition which provides support to over 15 SAFE Kids Chapters and coalitions at the community level. In addition two SAFE Communities projects have focused on a broad goal of prevention/reduction of unintentional injuries in children and families. The KDHE Healthy Kansas 2000 process has also identified injury control and prevention as one of seven priority needs in Kansas. The Trial Lawyer Association has become member of the SAFE Kids Coalition in the past year.

Program Activities

- "Please Be Seated" program - a statewide citizen reporting system in which owners of motor vehicles are sent reminders of the primary child safety seat law in Kansas and discount coupons for child safety seats. Currently unfunded.
- Promotion of bike helmets at low cost through schools, churches, hospitals, health departments, parks and recreation departments by the Kansas SAFE Kids Coalition.
- Community groups and businesses are sponsoring child safety seat checks to increase awareness of the need for proper installation of safety seats. Training and support for this effort are provided by the Kansas Safety Seat Belt Office.
- Through the SAFE Communities project, traffic crash data is being linked from the scene of the crash through the rehabilitation process, if appropriate. This increases the awareness about the importance of injury prevention programs, points to priority community needs, and helps direct resources and evaluation of injury prevention efforts.
- Collaborate with Office of Local and Rural Health on state trauma plan mandated by 1999 legislature and funded through proportional share of all traffic fines collected in the state.
- Collaborate with and support statewide efforts to increase compliance in the use of safety seats and booster seats. KDOT is the primary funding source for this effort.

09 National Performance Measure	Percentage of mothers who breastfeed their infants at hospital discharge
Type: Risk Factor Category: Population Based	

4.1 Program Activities Related to Performance Measures

Relationship to Priority Needs

Related to MCH priority needs: access to care; community needs assessment; improving the nutritional status of mothers and children; and provider education. The advantages of breastfeeding are indisputable and include nutritional, immunological and psychological benefits to both infant and mother, as well as economic benefits.

Capacity/Resource Capability

The Kansas Chapter of the American Academy of Pediatrics (AAP) has designated Nancy Powers, MD as Kansas AAP Breastfeeding Coordinator. MCH staff have been working with Dr. Powers and the Kansas Breastfeeding Coalitions to promote consistent and integrated breastfeeding messages across Kansas. It is our intent to build on these relationships.

Program Activities

- Maintain current communication and information flow with the variety of state and community agencies that provide breastfeeding support to the breastfeeding dyad.
- Continue collaboration with the Kansas AAP Breastfeeding Coordinator.
- Work with media to highlight breastfeeding in a positive light at every opportunity. This will broaden audiences that were covered during the 1999 and 2000 World Breastfeeding Week campaign.
- Target businesses and restaurants for outreach to encourage a supportive environment for breastfeeding mother.
- Work at increasing the number of breastfeeding coalitions across the state and communication between the coalitions.
- Broaden the statewide community referral network to include more communities in Kansas.
- Collaboration with the Perinatal Association of Kansas to promote breastfeeding through Kansas hospitals. This includes the support of baby friendly hospital practicies.

10 National Performance Measure	Percentage of newborns who have been screened for hearing impairment before hospital discharge.
Type: Risk Factor Category: Population Based	

4.1 Program Activities Related to Performance Measures

Relationship to Priority Needs

This performance measure relates to the following MCH priority needs: improving access to health care for mothers and children; ensuring healthy births through pre- and post natal interventions; promoting quality standards for health care; and assuring quality care through provider education.

Capacity/Resource Capability

Kansas legislation to screen every newborn is for risk for hearing loss was repealed as of July 1, 1999,, and was replaced by the law requiring newborn infant hearing screening.

Program Activities

- Birth hospital personnel will implement universal newborn hearing screening statewide.
- Some birth hospital personnel will also continue to screen newborns for risk for hearing loss to provide information concerning progressive, late onset and acquired hearing loss.
- Educational materials including developmental milestones and what to do if the newborn is identified as at risk for hearing loss continue to be distributed by hospitals. New brochures informing families about the results of their newborn's hearing screening will be developed.
- BCYF staff provide technical assistance to hospital personnel planning to implement universal newborn hearing screening (unhs). Use of trainig via interactive TV (Telemedicine) will be implemented.
- Kansas continues to take part in MCH grant activities to promote unhs and follow-up early intervention (assessment and intervention).
- Guidelines for newborn hearing screening, audiologic assessment, medical assessment, amplification and a resource guide for early intervention for families of infants with confirmed hearing loss will congtinue to be distributed. Regulations will be developed and approved..
- BCYF staff link with the Kansas Commission for the Deaf and Hard of Hearing (KCDHH) for continued support and imput into the implementation process.

11 National Performance Measure	Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care
Type: Capacity Category: Infrastructure Building	

4.1 Program Activities Related to Performance Measures

Relationship to Priority Needs

This performance measure addresses the priority needs of improved access to health care for mothers and children and community health assessment.

Capacity/Resource Capability

Kansas CSHCN program has been tracking insurance coverage for those children receiving case management services from SHS for many years. We are in the process of obtaining this information on all children accessing the services of SHS in a broader fashion. This will include tracking those children receiving care at SHS supported specialty clinics and hemophilia patients. During FY97 information was gathered on the total number of children served by SHS clinics, but insurance information was not available for a number of the children.

Program Activities

- Maintain current system of tracking insurance information for children receiving case management services from SHS.
- Utilize information in program development found by tracking those children seen in specialty clinics supported by SHS with the revised reporting form which includes information on all patients seen, insurance and SSI status.
- Monitor the impact and coverage of “Health Wave,” Kansas’ CHIP Program, for CSHCN.

12 National Performance Measure	Percent of children without health insurance
Type: Capacity	
Category: Infrastructure Building	

4.1 Program Activities Related to Performance Measures

Relationship to Priority Needs

This MCH performance measure relates to the state priority needs of improving access to care for mothers and children, and community needs assessment.

Capacity/Resource Capability

In FY 96, an estimated 60,000 children and youth in Kansas were underinsured or uninsured for health care. (This Census estimate drops to 52,000 for FY 97. In FY99 the estimated census of children continues to drop to 42,000. See Form 11, NPM 12.) This constitutes about 6% of all children under 19 years of age. The federal CHIP legislation provided $31 million to target those families whose children are uninsured or underinsured for health care. The State of Kansas was required to provide a match in the amount of $12 million which guarantees $43 million directed toward these families. Actual payments began in January 1, 1999. To assist in identifying and enrolling families with children the Kansas Department of Health and Environment, Bureau for Children, Youth and Families staff has entered into a collaborative partnership with the Kansas Department of Social and Rehabilitation Services and the Kansas State Department of Education.

Program Activities

- Support and promote outreach activities in local education agencies through school nurses, school social workers, and school psychologists.
- Encourage teachers to assist in enrollment efforts during parent/teacher conferences.
- Provide in-service to school and public health agency staff so they understand the process for enrolling and specifics about the health insurance program.
- Enlist public health agency staff to inform families, to enroll them during clinic visits and to engage in public educational efforts.
- Work on an interagency basis to establish an ongoing system, including public education effort, for enrolling families during contacts and interactions with them.
- Collaborate with the Department of Social and Rehabilitation Services to monitor progress toward enrolling all children in the child health insurance program.

13 National Performance Measure	Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.
Type: Process Category: Infrastructure Building	

4.1 Program Activities Related to Performance Measures

Relationship to Priority Needs

This performance measure relates to the following MCH Priority Needs: improving access to health care for mothers and children; improve nutritional status of mothers and children; reduce unintentional injury to children; and reduce intentional injury.

Capacity/Resource Capability

Kansas has a well-developed and established network of health care providers that provide for the health care needs of Medicaid eligible children. The KDHE/BCYF has an interagency agreement with SRS/Medicaid which outlines the role of Title V funded local agencies in identifying Medicaid eligible women and children and assisting them with enrollment procedures.

Program Activities

- Increase efforts to provide outreach and education to families, to enroll Medicaid eligible children in the program, and to promote use of health services.
- Streamlining the application process.
- Educate families of children who receive either free or reduced school lunches receiving information.
- Information packets on health care coverage provided in day care settings and in schools.
- Presentations at statewide meetings regarding the changes in Medicaid enrollment.
- Streamline certification process for local health department nurses who perform child health assessments.
- Provide information to local MCH agencies on roles and responsibilities, and coordination with MCO's through Statewide teleconference.

14 National Performance Measure	The degree to which the State assures family participation in program and policy activities in the State CSHCN program
Type: Process Category: Infrastructure Building	

4.1 Program Activities Related to Performance Measures

Relationship to Priority Needs

This performance measure will address the Kansas priority need of ensuring quality standards and provider education. Family participation with policy and program activities will ensure the use of family centered care for CSHCN.

Capacity/Resource Capability

Kansas CSHCN program has parent members on their Special Bequest Advisory Commission. CSHCN works with the state Parent to Parent (Families Together, Inc) organization regarding consultation needs of the program. Family participation was assessed on a very subjective basis for this grant. It will be necessary to develop a more quantitative method for determining family participation.

Program Activities

- A task force consisting of parents and CSHCN staff is meeting to develop quantitative measures for the six characteristics evaluated.
- CSHCN have a contract in place with Families Together, Inc to increase the use of family members in SHS policy development and program activities. Other activities involved with include: needs assessment process, MCH block grant discussion and review, focus groups regarding SHS, assessment of specialty clinics in the state, inservice presentations, and attendance at staff meetings.

15 National Performance Measure Percent of very low birth weight live births

Type: Risk Factor
Category: Infrastructure Building

4.1 Program Activities Related to Performance Measures

Relationship to Priority Needs

This MCH performance measure has multiple priority need relationships. Primary relationships are with MCH priority needs: access to care; community needs assessment; healthy births through pre- and postnatal interventions; strategies to reduce substance abuse; reduce intentional injury; address the reproductive health needs of men and women; promote quality standards for health care; and assure quality care through provider education.

Capacity/Resource Capability

There has been little change in the percent of low and very low birth weight live births in Kansas, to include the ongoing negative disparity for Black births over the last decade despite the implementation of multiple public and private strategies. These strategies have included, but are not limited to: identification of pregnant women at risk for pre-term labor and provision of risk related education, and nursing and medical management; efforts to increase accessibility to obstetrical services through the expansion of public health related reproductive services; favorable changes in Medicaid eligibility, expedited receipt of the medical card, and expansion of managed care; and, multi-media campaigns such as the Baby Your Baby initiative. Based on data that supports an increased risk for the delivery of low birth weight infants by adolescents, minority populations, low income families, substance users, and those who have less than a high school education, priority has been given to these populations by public health M & I services, in collaboration with the WIC, Family Planning and Healthy Start home visiting services throughout the State. In addition, a provider driven perinatal referral system that facilitates access to inter-city/county/regional consultation between primary obstetrical care providers and speciality maternal-fetal medicine professionals has served as a resource component for assuring access to risk-appropriate medical care and interventions.

Program Activities

- Continue monitoring of resident and hospital occurrence data relating to percent of very low birth weight live births.
- Continue comparison of birth weight outcomes for live births delivered by women receiving comprehensive case management through the public health maternal and infant services, Medicaid

recipients who are in a primary care versus HMO managed care system, and the at large live birth population.

- Continue public health M & I services, Healthy Start home visiting, WIC, and Family Planning services across Kansas to facilitate access to reproductive health, health education, and supplemental food program services that have a positive risk reduction impact.
- Continue distribution of annual Perinatal Outcome Data and Accuracy of Perinatal Utilization Index report to all in-patient obstetrical facilities for their use in evaluating appropriate management and referral of high-risk maternal/fetal cases to speciality and subspeciality perinatal care providers/centers.
- Continue adolescent pregnancy risk reduction efforts and abstinence education programs that have the potential to decrease the number of adolescent pregnancies and subsequent delivery of low and very low birth weight infants.
- Continue the use of strategies to identify women at risk for pre-term delivery and/or delivery of a low or very low-birth weight infants and referral to risk appropriate services such as substance use counseling and/or in-patient treatment.
- Support of federal Healthy Start projects and initiatives.

16 National Performance Measure	The rate (per 100,000) of suicide deaths among youths aged 15-19

Type: Risk Factor
Category: Infrastructure Building

4.1 Program Activities Related to Performance Measures

Relationship to Priority Needs

This performance measure relates to the following MCH Priority Needs: promote community health assessment to address priority needs; healthy births; initiate strategies to reduce substance abuse; reduce intentional injury through family supports and interventions; and address reproductive health needs of men and women.

Capacity/Resource Capability

BCYF coordinated with SRS' MH/RS in order to assess adolescent health needs ("1995 KAHA Adolescent Health Profile"). A priority need as identified in the report was adolescent suicide prevention strategies. Since the release of the report there have been ongoing interventions at both the state and local levels.

Program Activities

- Training for educators and school nurses about suicide prevention measures for school age children.
- Development of a statewide injury prevention plan through a federal grant, with suicide prevention as a primary need.
- Training for Title V staff through the National Conference on Suicide Prevention.
- Training for community health service providers on identification of at-risk youth.
- Emphasis on counseling services delivery at school-linked clinics.
- Assessment and implementation of family-centered assessments and services.
- Assessment of community mental health needs through the CHAP process.
- Finalize and disseminate state plan as a part of the followup from the Regional Conference.
- Support family advocacy for Governor's proclamation of Adolescent Suicide Prevention week.
- Followup on activities identified at the September 2000 conference.

17 National Performance Measure	Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
Type: Risk Factor Category: Infrastructure Building	

4.1 Program Activities Related to Performance Measures

Relationship to Priority Needs

This MCH performance measure has a primary relationship with the priority need to promote quality standards for health care. There is a secondary relationship with improving access to health care for mothers and children; ensuring healthy births through pre- and postnatal interventions; and reproductive health needs.

Capacity/Resource Capability

Kansas has a working provider driven perinatal referral system that facilitates access to inter-city/county/region consultation between primary obstetrical care providers and speciality maternal-fetal medicine professionals. This system includes five hospitals across the state that are self-designated sub-speciality (previously known as Level III Perinatal Centers) perinatal centers that provide out- and in-patient high risk obstetrical/fetal and neonatal services. These hospitals are Columbia Wesley Medical Center, Wichita; Via Christi-St Francis, Wichita; Stormont Vail Regional Medical Center, Topeka, Columbia Overland Park Medical Center, Overland Park and University of Kansas Bell Memorial Hospital, Kansas City. Obstetrical care providers in both the public and private sectors are utilizing a variety of methods to identify those women who are at risk for preterm deliveries or other complications that would lead to the delivery of a low birth weight or very low birth weight infant. In the absence of a formal regional perinatal program, the Perinatal Association of Kansas (PAK) is attempting to improve communication between and among basic, speciality and sub-speciality perinatal centers. The data set relating to the number and percent of very-low birth weight infants delivered in the self-designated sub-specialty perinatal centers is in place. There is not, however, a method to collect data relating to whether this was a planned or unplanned delivery of the very low birth weight infant at the sub-speciality center which would validate whether the referral/consultation system is comprehensive. Three of the sub-specialty perinatal centers have formalized perinatal transport systems to maximize the potential for the delivery of referred high-risk obstetrical cases at their centers.

Program Activities

- Continue monitoring of resident and occurrence data relating to delivery site for very low birth weight infants.
- Continue distribution of the annual perinatal casualty report to all in-patient obstetrical facilities for their use in evaluating appropriate transfer of high-risk maternal/fetal cases to speciality or sub-speciality perinatal centers.
- Identify established referral patterns from basic and speciality perinatal centers where the delivery of very low birth weight infants are anticipated and availability of transfer criteria and obstetrical care management protocols are in place.
- Work with sub-speciality perinatal centers to identify the number of obstetrical cases where there were non-emergency and emergency obstetrical transfers.
- Evaluate the potential for a review system that could evaluate the capacity of existing speciality centers and transition into a sub-speciality center based on a perinatal system needs assessment in cooperation with the Kansas Hospital Association and the Perinatal Association of Kansas.
- Work with Perinatal Association of Kansas to develop a plan for a study comparing outcomes between infants transferred into a subspecialty center versus those delivered in a subspecialty center.

18 National Performance Measure	Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.
Type: Risk Factor Category: Infrastructure Building	

4.1 Program Activities Related to Performance Measures

Relationship to Priority Needs

This MCH performance measure has multiple priority need relationships. The primary relationship is with the priority need of improving access to health care for mothers and children. Secondary relationships are with the remaining MCH Priority Needs. It is assumed that the remaining nine MCH priority needs could be addressed if women can and will access prenatal care during the first trimester and remain in that care for the rest of the pregnancy. During that care appropriate risk assessments and referrals will be initiated. General health, reproductive, and parenting education will be provided, and quality health care services will be available.

Capacity/Resource Capability

There has been a gradual increase in the percent of women receiving care during the first trimester during the last decade. In addition, there has been a decline in the number of women who obtain no prenatal care. As a part of the community health needs assessment being implemented across the State, local entities have been charged with identifying barriers to obstetrical service in relation to provider, system, and consumer driven barriers. With the increasing number of undocumented citizens in many areas of the State, there are problems assisting these pregnant women to access prenatal care services either for financial or culturally perceived reasons. There continue to be areas of the State where pregnant women must travel outside their counties of residence to obtain prenatal care, but this barrier is gradually being removed by the initiation of group obstetrical or family practice outreach clinics. The MCH Block grant funded maternal and infant public health clinics/case management services are available in 77 Kansas counties to reduce barriers to care, incidence of low birth weight live births and incidence of adolescent pregnancy. Close collaboration with private health care providers and among public health programs such as Maternal & Infant/Perinatal, Healthy Start home visit program, WIC, Family Planning, and Teen Pregnancy Prevention and Case Management Programs facilitate referral of women to financial and obstetrical services. The Kansas Medicaid Program works closely with MCH in their development and implementation of outreach, case management, and risk based nutrition and social work services to assure access to prenatal care and compliance with care. The Make a Difference Information Network (MADIN), a toll-free line, is available

to provide pregnant women information on resources that will facilitate their access to medical prenatal care and related services.

Program Activities

- Continued monitoring of prenatal care entry and compliance trends for all races and maternal age populations through data obtained from the live birth and fetal death certificate data sets.
- Continued distribution of the annual Perinatal Outcome Data and Accuracy of Perinatal Utilization Index report to all in-patient obstetrical facilities for use in evaluation of prenatal entry and potential identification of system, provider, or consumer barriers to care.
- Continue collaborative efforts with the Medicaid agency in designing outreach and case management strategies to assure entry into and compliance with prenatal care for the Medicaid pregnant woman.
- Evaluate the impact of the HealthWave initiative on increasing access to insurance coverage for eligible adolescents who are pregnant.
- Continue public health M & I services, Healthy Start home visiting, WIC and Family Planning services across Kansas to facilitate identification of women at risk for not entering and/or complying with the prenatal care continuum.
- Continue collaborative work with the Farmworker Program to assure access to prenatal care services for this at risk population.
- Support, as funds are available, public media initiatives addressing the importance of prenatal care.
- Distribute federally prepared print materials, e.g., Healthy Start Initiative, which publicize a toll-free line and ultimately connects with the Kansas MADIN toll-free line.
- Continue the inclusion and use of the "Perinatal Services Needs Assessments, Planning and Evaluation" standard in Volume I, Maternal and Infant/Perinatal, Children and Families Health Services Manual, published by the Children and Families Section, Bureau for Children, Youth and Families, KDHE.
- Provide technical assistance to Title V M & I clinics in their development of translation services and print materials, with an emphasis on the Spanish language.

08 State Performance Measure	Ratio of Densely-Settled Rural Kansas APNCU to Hispanic APNCU

Type: Risk
Category: Direct Health Care Services

4.1 Program Activities Related to Performance Measures

Relationship to Priority Needs

This performance measure relates directly to the priority need for improvement of access to all aspects of primary health care. Indirectly, this measure relates to the system of coordination and removal of categorical programs and funding. Densely-settled rural is defined as a county population density of 20 - 39.9 people per square mile. There are 20 counties that fit this description: (Finney, Seward, Ellis, Barton, McPherson, Sumner, Cowley, Dickinson, Pottawatomie, Lyon, Atchison, Jefferson, Allen, Neosho, Labette, Cherokee, Bourbon, Doniphan, Ford, Osage)

Capacity/Resource Capability

In the 19 counties there are 15 M&I projects: 8 provide case management services; 2 provide case management and medical services; and 5 provide referral services. Family Planning services are present in18 of the identified counties: 16 provide clinic services and 2 provide referral services. There are many hospitals providing birthing services, as well as, one birthing center. Of those hospitals, five have been identified as providing services for high-risk clients. Numerous private physicians provide prenatal care.

Program Activities

- Continue the distribution of the Perinatal Outcome Data and Accuracy of Prenatal Utilization Index (APNCU) report to hospitals and other expressing an interest in the document.
- Continue support of the M&I, Family Planning, and Teen Pregnancy projects and develop new programs and/or increase services provided by existing projects.
- Support the 2010 Disparity Initiative to improve pregnancy outcomes for the identified population.
- Increase availability of education materials to the Hispanic population using conventional and non conventional methods in consultation with the Farmworker Program and Refugee program staff.
- Review and modify the number and content of the educational materials in the Kansas Public Health Information and Education Library at Kansas State University available to Kansans.

09 State Performance Measure	MCH Data, Epidemiologic and Analysis Capacity Scoring

Type: Capacity

4.1 Program Activities Related to Performance Measures

Relationship to Priority Needs

This measure relates to the priority to increase data infrastructure, epidemiological capacity and products of analysis for improved state and community problem-solving. Indirectly this measure will impact all of the priority needs as the MCH capacity is increased.

Capacity/Resource Capability

MCH programs have data resources available through the Center for Health and Environmental Statistics, Vital Statistics section on a regular and on-call basis. This data is aggregate data. The newborn screning programs have linkages with the Neonatal Screening Section, Health and Environmental Laboratory, which links births in Kansas with children screened for the required conditions. The data is child specific. The Children and Families Section, Bureau for Children, Youth and Families (BCYF), has an integrated reporting system for the M&I, Family Planning, and Healthy Start Home Visitor programs and the school-linked clinic projects. This data is aggregate data. The CHSCN Section, BCYF, has a child specific data base which contains case management information on children receiving services and an electronic linkage with the SRS Medicaid data system. WIC and Infant - Toddler Services are developing automated statewide data systems. Kansas has a passive birth defects reporting system. The physicians and hospital are required by regulation to report children with birth defects. This is child specific data, incomplete data and not available for use in program service delivery.

The following tool will be used to score the capacity for this performance measure in future years. The baseline score is 23 of 56.

MCH Data, Epi, and Analysis Capacity

0 = This function has not yet been institutionalized.
1 = The development of this function has begun.
2 = This function is performed sporadically, but data is incomplete and/or quality is questionable.
3 = The development of this function is in-process, and significant progress has been made towards institutionalizing this function.
4 = This function is performed regularly. However, the data is incomplete and/or quality is questionable.
5 = This function is performed sporadically, and the data is complete with acceptable quality.
6 = This function is performed regularly, and data is complete and of acceptable quality.
7 = Quality data is provided regularly, and MCH program staff have the ability and resources to obtain special analyses for programmatic and policy purposes.
8 = Quality data is provided regularly, and epidemiological, statistical, and information systems

resources are readily available to MCH program staff to assist with analyzing and interpreting standard and special reports.

A.	*Linkage of infant birth and infant death certificates*	*7*
B.	*Linkage of birth certificates and Medicaid claims files*	*1*
C.	*Linkage of birth records and WIC eligibility files*	*0*
D.	*Linkage of birth records and newborn screening files*	*7*
E.	*Hospital discharge survey with at least 90% of in-patient discharges*	*2*
F.	*At least 90% of hospital discharges E-coded*	*1*
G.	*Annual birth defects surveillance system*	*0*
H.	*Survey of adolescent health behaviors (YRBS) at least every two years*	*4*
I.	*Identify all CSHCN in the state*	*1*
Total (56 possible)		*23*

Program Activities:

- Increase capacity to link data bases between MCH, FP, WIC, IT, and other MCH related programs to provide aggregate numbers.
- Hire an epidemiologist to focus on data production, analysis and planning for MCH and MCH related programs, using funds from multiple funding streams to support the position and to have the position housed with the MCH program staff.
- Continue CSHCN electronic linkage with the Medicaid information systems at the Central and Field offices and develop the same capability with other state level MCH programs needing client based data.
- Encourage KSDE to implement the YRBS statewide and analysis the data or investigate transfering the YRBS activity to KDHE
- Increase linkages with Kansas Hospital Association to obtain additional hospital discharge and other data necessary for MCH program planning needs.

10 State Performance Measure	Percent under age 4 children involved in motor vehicle creases using proper child safety equipment

Type: Risk
Category: Population Based Services

4.1 Program Activities Related to Performance Measures

Relationship to Priority Needs

This measure relates to the priority to reduce unintentional injuries. Indirectly, this relates to systems coordination and removal of barriers caused by categorical programs and funding and to access to primary care and all aspects of care for CSHCN.

Capacity/Resource Capability

Kansas Department of Transportation (KDOT) funds and supports car seats and booster seat activities across the state. SAFE Kids Coalition is promoting the passage of a statute that would allow law enforcement officers to cite individuals for not using a seat belt - a primary seat belt law. Hospitals require that all infants being discharged after birth be placed in car seats. Some hospitals make car seats available for purchase at the hospital. The Safety Belt Education Office provides "train the trainer" education on the proper use of seat belts and provides opportunities for the general public to have their use of seat belts checked for proper usage. General Motors has provided to Kansas a van that goes around the state providing education related to child safety seats. Insurance on the vehicle has been provided by State Farm Insurance. This activity began January, 2000.

Program Activities:

- Provide support and consultation to Child Care Facilities Inspection and Licensing Section, Bureau of Consumer Health, to update the regulations to make them reflective of the current recommendations of the National Highway Traffic and Safety Board.
- Coordinate with the facilities providing care for CSHCN to assure that appropriate car restraints are available for use of the child with disabilities. A focus will be with the tertitary care centers on the care restraints needed for short term use, such as while a child is in a cast following surgery.
- Assure that appropriate educational materials are maintained in the Kansas Public Health Information and Education Library, in conjunction with KDOT, SAFE Kids and other programs with the focus on child safety in cares.
- Monitor the availability of car restraints available through the Assistive Technology Program equipment bank.
- Provide staff support to the "Please be Seated" program.

11 State Performance Measure Violent acts per 100 enrolled students, 6th through 9th grades

Type: Risk
Category: Population Based Services

4.1 Program Activities Related to Performance Measures

Relationship to Priority Needs

This measure relates directly to the intentional injury priority. Indirect relationships are to behavioral health and systems coordination.

Capacity/Resource Capability

Schools are required to report incidents of school violence toward teachers and other students, following state statute/regulation and local school district policy. The KDHE school nurse consultant looks at the school nurse role and methods to address the issue and is available for consultation to the Kansas State Department of Education (KSDE) and local schools. A BCYF staff person is a member of the Special Education Advisory Council, KSDE.

Program Activities

- Assist Child Care Facilities Inspections & Licensing Section, bureau of Consumer Health to develop regulations for After School programs for the target population.
- Work with the Office of Local and Rural Health to assure that the Community Health Assessment Process identify programs/activities for the target population.
- Increase linkages with the Juvenile Justice system to identify data needs and develop program standards of care for use in the institutions.
- Collaborate with the Attorney General's Office in offering community education on bullying.

12 State Performance Measure Percent Overweight WIC children, aged 36 - 59 months

Type: Risk
Category: Population Based Services

4.1 Program Activities Related to Performance Measures

Relationship to Priority Needs

This measure relates to the priority to increase proper nutrition/physical activity. Indirectly this measure relates to access to primary care and all aspects of health care for CSHCN, oral health capacity, behavioral health and systems coordination.

Capacity/Resource Capability

The capability and resource capability includes schools, school nurse activities, WIC program, EPSDT, Head Start, local public health departments and Kansas LEAN program. Physicians, also, provide services related to nutrition and physical activity. The Kansas Council on Physical Fitness has a Kansas Kids Fitness Day yearly in which 50% of all third graders participate. Kansas LEAN Preschool Task Force has a grant from Kansas Child Care Training Organization to develop a lesson on the interrelatedness of physical activity and nutrition. This curriculum is geared to child care providers in Kansas. Forty Kansas counties participate in the Chronic Disease Risk Reduction grants. These grants provide local health departments with an avenue for the lead role in community activities supporting physical activity. The Kansas Nutrition Network goal is to educate all Kansans about resources for good nutrition and physical activity.

Program Activities

- Support the nutrition education and/or nutrition assistance programs of the Kansas Nutrition Network and the Kansas LEAN Preschool Task Force.
- Provide training for staff who work with parents on healthy eating, physical activity and nurturing for children, included but not limited to, school nurses, EPSDT providers, Head Start staff, Healthy Start home visitors, Parents as Teachers staff.
- Encourage KSDE to implement the YRBS statewide and analysis the data or investigate transferring the YRBS activity to KDHE
- Review and modify the number and content of the education materiels held in the Kansas Public Health Information and Education Library at Kansas State University for distribution to Kansans.
- Develop a system to collect baseline data on Body Mass Index in selected groups of children using the new height/weight graphs.
- Develop a system of education and training on utilization of the new height/weight graphs.

13 State Performance Measure	Percent of Kan Be Heathy (KBH) (EPSDT) - eligible children aged 6 -9 years who have received at least one dental screen.

Type: Process
Category: Enabling Services

4.1 Program Activities Related to Performance Measures

Relationship to Priority Needs

This measures relates to the oral health capacity priority. Indirectly it relates to systems coordination, nutrition/physical activity and behavioral health.

Capacity/Resource Capability

KBH programs participation is required of all Medicaid eligible persons 0 - 21 years of age. There is a shortage of dentist, especially in the more rural areas of the state. Of these dentists, few are EPSDT providers. There are dental schools in Kansas City, MO and Omaha, NB ,however, there are not dental schools in Kansas. Both University of Missouri, Kansas City and Creighton, Omaha have recently increased the number of student slots that can be filled by Kansas residents, it is too soon to see an increase in the dentist population in Kansas.

Program Activities

- Continue education/referral to KBH for all MCH and MCH supported and related programs.
- Continue to increase the student slots available for Kansas residents at the nearby dental schools.
- Identify local dentists accepting Medicaid reimbursement and disseminate their names to the appropriate referral sources.
- Initiate tracking of dental screens by the CSHCN program utilizing their access to the Medicad automated information services and make appropriate referrals.
- Support the creation of the position of Dental Director to focus on the development of the oral health capacity including, but not limited to, coordination with programs serving the MCH population, schools, SRS program. Multiple funding streams, potentially from multiple agencies, could be used to support this position and activities.
- Develop a system to monitor school based dental inspection programs and the number of students screened.
- Continue participation/representation in the United Methodist Health Ministries activities and funding of projects on dental sealants
- Support school nurses in provision of classroom nutrition and dental health education.

Type: Capacity
Category: Infrastructure Building Services

4.1 Program Activities Related to Performance Measures

Relationship to Priority Needs

This Measure relates to the priority to develop behavioral health infrastructure. Indirectly there are relationships to CSHCN access, intentional injuries and systems coordination.

Capacity/Resource Capability

School nurse consultant collaborates and coordinates activities with KSDE and provides health perspecitve into school policies and regulations. KSDE has data related to Special Education behavioral data. SRS oversees service delivery to various populations. There is full coverage of the state by the mental health centers. There are three residential centers for persons with mental health diagnoses; two of which serve children. SRS has a Seriously Emotionally Disturbed Home and Community Based Waiver from HFCA which provides enhanced services for the child at home in an effort to keep them out of the residential setting. Kansas is one of very few states with this waiver. Keys for Networking, a resource for families and individuals with mental health diagnosis, focuses on delivery of services for persons with mental health diagnosis and advocates for change. Families Together, Inc (parent to parent organizations) also, assists families to find services and advocates as needed.

The following tool will be used to score this measure. The baseline is a score of 18 out of 65, leaving a lot of room for improvement.

Behavioral Health Infrastructure Scoring Tool

For all indicators, use the following scale:
0 = No
1 = In-process
2 = Yes, partially
3 =Yes, mostly
4 = Yes, completely
5 = Yes, and we are able to continue this function on an on-going basis

***A. Behavioral Health Resources**: **Who are the resources? Where are the services?** Ability to identify behavioral health resources.*

1. ***Provider availability*** 1
   We have comprehensively identified behavioral health providers (e.g., psychiatrists, clinical psychologists, social workers, registered professional counselors, marriage & family therapists) FTEs by practice location.
2. ***Practices and organizations offering behavioral health services*** 1
   We have comprehensively identified practices and organizations offering behavioral health services, particularly those serving children and adolescents.
3. ***Safety net providers*** 1
   We have comprehensively identified safety-net behavioral health providers, i.e., those serving the Medicaid population or those with sliding fee scales.

Behavioral Health Resources Subtotal (15 points possible) 3

***B. Behavioral Health Utilization**: **Who is using the services? To what level?** Ability to identify utilization of behavioral health services by the following population groups.*

1. ***Low Income / Medicaid*** 0
   We have comprehensively identified the utilization of behavioral health services by the low income / Medicaid population.
2. ***Children and Adolescents, including CSHCN*** 1
   We have comprehensively identified the utilization of behavioral health services by Children and Adolescents, including CSHCN.
3. ***Women, especially Pregnant and Postpartum Women and Mothers*** 2
   We have comprehensively identified the utilization of behavioral health services by women, especially pregnant and postpartum women and mothers.

Behavioral Health Utilization Subtotal (15 points possible) 3

***C. Behavioral Health Status**: **What is the <u>need</u> for services?** Ability to identify need for behavioral health services by measuring the general behavioral health status of the following population groups.*

1. ***Low Income / Medicaid*** 2
   We have identified the behavioral health status of the low income / Medicaid populations.
2. ***Children and Adolescents, including CSHCN*** 2
   We have identified the behavioral health status of children and adolescents, including CSHCN.
3. ***Women, especially Pregnant and Postpartum Women and Mothers*** 2
   We have identified the behavioral health status of women, especially pregnant and postpartum women and mothers.

Behavioral Health Status Subtotal (15 points possible) 6

***D. Integration of Behavioral Health into Public Health Infrastructure**: **How can we help meet the needs?** Presence and integration of behavioral health into KDHE programs and planning.*

1. ***Identification of Stakeholders*** 1
   We have identified and contacted stakeholders in key agencies and organizations in the

state who are addressing behavioral health issues. We understand and can clearly articulate their views related to behavioral health in Kansas.

2. ***Collaboration with Stakeholders*** *1*

We have established a working relationship (informal or formal) with behavioral health stakeholders and can identify specific collaborative efforts (e.g., service on advisory groups, joint program activities, etc.) related to each identified population group (low income, children, women).

3. ***Presence in Program Activities*** *2*

Behavioral health issues have a presence in program planning for the following KDHE programs: Family Planning, Maternal and Infants, Infant - Toddler, Child Health, CSHCN, School Health, Teen Pregnancy, WIC, and Primary Care (including Farmworker and Refugee programs).

4. *Working Referrals at Local Levels* *2*

Local Health Departments can and do regularly refer clients to safety net behavioral health providers as needed.

Integration of Behavioral Health Subtotal (points possible) ***6***

Behavioral Health Infrastructure Score (65 points possible) ***18***

Program Activities

- Collaborate with relevant agencies and organizations to identify statewide resources and system gaps, including but not limited to, the agencies who license individuals working in the mental health arena, KSDE, KDHE entities.
- Continue educational offerings on mental health issues for school and community health nurses on role expansion, skills development, early identification, referral and followup.
- Collaborate with the Bureau of Health Facility Regulation, Mental Health/Residential Facilities Program to provide input regarding the MCH populations into the development of policy and regulations.
- Encourage the Department of Insurance to require increased coverage for mental health services by all insurance companies, in conjunction with public and private organizations and the community of persons with mental health diagnosis.

15 State Performance Measure	Observed to Expected Kan be Healthy (KBH) (EPSDT) screening ratio for infants under1

Type: Process
Category: Enabling Services

4.1 Program Activities Related to Performance Measures

Relationship to Priority Needs

This measure relates to coordinated systems of care priority. Indirectly, this measures relates to intentional and unintentional injuries, nutrition/physical activity, oral health capacity and behavioral health.

Capacity/Resource Capability

SRS is required by Kansas statute to have a statewide managed care systems for their clients, including the KBH population. Recent changes have been made which require a referral from a Primary Care Physician (PCP) before a local health department provider can perform an EPSDT screening and receive reimbursement for the screening. The experience to date is that the PCPs are not making referrals nor are they providing timely screenings themselves. Transportation for families to the EPSDT provider is problematic for some families.

Program Activities

- Continue participation and advocacy for the children/families by the MCH staff on the KBH Advisory Committee
- Continue active referral by the local M&I, Healthy Start, WIC programs and by CSHCN for EPSDT screenings.
- Support other collaborative programs, i.e. Infant - Toddler Services, and Parents as Teachers programs to continue to make referrals.
- Monitor the availability of EPSDT providers.
- Review the EPSDT data, utilizing the core public health functions as a basis.

4.2 Other Program Activities

Direct Health Care Services

1. Pregnant Women and Infants

Seven Title V local agencies provide on site comprehensive prenatal care, to include obstetrical medical care by physicians or nurse midwives, nursing case management and services of a registered/licensed dietitian and licensed social worker and direct collaboration with WIC and the Kansas home visiting program, Healthy Start. The remaining sites assist the clients to access obstetrical medical care in the private sector, either through direct referral with the client assuming the financial responsibility (private pay or Medicaid) or by providing limited financial assistance to cover physician, lab and select antepartal testing. At the time of enrollment in these public health services in 1997, 34.9% of the pregnant women had a medical card (Medicaid) at the initial enrollment in the program. Subsequently, many were referred for eligibility determination to Department of Social and Rehabilitation (SRS). The birth outcomes for the Title V prenatal clients have been better than the State birth population, specifically in the area of low birth weight.

2. Children and Adolescents

Child health assessments, screenings and other clinical and dental services are provided to children by Title V local agencies. School entry physicals are required of all new school entrants under age nine. Many of the local projects hold "Kindergarten Roundups" during which the communities come out to help with assessments. This has proven a very effective program in assuring a medical/health home for Kansas school children and in providing baseline medical/health information to school nurses for continuing health supervision of the children in their schools. In addition to these efforts, school-based preventive and primary care is provided through three local projects. The projects are located in Geary County and in low-income areas of Wyandotte (Kansas City) and Sedgwick (Wichita) counties.

3. Children with Special Health Care Needs

Direct services are provided through fee-for-service, memoranda of agreement and contracts with a variety of public and private providers such as hospitals and physicians. Multidisciplinary teams provide services to any special needs child in the state, not just the CSHCN eligible child. CSHCN eligible children must see the appropriate specialist or attend clinic at least annually with follow-along care provided by the primary care physician and other providers in the community, consistent with the treatment plan developed with the multidisciplinary team. A variety of outreach clinics are held throughout the state.

Enabling Services

1. Pregnant Women and Infants

As of June, 2000, 20 counties have expanded services and all utilize Title V funds to support Healthy Start activities. Paraprofessional home visitors under public health nursing supervision visit families. An initial visit may result in one or more follow up visits depending on family need. While the program was designed as a prenatal/postnatal program, counties with sufficient resources in terms of staff time have extended support services through continued visits for some families.

Prenatal care coordination through M & I is provided to pregnant women in *77* of 105 counties by local Title V providers. This service is used to identify pregnant women with barriers to accessing prenatal care, and assist women with prenatal care compliance. In some instances local physicians have been unwilling to accept these women due to prior negative experiences with the woman, e.g. non-compliant with care or previous unpaid medical bills. Program case managers either provide or assist the clients to access appropriate services based on their individual risks. Postpartum follow-up is provided for all mother/baby units that have been referred to the agency to assure/facilitate access to health care services and follow-up based on individual needs/risks.

Medicaid and MCH have worked over the past two years to identify a method for financial coverage of HIV testing for childbearing families. Through close coordination with SRS, all obstetrical providers can submit blood samples to the KHEL or to private laboratories for analysis and Medicaid will reimburse them for analyses of tests for Medicaid eligible women and children. This collaboration has facilitated access to HIV testing for Medicaid pregnant women.

During this same period of time, SRS and KDHE have worked collaboratively to publish a document that outlines guidelines for HIV counseling and testing for pregnant women, source of funding for these services and subsequent follow-up/treatment necessary. The distribution of these guidelines has taken place concurrently with regional workshops for health care providers across the state addressing perinatal HIV.

The Kansas Child Death Review Board (CDRB), under the auspices of the State Attorney General's Office, reviews of unanticipated infant and child deaths (0-18 years of age). The Board categorizes the death into natural, unintentional injuries, suicide, homicide, SIDS, and undetermined. Medical records, autopsy reports, law enforcement reports, and SRS records are utilized in the individual case reviews. In some instances the Board has felt it appropriate to refer a case back to the County or District Attorney in the jurisdiction where the death occurred for follow-up

investigation or possible prosecution. At this time, Title V is not included in these reviews. The State Registrar, is the KDHE representative on the Board.Per the CDRB statute. The Board's analysis and recommendations are to address methods to improve child protection, including recommendations for modifying statutes, rules, regulations, policies and procedures. The Board presents an annual data summary, comments and recommendations (as required by K.S.A. 22a-244(4)(I). To promote public health use of this information and/or identification of public health strategies M & I distributes copies of the annual report to each local MCH agency.

2. Children and Adolescents

Case management services are provided to pregnant teens through two Residential Maternity Home Projects located in Douglas Co. and Sedgwick Co. Prenatal care coordination is provided to pregnant adolescents through the M&I projects. Intensive case management services are provided to pregnant and parenting teens through this collaborative project with Medicaid. BCYF contracts with five local agencies who provide Teen Pregnancy Case Management.

Title V coordinates its activities relating to children and youth with state education (KSDE) and Medicaid (SRS) agencies in meeting the needs of children and youth. MCH staff serve on the SAFE Kids Executive Board.

Coordination activities have resulted in a number of funding and other enhancements to existing programs and development of new interventions to address identified needs.

Health education printed materials are available from the KPHEIL library administered by Kansas State University and funded by KDHE. BCYF staff review printed materials at periodic intervals to determine accuracy of information and to select the most suitable materials from among many devoted to a particular maternal and child health topic. The majority of requests for these materials come from schools in the State. Title V funds support these efforts which are outsourced to the Kansas State University.

Health education with an Abstinence Education focus has been implemented in six Kansas communities. A statewide media campaign was completed through the Kansas Radio Network utilizing Maryland's "Campaign for our Children" materials.

3. Children with Special Health Care Needs

SHS case management teams, in conjunction with the family members, develop a health care plan for each child entering the program and annually thereafter. The health care plan attempts to identify the comprehensive needs of the child and methods to provide and obtain appropriate services.

Needs of the entire family are also addressed and include family support, referral to other programs such as Medicaid and HealthWave, interpreter services and transportation.

Case management services are also provided to all individuals less than 21 years of age who receive SSI benefits. SHS receives transmittals from Disability Determination at which time SHS applications are sent to the families. If the SHS application is not returned, the case is closed. A shortened application is used for children with conditions not medically eligible for SHS specialty services but the family would like assistance with care coordination. Many children eligible for SSI have mental illness and/or MR/DD diagnoses and are served by appropriate services in the community. Follow up is also provided to those individuals identified as ineligible for SSI but appear to be eligible for SHS.

Population-Based Services

1. Pregnant Women and Infants

Local agencies receiving MCH grant funds for M & I and Healthy Start services, develop local outreach strategies to identify and locate pregnant women who have not accessed prenatal care. This outreach includes close collaboration with the Farmworker Program, to facilitate access to comprehensive prenatal and infant care for eligible farmworkers.

2. Children and Adolescents

Health education printed materials available through KDHE are listed in a Directory from which any Kansas resident may order. The majority of requests for these materials come from schools in the state. Title V funds support these efforts which are outsourced to the Kansas State University. BCYF staff review printed materials at periodic intervals to determine accuracy of information and to select the most suitable materials from among many devoted to a particular topic.

Newborn screening and follow up are provided for: PKU, galactosemia, hypothyroidism and sickle cell. Nutrition consultations are available by phone or in person to individuals, schools, organizations and other agencies. Title V supports state injury prevention activities provided through the *BHP*. Staff attend regional and state injury prevention meetings. MCH supports some limited lead screening activities through local MCH agencies. There is no universal screening program in Kansas.

3. Children with Special Health Care Needs

Make-a-Difference Information Network (MADIN) is an interagency initiative involving the State departments of health, education and social service (KDHE, KSDE, SRS). MADIN is

accessed by a toll-free number and provides information about the following: legal organizations; respite care; screening, diagnosis and evaluation; SHS; WIC vendors; MCH programs; education; parent support groups; resource material;, Infant-Toddler Services; Abstinence Education program; and Bee-Wise Immunize. Section 4.2 provides additional information.

Infrastructure-Building

1. Pregnant Women and Infants

Since 1997, SIDS of Kansas has provided community education and family support services. Title V provides a mini-grant to assist this organization. Provider education, print materials, and a toll-free line are already in place.

Each year, M & I and Healthy Start manuals are reviewed and necessary updates are distributed to local public health providers. These manuals contain standards and guidelines related to local perinatal system needs assessments, clinical assessments, and education, referral and outreach guidelines. Although this volume is primarily designed for the public health maternal and infant program, numerous private prenatal care providers, other organization and other states have requested copies to develop their own service protocols. The standards contained in these volumes are used for grant program monitoring and staff training. Community needs assessment support is provided to local providers. (See Children and Adolescent Section below.)

2. Children and Adolescents

Community Needs Assessment support is provided to local Title V providers. The Title V contract with local providers requires community assessment prior to reallocation of funds. Written standards have been developed for a number of child health issues such as, Child Health, School Health, Home Visiting, EPSDT Nurse Providers, Child Care Health & Safety. Title V participates in evaluation and quality assurance activities focusing on child health issues such as CHIP evaluation standards and quality assurance standards for the federal proposal. District nurses assist in on-site monitoring, training and technical assistance to local Title V agencies. Child Care Licensing activities are supported through Title V. Data systems relating to child health outcomes and client activities are an infrastructure function carried out through Title V. Other infrastructure building activities include manuals (quality standards development, oral health assessment activities and health department accreditation promotion).

3. Children with Special Health Care Needs

SHS is responsible for the planning, development and promotion of the parameters and quality of specialty health care for children and youth with special health care needs in Kansas. CSHCN's provider standards are defined through written standards of care and guidelines which are developed by teams of state/local and public/private providers. CSHCN staff provide as-needed workshops and consultations to local providers and to the public. Tertiary care staff are also available to provide consultation and direction for the local community-based providers.

A provider survey has been completed which addresses the geographic area served, patient characteristics, provider/patient relationships, relationship with SHS staff and their knowledge of the SHS program. The results of the analysis will determine education needs of the providers and education activities will be developed.

SHS collaborates with numerous agencies and programs at the state and local level to provide a system of care. These include but are not limited to: local education agencies, Social and Rehabilitation Services (Medicaid, Disability Determination, Vocational Rehabilitation, HealthWave, etc.), local health departments, Commission on Disability Concerns, Assistive Technology project, Kansas Department of Education, State Interagency Coordinating Council and Board of Emergency Medical Services.

Medicaid managed care and HealthWave contracts have language requiring the HMO to contact KDHE and follow CSHCN advice on referral and coordination of care. Referrals are obtained from the HMO primary care physician to direct the care and the child's health care plan is shared with both the HMO and primary care physician.

4.2 Other Program Activities

Toll-Free Hotline By calling 1-800-332-6262, Kansans can reach the Make-a-Difference Information Network (MADIN). It is a network of many cooperating agencies including Department of Education, Department of Social and Rehabilitation Services, and programs providing information about the services and resources available in Kansas for children and adults with disabilities. The following programs can be reached by calling MADIN ; Special Education (State and Local), Families Together, Parent Center, SHS, Infant-Toddler program, WIC, CASSP MH/MR program, Keys for Networking, Operation Immunize, Kansas SAFE Kids, Abstinence Education Program, Woman's Right to Know and chronic disease programs. Callers also have access to a computerized database of information regarding other programs and support groups. The toll-free number is listed by the media campaign contractors on all statewide campaign posters, billboards and PSA's as a means of assessing public opinion and obtaining public input for the Abstinence Education Program

Nutrition and WIC Services The Nutrition and WIC services section (NWS) interacts with Title V, Maternal and Child Health (MCH) Block Grant in a variety of ways. NWS develops nutrition management guidelines for MCH local agencies to provide quality nutrition services to high risk clientele, including children with special health care needs. Nutrition management guidelines for HIV/AIDS, Down Syndrome, low risk breastfed infant, low hemoglobin/hematocrit in infants and children, overweight (obesity) in children, underweight in children, infant/child failure to thrive, constipation in infancy, constipation in childhood, infant/child congenital heart disease, cystic fibrosis, cerebral palsy, cleft lip and/or cleft palate, phenylketonuria, and lead poisoning. Additionally, nutrition management guidelines on impaired renal function are targeted to be published prior to the end of FFY01. NWS staff share their expertise on nutrition topics to MCH state and local staff through newsletter articles, presentations, and editorial comments for manual development. NWS, March of Dimes, Services for Children with Special Health Care Needs (SHS), MCH and Title V staff are joined forces to launch a statewide media campaign to stress the importance of folic acid consumption prior to conception. NWS staff provide direct nutrition counseling services to infants and children at the SHS Multidisciplinary clinic in Parsons, Kansas. NWS and SHS staff worked jointly to complete a comprehensive review and analysis of the nutrition services available at the various SHS clinics located throughout Kansas. Collaboration occurs with the Infant-Toddler Program to screen infants and children with nutrition concerns and provide nutrition services and referral. NWS works with the Kansas American Academy of Pediatrics

Breastfeeding Coordinator to development community level breastfeeding promotion programs and coordinate breastfeeding messages. Plans are underway for Bright Futures: Nurtition and CDC Growth chart training. NWS is pilot testing high risk nutrition counceling using video conferencing technology.

Telemedicine Recently, Kansas has seen a surge in interest in Telemedicine due largely to the work of the Tele-KidCare Project in Kansas City at 10 school sites. Referrals from the Tele-KidCare program have been received by CSHCN. There are 31 telemedicine sites in Kansas located at medical facilities. CSHCN is working with KUMC to provide in-service programs and outreach clinics to rural providers and patients in Kansas. In-service programs have included topics such as spina bifida (secondary prevention issues and bowel management), management of spasticity, seating clinics and wheelchairs, car seat misuse and early identification of autism. Educational modules for physician and dental education have been developed for use with telemedicine, however the professionals prefer to purchase the modules for use at their leisure rather than attend a video session. Also, a trial has been completed using Telemedicine for Special Child Clinics. Tele-KidCare was showcased at the September, 1999 Tri-Regional CSHCN meeting in Kansas City and at the MCHB Partnership meeting in October, 1999.

Special Child Clinics KDHE, Kansas State Department of Education and the Local Education Agency engage in this collaborative effort. Teams of specialists are developed based on the needs of the local special education program or cooperative. Interdisciplinary evaluations, specialty consultation and treatment planning are available for those with a chronic health problem that results in physical disability, behavioral disorder or functional impairment. An “Autism” team has been added to the types of teams available for the special child clinics.

Emergency Medical Services for Children (EMSC) In Kansas, EMS is a separate entity from the State Health Department. It is under the direction of an independent Board of Directors appointed by the Governor. Title V are working members of the management team for the EMSC grant in Kansas. At this time the focus of activities is on: training for EMS personnel related to children; annual Statewide Multi-Disciplinary Conference; and, the development of a Prehospital Data System.

Leadership Education in Neurodevelopmental Disabilities (LEND) The Child Development Unit at the University of Kansas Medical Center continues to work in collaboration with the MCH and CSHCN programs in Kansas to provide leadership education which emphasizes prevention of developmental disabilities and the principles of family centered, culturally sensitive, coordinated care

for children with special health care needs and their families. A CSHCN field office is located in the training unit which allows for greater coordination and collaboration. The CSHCN field office staff will assist in the development of the 2001 application for continuation of the LEND grant.

Hemophilia Nurse Currently, Kansas is contracting with University of Iowa for a part time Hemophilia Nurse Coordinator. Kansas does not have a Hemophilia Treatment Center and the position helps to ensure that Kansas citizens with hemophilia are identified and are informed regarding benefits of the comprehensive hemophilia treatment centers. Case management of those individuals eligible for SHS is provided by this nurse. Children's Mercy Hospital, Kansas City, Missouri will become the Regional Hemophilia Center.

Assistive Technology Project CSHCN and Infant Toddler staff work closely with the Assistive Technology project through participation on their Board. Infant-Toddler staff work closely with the Assistive Technology project through the purchase of equipment for the loan bank and assurance of assistive technology evaluations for infants and toddlers The Project looks at the statewide system of access to and information about assistive technology. The Assistive Technology Project continues to work with Medicaid concerning reimbursement for assistive technology case management services.

Sudden Infant Death (SIDS) Since the late 1980's, SIDS efforts in the state have included professional and consumer education such as the "Back to Sleep Campaign", cooperatively initiated by the federal MCH Bureau and the American Academy of Pediatrics. This education has been provided in cooperation with hospitals, health departments, and other professional organizations throughout the state. "Back to Sleep" materials were distributed by KDHE to Kansas hospitals providing obstetrical services, with the recommendation that this information be provided to families with newborns and/or other families who had children under the age of one who were re-admitted to hospitals. See Section 4.1 Infrastructure Building, Pregnant Women and Infants for a discussion about efforts in community education and family support.

Women's Right to Know (WRTK) In 1997, Kansas legislature passed a bill that requires the preparation of public information handbooks regarding methods of abortion, resource directory for pregnant women, informed consent forms and related reporting protocols. Annual updates of the WRTK material (English and Spanish) require close collaboration with administration, legislators, Governor's office, and members of the Kansas medical community. Thousands of these materials have been distributed each year.

Medicaid Provider Manual Updates Guidance for the implementation of the prenatal care

coordination for pregnant Medicaid recipients has been updated. These guidelines include: the Prenatal Health Promotion/Risk Reduction (PHP/RR) services (care coordination); PHP/RR High Risk Nutrition services and PHP/RR Enhanced Social Work services; and Postpartum/Newborn Home Visit. The guidance provides information to local providers and the HMO agencies who are required to provide these services to their Medicaid members.

Perinatal Systems Since 1991, the State of Kansas has been without an effective system to promote communication and collaboration among public and private perinatal health care providers (both in-patient and out-patient). In late 1992, the Perinatal Association of Kansas (PAK) was organized to address this need.

Title V staff continue to serve ad hoc on the PAK Board of Directors. PAK has provided recommendations to KDHE regarding perinatal system needs and recommendations relating to perinatal guidelines. Through the relationship with PAK, Title V has been represented at the regional perinatal meetings, e.g., Great Plains Organization for Perinatal Health Care (GPO). In addition, the Perinatal Consultant has met with new neonatologists and perinatologists in the state, to provide them an orientation to the existing perinatal systems, availability of perinatal outcome data in an effort to continue close communication with private providers, specifically at sub-specialty facilities.

WIC Automation Automating the WIC certification and food voucher system continues to be a goal. Currently, the WIC system is a centralized paper-based batch system. The new WIC system will allow certification to be accomplished using a Personal Computer environment. WIC food vouchers will be printed “on demand” at local agencies. This flexibility will allow local agency staff to spend more time on mission oriented educational activities and less time on administrative duties. Participating grocers will also be reimbursed in a more timely manner. It is anticipated that the CDC oral health data requirements will be a component of the automated WIC system.

Coordinating Council on Early Childhood Developmental Services The Coordinating Council on Early Childhood Developmental Services (CCECDS) addresses issues and coordinates interagency activities for children, ages birth through five, with developmental delays/disabilities. The CCECDS supported the “tiny-k” (Toddlers and Infants Need You - Kansas) initiatives in SFY 1998 and in 1999, resulting in an increase in state general funds for Infant-Toddler early intervention services of almost $1.5 million and $1 million respectively. The 2000 state legislature modified these appropriations for “tiny-k” downward by $500,000 for both SFY00 and 01. The CCECDS funding committee, which facilitates the Infant-Toddler services (ITS) funding initiatives, has been

instrumental in the development of the Medicaid funding streams for ITS and for children ages 3-5 (in the Kansas State Department of Education). The CCECDS links with the many other children's committees, boards, councils and commissions as an advocate for children ages birth through five with developmental delay/disability.

Medicaid Reimbursement for Infant-Toddler Early Intervention Networks In 1999, Medicaid agreed to reimburse the Infant-Toddler Early Intervention Networks for service coordination (targeted case management) for Medicaid eligible infants and toddlers in addition to reimbursing for the intervention services (e.g., OT, PT) which was begun in SFY 1998. Previously, access to Medicaid funds was limited due to many systems barriers. The ECI provider type was developed in close cooperation with the state Coordinating Council on Early Childhood Developmental Services (CCECDS), Kansas Social and Rehabilitation Services (SRS) Adult and Medical Services staff and their fiscal agent, Blue-Cross/Blue Shield.

In addition, Infant-Toddler Services is working with Medicaid to have developmental intervention, as provided by credentialed early childhood special educators, a reimbursable service for infants and toddlers who are Medicaid eligible. Under this option, Infant-Toddler Early Intervention Networks will be able to bill Medicaid for developmental intervention provided to all children, ages 0-3, who meet both Infant-Toddler Services and Medicaid eligibility guidelines. This option is expected to be operational sometime in FY 2001.

Kansas Website In 1997, the KDHE website was developed with input from all areas of the agency. The site presents information to the public about all the agency's programs, services and activities. The Bureau for Children, Youth & Families provides fact sheets, statistical information and program information. In addition, the MCH Year 2000 Midcourse Review document which contains an overview of Kansas progress in meeting Year 2000 Objectives for mothers and children is available on the internet. The home page address is: *www.kdhe.state.ks.us/bcyf*. See SSDI Grant for website hits.

Year 2010 Objectives Planning is underway within KDHE for development of a Kansas Year 2010 State Plan. The lead Bureau within KDHE is the Bureau of Health Promotion. Title V has involved the 2010 coordinator in planning sessions relating to the new GPRA-inspired Title V reporting requirements so that state-negotiated and state-outcome measures can be included in the Kansas document.

4.3 Public Input [Section 505 (a) (5) (F)]

The State of Kansas has made this application available for public review and comment throughout the development period. (1) A presentation was made February 10, 2000 to the Kansas Senate Ways and Means Committee as a part of the budget hearings. (2) As a component of the Joint State Needs Assessment a prioritization retreat was held 5/18/2000 followed in the next week with a statewide video conference (See Section 3.1 for additional information.); (3) Copies of the Annual Report and Block Grant Application are made available thorugh the State Library. (4) The Annual Report and Block Grant Application are available in the Title V information system through a linkage with the KDHE website. (5) Personal copies of the Annual Report and Grant Application may be obtained directly from BCYF, KDHE.

4.4 Technical Assistance [Section 509 (a) (4)]

See Form 15 in Supporting Documents.

Section V SUPPORTING DOCUMENTS

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GLOSSARY

Adequate prenatal care - Prenatal care where the observed to expected prenatal visits is greater than or equal to 80% (the Kotelchuck Index).

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment - (see "Needs Assessment")

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, "What does the State need to achieve the results we want?"

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for Children With Special Health Care Needs (CSHCN, see definition below) - those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. *[Title V Sec. 501(b)(3)*]

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous years MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. *(Title V Sec. 501(b)(4)*

Children -A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - *(For budgetary purposes)* Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. *(For planning and systems development)* - Those children who have or are at increased risk for a chronic physical,

developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations. States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

2. State Support for Communities. State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development to assure that the unique needs of CSHCN are met.

3. Coordination of Health Components of Community-Based Systems. A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

4. Coordination of Health Services with Other Services at the Community Level. A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - authorized persons to be served with Title V funds. See individual definitions under “Pregnant Women,” “Infants,” “Children with Special Health Care Needs,” “Children,” and “Others.”

Community - a group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - services provided within the context of a defined community.

Community-based Service System - an organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - the recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - the ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - women who received a medical care procedure (were provided prenatal, delivery or postpartum care) associated with the delivery or expulsion of a live birth or fetal death.Direct Health Care Services - those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of with Medicaid, WIC and educations. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

EPSDT - Early and Periodic Screening, Diagnosis and Treatment - a program for medical assistance recipients under the age of 21, including those who are parents. The program has a Medical Protocol and Periodicity Schedule for well-child screening that provides for regular health check-ups, vision/hearing/dental screenings, immunizations and treatment for health problems.

Family-centered Care - a system or philosophy of care that incorporates the family as an integral

component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - the entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals.Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Jurisdictions - As used in the Maternal and Child Health block grant program: the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshal Islands, the Federated States of Micronesia and the Republic of Palau.

Kotelchuck Index - An indicator of the adquecy of prenatal care. See *Adequate Prenatal Care.*

Local Funding (as used in Forms 2 and 3) - Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - an individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.[Title V, Sec. 501 (b)(2)]

MCH Pyramid of Health Services - (see “Types of Services”)

Measures - (see “Performance Measures”)

Needs Assessment - a study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is to aimed at determining: 1) What is essential in terms of the provision of health services; 2) What is available; and, 3) What is missing

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also "Performance Objectives")

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, HIV/AIDs monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, "Why does the State do our program?"

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - a narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: "The rate of women in [State] who receive early prenatal care in 19__." This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

PRAMS - Pregnancy Risk Assessment Monitoring System - a surveillance project of the Centers for Disease Control and Prevention (CDC) and State health departments to collect State- specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - the provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual's or family's health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, "Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?"

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, "Why should the State address this risk factor (i.e., what health outcome will this result support)?"

State - as used in this guidance, includes the 50 States and the 9 jurisdictions. (See also, Jurisdictions)

State Funds (as used in Forms 2 and 3) - The State's required matching funds (including overmatch) in any given year.

Systems Development - activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - the process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration and, identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State's Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State's Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the *Federal* Title V Block grant allocation, the *Applicant's* funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the *State* funds (the total matching funds for the Title V allocation - match and overmatch), *Local* funds (total of MCH

dedicated funds from local jurisdictions within the state), *Other* federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and *Program Income* (those collected by state MCH agencies from insurance payments, MEDICAID, HMO's, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building", "Population Based Services", "Enabling Services" and "Direct Medical Services".

YRBS - Youth Risk Behavior Survey - A national school-based survey conducted annually by CDC and State health departments to assess the prevalence of health risk behaviors among high school students.

5.2 Assurances and Certifications

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive

Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)

14. Will comply with P.L.93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

(a) are not presently debarred, suspended proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled “Certification Regarding Debarment, Suspension, In-eligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions” in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee’s workplace and specifying the actions that will be taken against employees for violation of such prohibition;
(b) Establishing an ongoing drug-free awareness program to inform employees about-
(1) The dangers of drug abuse in the workplace;
(2) The grantee’s policy of maintaining a drug-free workplace,

(3) Any available drug counseling, rehabilitation, and employee assistance programs; and
(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
(d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
(1) Abide by the terms of the statement; and
(2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
(e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or
(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled “Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,” generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC

grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

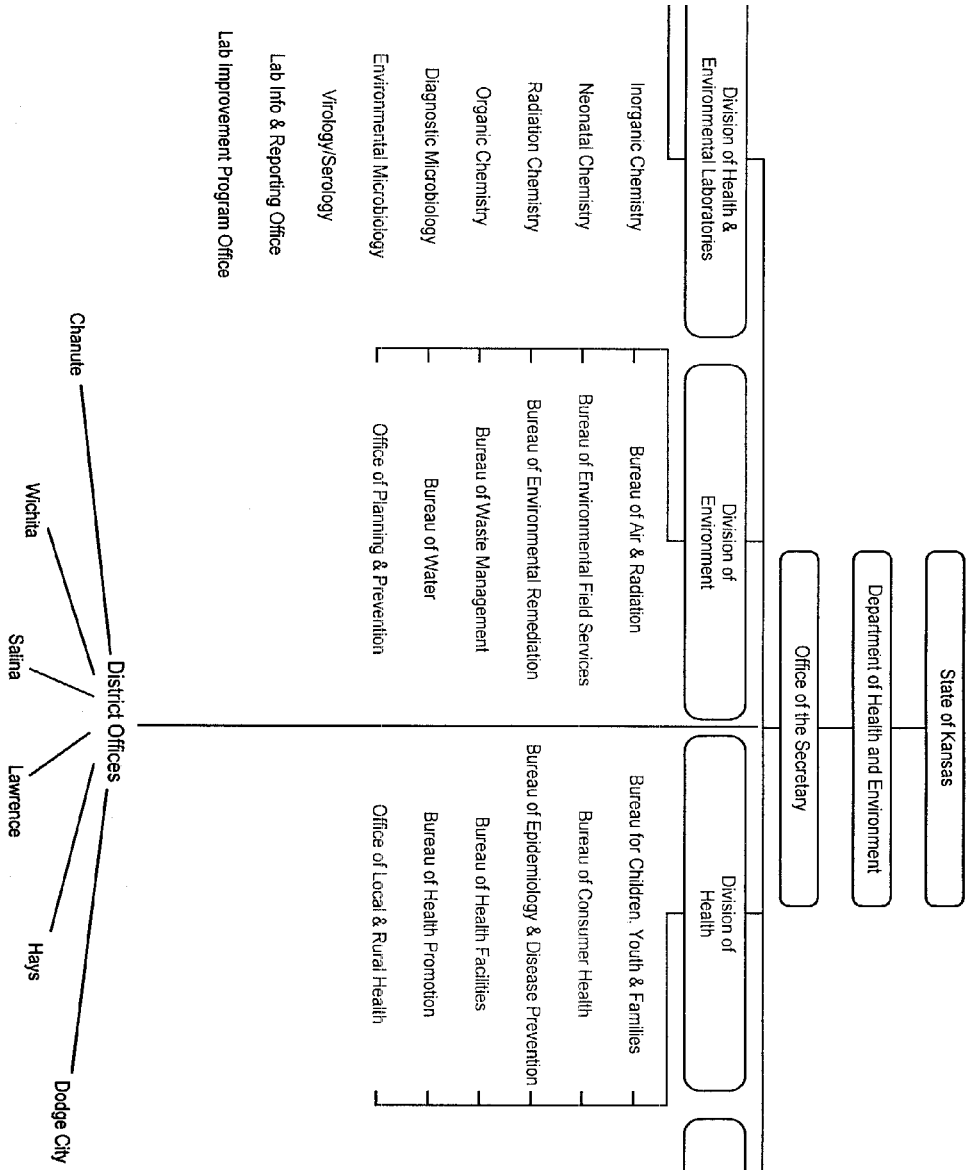
5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also know as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law doe not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.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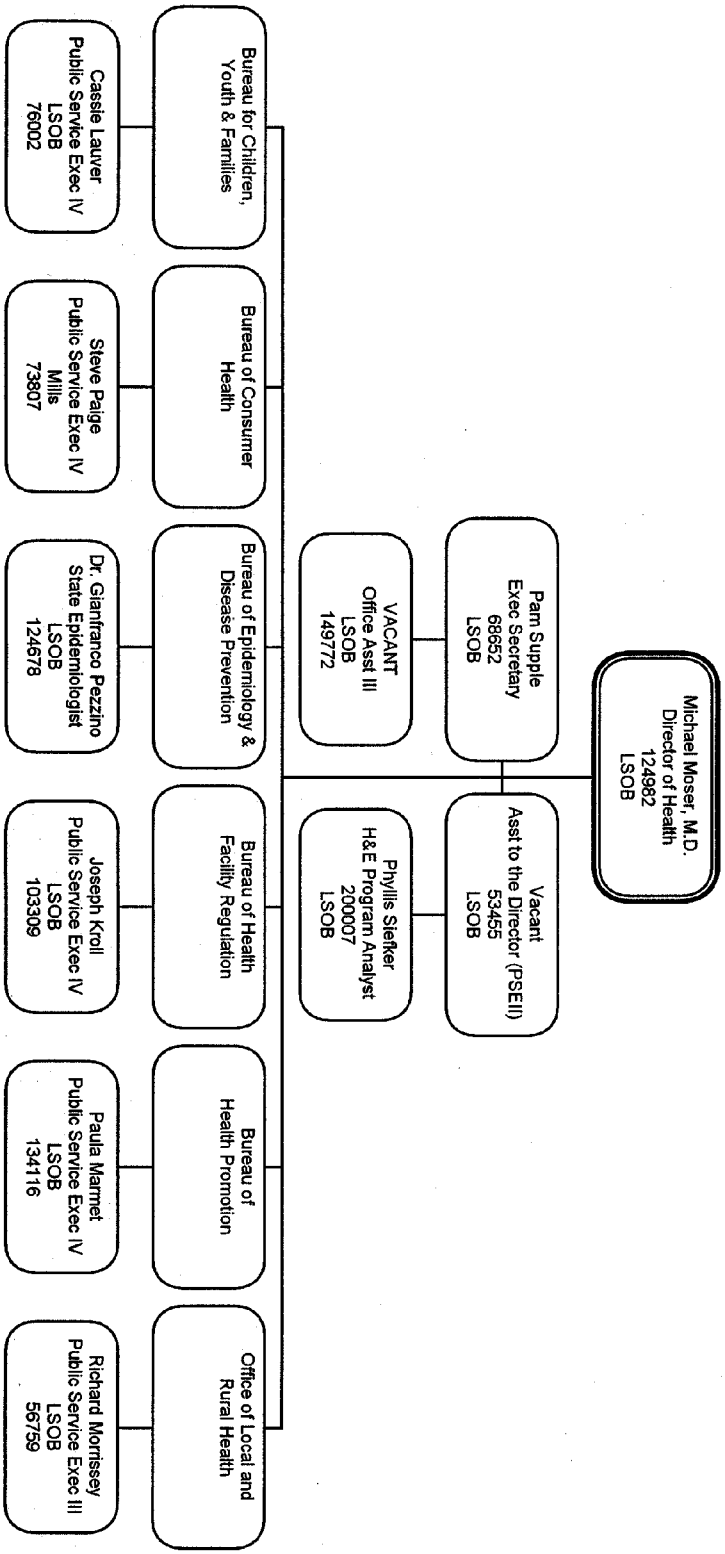
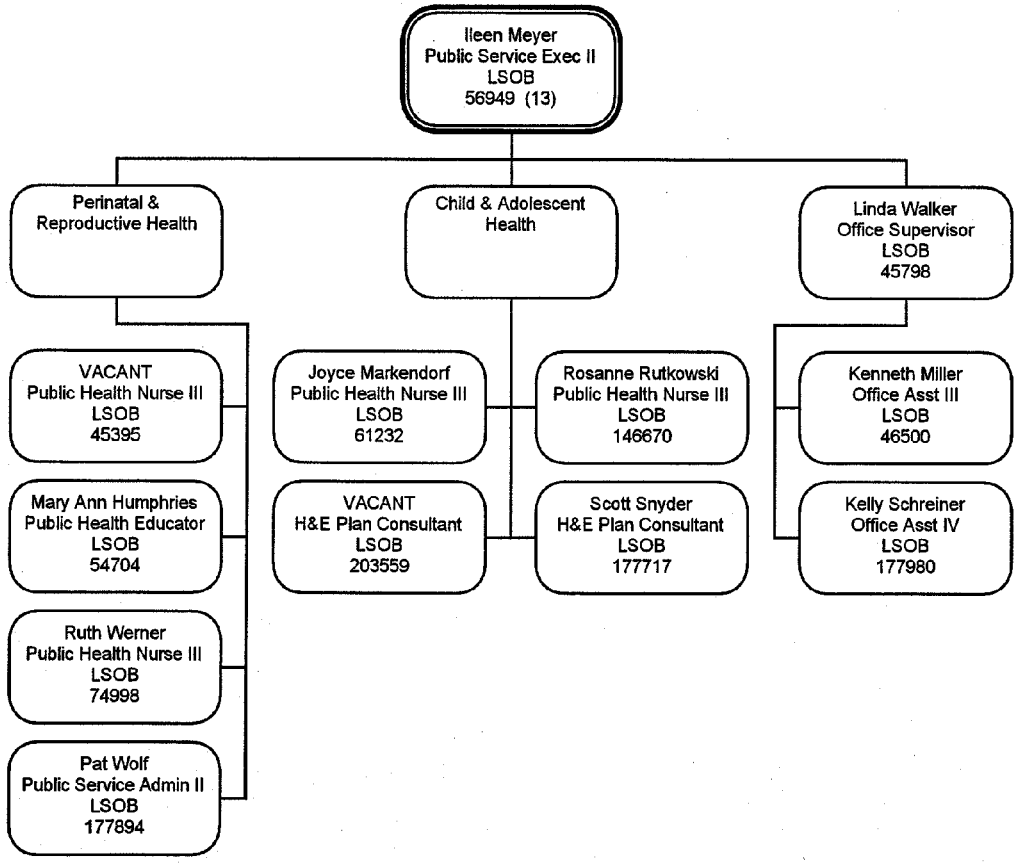
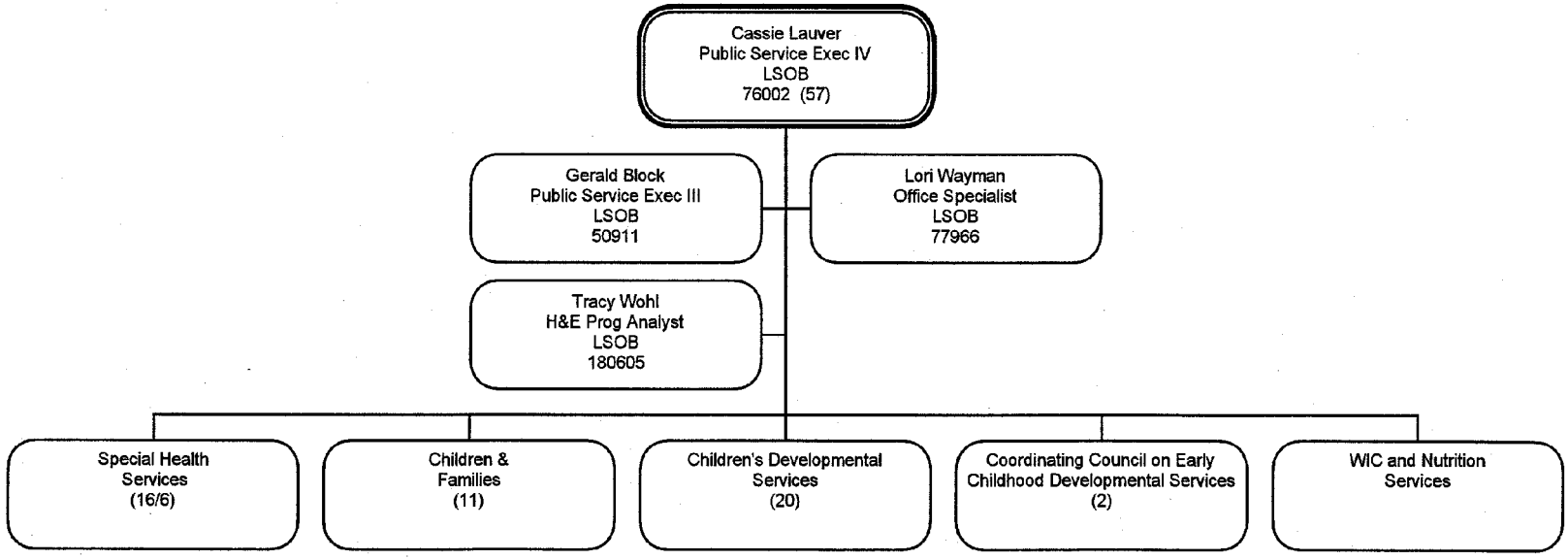
Department of Health and Environment
Office of the Secretary
Division of Health & Environmental Laboratories
Division of Environment
Division of Health
Center for Health & Environmental Statistics
Inorganic Chemistry
Neonatal Chemistry
Radiation Chemistry
Organic Chemistry
Diagnostic Microbiology
Environmental Microbiology
Virology/Serology
Lab Info & Reporting Office
Lab Improvement Program Office
Bureau of Air & Radiation
Bureau of Environmental Field Services
Bureau of Environmental Remediation
Bureau of Waste Management
Bureau of Water
Office of Planning & Prevention
Bureau for Children, Youth & Families
Bureau of Consumer Health
Bureau of Epidemiology & Disease Prevention
Bureau of Health Facilities
Bureau of Health Promotion
Office of Local & Rural Health
Health Care Information
Vital Statistics
District Offices
Chanute
Wichita
Salina
Lawrence
Hays
Dodge City

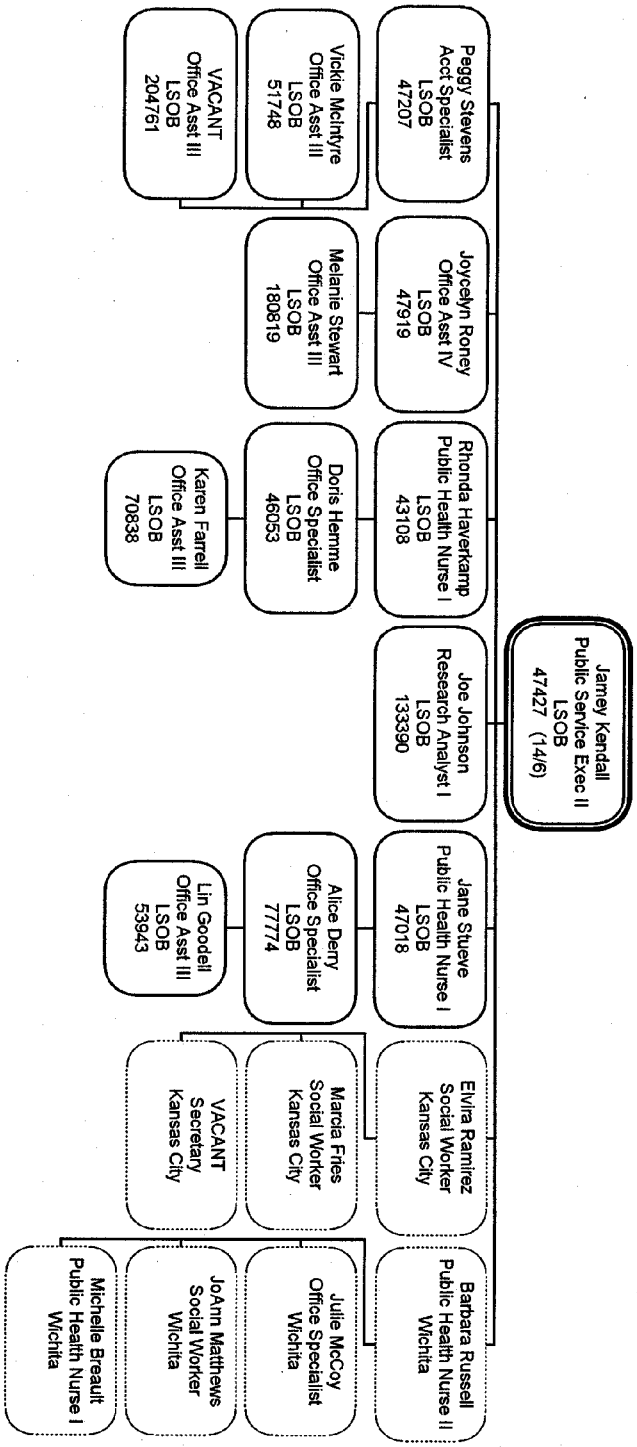

Michael Moser, M.D.
Director of Health
124982
LSOB
Pam Supple
Exec Secretary
68652
LSOB
VACANT
Office Asst III
LSOB
149772
Vacant
Asst to the Director (PSEII)
53455
LSOB
Phyllis Siefker
H&E Program Analyst
200007
LSOB
Bureau for Children, Youth & Families
Cassie Lauver
Public Service Exec IV
LSOB
76002
Bureau of Consumer Health
Steve Paige
Public Service Exec IV
Mills
73807
Bureau of Epidemiology & Disease Prevention
Dr. Gianfranco Pezzino
State Epidemiologist
LSOB
124678
Bureau of Health Facility Regulation
Joseph Kroll
Public Service Exec IV
LSOB
103309
Bureau of Health Promotion
Paula Marmet
Public Service Exec IV
LSOB
134116
Office of Local and Rural Health
Richard Morrissey
Public Service Exec III
LSOB
56759

Children & Families (page 3 of 6)

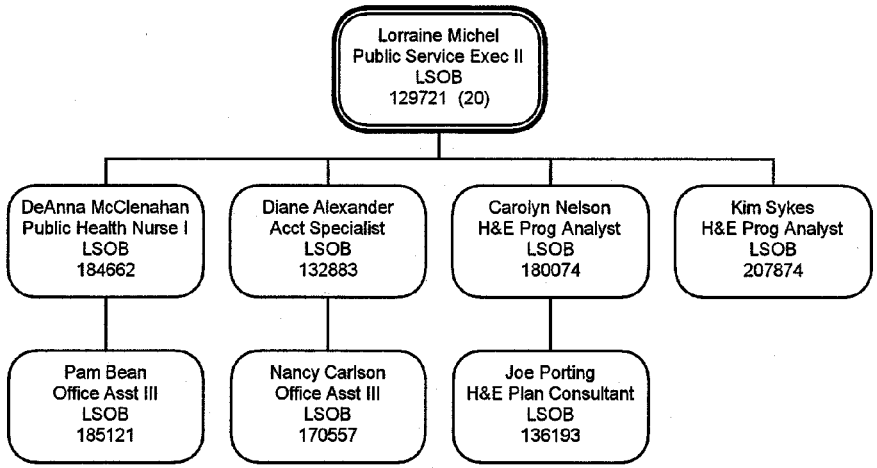


Children, Youth and Families (page 1 of 6)

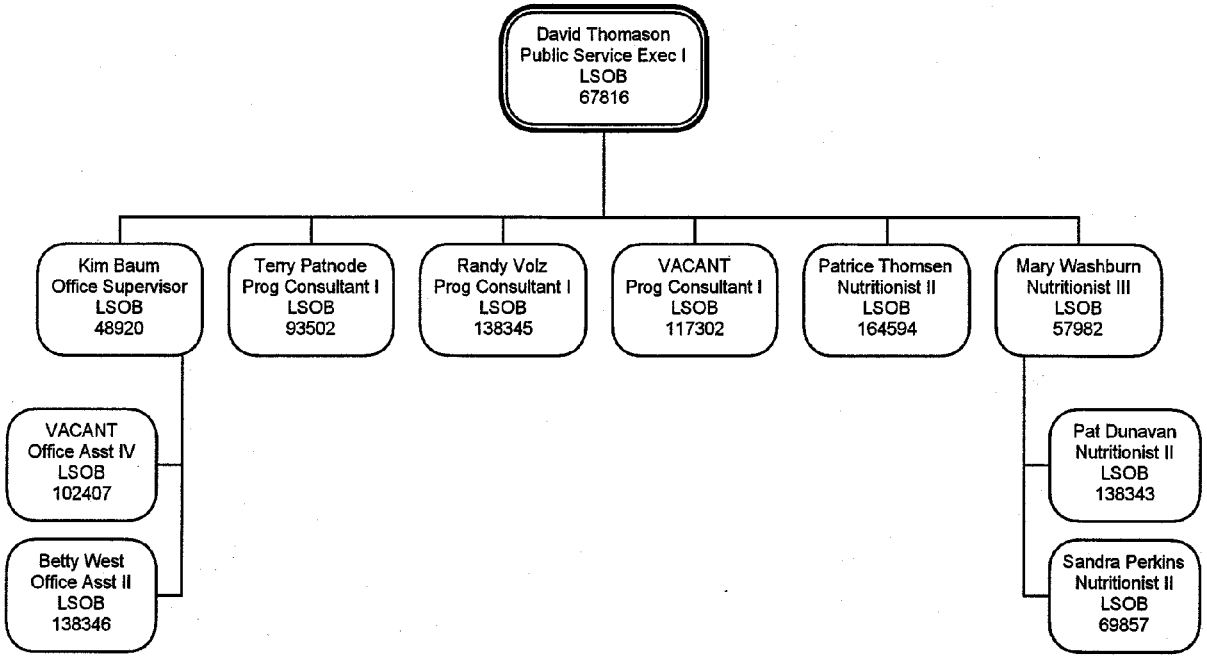


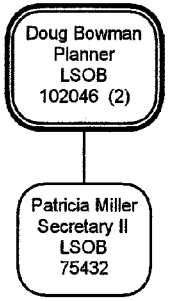

Jamey Kendall
Public Service Exec II
LSOB
47427 (14/6)
Peggy Stevens
Acct Specialist
LSOB
47207
Vickie McIntyre
Office Asst III
LSOB
51748
VACANT
Office Asst III
LSOB
204761
Joycelyn Roney
Office Asst IV
LSOB
47919
Melanie Stewart
Office Asst III
LSOB
180819
Rhonda Haverkamp
Public Health Nurse I
LSOB
43108
Doris Hemme
Office Specialist
LSOB
46053
Karen Farrell
Office Asst III
LSOB
70838
Joe Johnson
Research Analyst I
LSOB
133390
Jane Stueve
Public Health Nurse I
LSOB
47018
Alice Derry
Office Specialist
LSOB
77774
Lin Goodell
Office Asst III
LSOB
53943
Elvira Ramirez
Social Worker
Kansas City
Marcia Fries
Social Worker
Kansas City
VACANT
Secretary
Kansas City
Barbara Russell
Public Health Nurse II
Wichita
Julie McCoy
Office Specialist
Wichita
JoAnn Matthews
Social Worker
Wichita
Michelle Breault
Public Health Nurse I
Wichita

Children's Developmental Services (page 4 of 6)



WIC and Nutrition Services (page 5 of 6)




Doug Bowman
Planner
LSOB
102046 (2)
Patricia Miller
Secretary II
LSOB
75432