

STATE TITLE V BLOCK GRANT NARRATIVE

STATE: KY

APPLICATION YEAR: 2005

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I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

Assurances and Certifications for the Title V Block Grant are on file in the office of the Division of Adult and Child Health. 502-564-4830.

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

Public input during the Title V Block Grant development process is accomplished in several ways.

The Department for Public Health schedules a public hearing annually, during June or July prior to submission of the application. Information about the Title V Application process, overview of the purpose and data compared over multiple years is mailed to approximately 125 interested parties. These include local health departments, parent organizations and other advocates. A news release is also sent to major media within Kentucky announcing the public hearing. The FY 05 hearing is scheduled for July 12, 2004.

In addition, ten community forums will be conducted for public input in Fall 2004 as part of the Early Childhood Comprehensive Systems grant.

The Commission assures family and consumer in-put to program development by including two parent representatives and one young adult patient representative on the seven-member Board of Commissioners. Families and patients are also represented on the Commission's Hemophilia Advisory Committee and on a volunteer advisory committee for the Universal Newborn Hearing Screening program. Parents are well represented on the Inter-agency Coordinating Council for First Steps. All these groups receive regular program updates and have the opportunity to provide consultation and work with the Commission on various committees or workgroups throughout the year. Information about the Block Grant performance measures is share with these advisory groups as well as information about the use of Title V block grant funds. Commission and ICC meetings are open to the public

II. NEEDS ASSESSMENT

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

Geographic

Kentucky is a state with diverse topography including fertile fields in the Central and West used to support agriculture, the Appalachian Mountain Range (East) supporting lumber and coal industries, the Bluegrass (Central) which is world renowned for its thoroughbred horse industry and major waterways, such as the Kentucky River. Louisville is Kentucky's largest city and Lexington is second in population. Both cities have major universities, the University of Louisville and the University of Kentucky, with research and teaching facilities that support public health throughout the state. Other universities also support public health including Kentucky State University (Frankfort), Eastern Kentucky University (Richmond) and Western Kentucky University (Bowling Green), among others.

Several major interstates and Kentucky Parkways run through Kentucky. North/South routes include I-65 and I-75; East/West Routes include I-64 and I-24. While these major thoroughfares serve much of the state population, key areas still remain isolated and distant from major cities, universities and services. The Eastern Kentucky Coal Field is the primary area falling into this category. In mountainous areas with winding and narrow roads, residents must drive for several hours to reach a main interstate artery. Many of these areas also have a shortage of health care professionals and rely heavily upon local health department and regional hospitals for services.

Kentucky has 120 counties. These vary from the small Eastern Kentucky county of Robertson (pop. 2,266 in 2000) to Jefferson County (pop. 693,604 in 2000). Because of the small populations in many counties, county-specific health data is difficult to obtain and may have questionable accuracy when available. This means that regional data is often the only information available to health professionals planning interventions and assessing need.

Demographic

Kentucky's total population is 4,041,769 according to 2000 Census figures. During the past decade, Kentucky's population grew by 356,473 persons, a growth rate of 9.7 percent. This places Kentucky 25th among states in population. During the previous decade, Kentucky's population grew by only 7 percent. Kentucky's rate of live births has also steadily increased; from 52,054 in 1995 to 55,978 in 2000; an increase of 8%.

Kentucky continues to experience inequities between the infant mortality rate for black and white infants, although the black infant mortality rate is slowly decreasing (from a high of 14.7 in 1998 to a provisional level of 13.8 in 2002). Only 9 percent of the total births in 2002 were classified as black. In the Louisville/Jefferson County area, Kentucky's largest urban area, the African-American population comprised 17.7 percent of the total county population (for a total of 118,960 citizens) in 1998, yet this accounted for 42 percent of the entire African-American population in the Commonwealth of Kentucky. Other counties with substantial African-American populations (as a portion of the total population in the state) in 2000 include Fayette (12%), Christian (6%), Hardin (4%), Warren (2.7%), McCracken (2.4%) and Kenton (2%).

2000 Census data also shows that the Hispanic population in Kentucky is growing rapidly, with an increase of 172.6 percent over 1990 Census totals. The Hispanic population nearly tripled from 20,363 in 1990 to 59,939 in 2000. This figure, of course, does not take the illegal population into account, which is thought to be a substantial number.

This data reports counties with the largest Hispanic population include Jefferson (12,370), Fayette (8,561), Hardin (11,178), Christian (3,494), and Warren (2,466).

Patient data for children enrolled in the Commission for Children with Special Health Care Needs reflects the growing Hispanic population and comparatively low numbers of other immigrant

populations. A data snapshot of the Commission's population taken on June 20, 2003 showed the following distributions among the 7,825 active enrollees, 87.13%- white; 7.9%-Black/African American; 2.59%-Hispanic; 1.56%-Other;.58%-Asian;.15%-Native American/Native Alaskan; and .03% Native Hawaiian/Pacific Islander. Of these same 7,825 Title V/CSHCN enrollees, 7,636 listed English as their preferred language and 117 individuals listed Spanish as the next highest preferred language. The third preference was Sign Language for 38 enrollees with hearing loss and the fourth highest was 17 enrollees who preferred Bosnian. Other preferences following were significantly less: Vietnamese-7;Russian-3; Not Designated-3; French-2;Arabic-1; and Chinese-1.

Socioeconomic Indicators

Socioeconomic indicators for Kentucky's population also vary widely. A few of the key indicators are reviewed below for Kentucky. Data is supplied by 1999 County Health Profiles, produced by the Kentucky State Center for Health Statistics, Kentucky Department for Public Health.

Rates of Medicaid Eligibility and Use: In 1999, 13.7 percent of the population of Kentucky was Medicaid eligible. Owsley County ranked highest in Medicaid eligible percent (43.6%) and Oldham County ranked lowest (3.3%). Statewide, of the 13.7 % eligible for Medicaid, only 11.2% of those individuals actually used Medicaid services. Medicaid Utilization ranges from a high in Jackson County (28.3%) to a low in Boone County (2.8%).

Food Stamp, AFDC, and WIC Recipients: These measures present data on the proportions of the population who accessed programs for the indigent. In fiscal year 1999, 10.1% of the total population received food stamps. In calendar year 1999, 2.4% received AFDC benefits, and 9.3% of the eligible population was served by the WIC program. Owsley County ranked highest in food stamp percent (38.2%), Wolfe County, highest in WIC percent (19.7%), and Martin County, highest in AFDC percent (12.2%).

Median Household Income: In 1999, the most recent available at the time of this publication, the median household income for Kentucky was \$33,672.

Persons in Poverty: Based on 1999 statistics, the most recent available, 15.8% of the population in Kentucky were below the poverty level, a decrease from 17.9% in 1995. Kentucky counties ranged from 35.2% in Owsley County to 4.9% in Oldham County. It is estimated that slightly over one-fifth (21.2%) of the total population under the age of 18 lived in poverty in 1998, a marked decrease from 26.0% in 1995. Breathitt County was the highest in this measure at 37.8%.

Unemployment Rate: The unemployment rate in December of 2002 was 5.4 percent, an increase over the previous year. This ranged from a high in Taylor County of 15.5% as a result of the closing of the Friut of the Loom plant several years ago to a low in Jessamine County of 1.5% (an affluent suburb to the south of Fayette County).

Educational Status: The educational status of both men and women is closely related to socioeconomic status and also has implications for health, as women are key to the provision of health care in most families. In 1999, the educational status of mothers remained steady with one in five (21.7%) of Kentucky women with less than 12 years of education. This measure ranged from 43.7% in McCreary County to 8.1% in Oldham County.

Access to Primary Care

Access issues are still a problem for many families due to poverty, transportation issues and cultural isolation. Of the 120 counties in Kentucky, most of the Health Professional Shortage Areas (HPSA's) are based on the county as the service area.

/2005/ In 2004, there are 41 Geographic HPSAs and 33 low-income HPSAs in Kentucky. There are also 15 dental HPSA designations and 96 counties identified as Mental Health HPSAs. A

map showing the locations of Kentucky's Primary Care HPSA's is attached. //2005//

Discussion about Kentucky's KCHIP and KenPAC programs (Medicaid Managed Care), as well as federally funded primary care centers, which improve access to care within our state, is included later within the narrative (Section III-D).

Cabinet for Health and Family Services -- Provision of Health in Kentucky

//2005/ Upon taking the oath of office in December 2003, Governor Ernie Fletcher announced the reorganization of Kentucky state government. The Cabinet for Health Services and the Cabinet for Families and Children were consolidated into a single cabinet called The Cabinet for Health and Family Services. The Cabinet is divided into four administrative units each lead by an undersecretary. The four units are: Administrative and Fiscal Affairs; Health Services; Human Services; and Children and Family Services.

Effective June 16, 2004, the Division of Adult and Child Health Improvement, Department for Public Health will report to the Undersecretary for Health. The Commission for Children with Special Health Care Needs will report to the Undersecretary for Children and Family Services. //2005//

On October 30, 2001, the Cabinet for Health Services submitted their approved Strategic Plan to the Office of State Budget Director (OSB), via the electronic template designed by the Governor's Office of Technology. Details regarding this plan are available at the Cabinet for Health Services website: <http://chsnet/strategicplanning/chsplan.htm>

More about the Cabinet for Health and Family Services is included within Section IIIB - Organizational Structure.

Department for Public Health - Mission

As mandated under KRS 211.005 the definition of core public health was specified at the beginning of the chapter on public health laws. This revision mandates that the Department for Public Health develop and operate all programs for assessing the health status of the population, for the promotion of health and for the prevention of disease, injury, disability, and premature death. Services provided by the Department for Public Health and all local health departments include: enforcement of public health regulations, surveillance of public health, communicable disease control, public health education, implementation of public health policy, efforts directed to population risk reduction, and disaster preparedness. This identification by statute fosters the development of the role of the Title V agency to provide a comprehensive approach to health. The Department for Public Health, in conjunction with the Title V program, provides preventive clinical services in circumstances where providers are not accessible.

Prior to 1998, the Department for Public Health brought together the stakeholders within the public health community to develop a vision, mission and core values around the role of public health. Included in the ensuing discussion was an emphasis on the core functions of public health; assessment, assurance and policy development. Emerging from these efforts a Public Health Improvement Plan was developed for Kentucky, which is still currently in use. The planning efforts which were published in 1998 identified the following priorities:

- Teenage pregnancy and low birth weight babies
- Infant death
- Deaths due to heart disease, cancer, and stroke
- Health issues related to a rapidly growing elderly population
- Immunizations for children
- Disability and premature death of children and youth
- Lifestyle activities, including physical fitness and exercise, nutrition, sexual practices, use of tobacco, alcohol, and illegal substances, and seat belt use

- Prenatal care for pregnant women
- Access by both private and public health providers to health and health-related information
- Environmental health standards
- Food safety
- Communicable diseases

Within the same timeframe, the state developed comprehensive, integrated strategies for improvement of economic opportunity and a standard of living above the national average. Five distinct strategies were designed:

- Promoting economic development
- Improving education product
- Building self-sustaining families
- Strengthening efficiency and operations of government
- Reducing crime and its cost to society

The Department for Public Health had a role in all of these strategic initiatives, but the efforts identified within the building of self-sustaining families affect the maternal and child health population most significantly.

Kentucky's Public Health Challenges in Maternal and Child Health

Low birth weight and prematurity continue to be a challenge for Kentucky's mothers and infants. Provisional data from Kentucky Vital Statistics Files, Live Birth Certificate Files show that in 2002, 8.6 percent of Kentucky's infants are born weighing less than 2,500 grams and 1.7 percent were born weighing less than 1,500 grams (very low birth weight). Preterm births (defined as live births at less than 38 weeks gestation) have risen from 13.1 percent in 1991 to 20.9 percent in 2002. The percentage of preterm births by race also varies significantly. In 2002, 25.2% of black infants (one quarter of all black live births in the state) were born prematurely as opposed to approximately 20% of all white births.

Smoking during pregnancy, sexually transmitted and oral infections as well as late or no prenatal care are just a few of the known risk factors which impact these health indicators. While birth certificate data reports that the number of women who smoked during pregnancy has been steadily declining (from 27% in 1991 to 24% in 2002), this data is self-reported and is therefore suspect. Additional information about smoking may be available when the new live birth certificate becomes official, in 2004. (Question 37 on the new live birth certificate asks not just generally whether a woman smokes or not but how many cigarettes she smoked before, during and after pregnancy, by trimester. Data will still be self-reported.) Discussion about many of the risk factors associated with prematurity and low birthweight and the programs that address them will be discussed within various performance measures later within this narrative.

Where is Kentucky going in the fight against prematurity and low birth weight? Within the past year, several major initiatives have begun to address this significant health problem.

First, through a long-established relationship with the Greater Kentucky Chapter of the March of Dimes Birth Defects Foundation, public and private health professionals are learning more about the causes and health outcomes of low birth weight and prematurity. The 2002 Maternal and Child Health Conference, reaching more than 700 health professionals throughout the state, focused on prematurity; inviting Dr. Jennifer Howse, President of the March of Dimes National Foundation as the Keynote Speaker. Dr. Howse called health professionals to action and unveiled the national March of Dimes Prematurity Campaign effort. Throughout the next one and one half days, many breakout sessions discussed specific aspects of prematurity; from the suspected link to oral health infections to racial and ethnic disparities in preterm delivery. The closing plenary speakers included Dr. Henrietta Bada, M.D., M.P.H. (the long-term impact of public health on prematurity and low birth weight) and Magda Peck, Sc.D., Chief and Executive Director of CityMatCH, who taught participants how to build

effective partnerships to assure change.

The fight against prematurity continues with another example of a cooperative effort to jointly addressing this issue. Funding was allocated by the Greater Kentucky Chapter of the March of Dimes to support the Kentucky Perinatal Association Conference presentation of "Summit on Prematurity; Caring for Our Smallest Citizens".

This conference is traditionally attended by those working in the field of perinatology and is an excellent opportunity to reach physicians and neonatal nurses from across the state. Topics such as "Managing High Risk Pregnancies to Prevent Prematurity" by John O'Brien, M.D., "Focus on Prematurity in the Commonwealth of Kentucky" by James S. Davis, M.D. and "Premature Birth -- The Answers Can't Come Soon Enough" by Karla Damus, Ph.D, M.S.P.H., R.N. (March of Dimes National Foundation), and "Update on New Aggressive Therapies in Nutrition for Preterm Infants" by David H. Adamkin, M.D. were included within the Summit Agenda.

//2005/ What is the next step for Kentucky as it addresses the issue of prematurity? The Department for Public Health will continue to participate with the March of Dimes as a primary member of the Prematurity Campaign Committee and ACH Director Steve Davis has agreed to act as co-chair for the Campaign. Kentucky's Early Childhood Initiative KIDS NOW will continue to support programs (such as HANDS Voluntary Home Visitation) which impacts prematurity and low birth weight. Kentucky will also be a participant in the Region IV Maternally Linked Dataset Project funded by a grant from the National Institute of Child Health and Human Development. Goals for this project include the improvement of methods for creating maternally linked records, epidemiologic studies of the linked records and research. //2005//

Kentucky also leads the nation in the incidence of birth defects as a cause of infant mortality.

Kentucky has unique characteristics that may lead to an increased prevalence of certain birth defects such as neural tube defects and diabetic embryopathy. The eastern portion of Kentucky is along the Appalachian foothills. For years, individuals in this part of the state were isolated geographically and culturally. Dr. Bryan D. Hall, Dymorphologist recently retired from the University of Kentucky, estimates that the rate of consanguinity in this population, for which he provides clinical genetic services, to be approximately seven percent (7%). While this is biased as it is drawn from individuals seeking genetic evaluations or counseling, it is still greatly in excess of the national rates of consanguinity that are estimated to be approximately 0.5 percent. The high rate of consanguinity results in increased numbers of children with autosomal recessive conditions as well as multifactorial birth defects.

Kentucky is addressing this problem with the development and support of the Kentucky Birth Surveillance Registry (KBSR). KBSR not only identifies specific ICD9 and ICD10 codes to study and map clusters of selected anomalies identified through the state but will also include referrals to appropriate services for affected families. Data resulting from this surveillance system will enable program staff to target intervention efforts to areas of the state most in need and should result in lower rates for all six national outcomes measures.

Significant work has taken place over the past few years within KBSR. The KBSR System was successful in securing a three-year grant from the Center for Disease Control and Prevention (CDC) which will fund the Kentucky Birth Surveillance Registry in full for three more years (2002 -- 2005). The level of funding is \$ 165,000 each year. Additionally, the KBSR system, which has only been functional for a short time-period, recently received a "B" from a national review of all birth surveillance systems in the nation. Very few systems received such a high grade, particularly for those that have only been in existence for a few years.

Staff for the KBSR successfully developed an integrated data system, which links Vital Records (live births, stillbirths and death certificates) with UB-92 hospital discharge data, to gain a complete record

on each child reported to have a congenital anomaly. Many agencies report to the Registry, including the Spina Bifida Association and the Commission for Children with Special Health Care Needs, as well as birthing hospitals throughout the state. This data system was the first of its type within the Maternal and Child Health Branch and is now complete with detailed reporting options for KBSR staff. State Systems Development Initiative Grant funding also supported this project.

The KBSR staff of two conducts medical record abstraction and data analysis, traveling throughout Kentucky as they visit birthing hospitals that report to the Registry system. Medical record abstraction is extremely important to the Registry, as much pertinent data is simply not conveyed or is inaccurate on Vital Statistics records and hospital discharge data. Once potential congenital anomalies are identified at a particular hospital (or grouping of hospitals), they are contacted and records are abstracted. Once commonly occurring errors have been identified, trainings for health professionals working with hospital records will be planned with the expectation of better data as a result of this process.

Medical record abstraction has taken place for the following congenital anomalies: Neural Tube Defects, Down Syndrome, Cleft Lip/Palate, Diaphragmatic Hernia, Omphalocele, Gastroschisis, Trisomy 13 and Trisomy 18.

Working with data about birth anomalies occurring within Kentucky is just a piece of the Registry. With this information, interventions for some of these can be applied and families who are challenged with these health problems may be directed to resources and support services. This is the true mission of the Kentucky Birth Surveillance Registry.

In 2002, the law related to the Kentucky Birth Surveillance Registry data collection was amended. Legislative successes include mandatory laboratory reporting for children age birth to five and voluntary outpatient reporting. The addition of mandatory outpatient reporting was unsuccessful during this term. KBSR currently does not collect prenatal testing data, and would not include pregnancy losses prior to 20 weeks gestation.

Conditions added for abstraction in 2002 included Fetal Alcohol Syndrome, Renal Agenesis and Infants of Diabetic Mothers. In 2003, selected heart conditions have been abstracted. These include: Common Truncus; Transposition of the Great Vessels; Tetralogy of Fallot; Common Ventricle; Endocardial Cushion Defects and Hypoplastic Left Heart. KBSR has hired two local health department nurses (.25FTE each) to assist with data abstraction and prevention activities in Western and Eastern Kentucky.

Data abstracted from 1998 - 2000 will be published in a report to be released during the summer of 2004. Additionally, a manuscript on Neural Tube Defects rates in Kentucky is being submitted to the Kentucky Medical Association for inclusion in their publication. Other activities currently underway include quality assurance and auditing protocols to improve data quality from participating hospitals, educational activities and collaboration with statewide family planning clinics to facilitate preconception health promotion including the identification of high-risk individuals and referral to appropriate services.

//2005/ The Kentucky Birth Surveillance Registry now has reporting of birth defects from cytogenetics laboratories, level III neonatal intensive care units, and outpatient genetics clinics. These additional reporting sources have improved the completeness of ascertainment of birth defects. Abstraction of major structural birth defects will continue during this year. KBSR will have five years' worth of data this year for analysis that will include rates as well as geographical mapping. KBSR plans to develop interstate agreements with bordering states' surveillance programs or individual hospitals to further improve case ascertainment. KBSR will be implementing a service referral component with First Steps, Kentucky's Early Intervention System this year, and educational efforts for health professionals and the general public on birth defects will continue. //2005//

The oral health of children is a major health issue for Kentucky. Kentucky's 2001 Children Oral Health Survey showed that nearly one-third of a sample of 2-4 year olds were affected by early childhood caries (ECC). Thirty percent had severe ECC, 39% had never been to a dentist and 35% of their parents had not seen a dentist in the last year. Of these children, 39% had Medicaid, 15% had KCHIP and 29% had private dental insurance.

When school-aged children (3rd and 6th graders) were surveyed, 57% had caries experience with 29% having visible decay, 51% reported bleeding gums and 15% had signs of gingival inflammation. Twenty percent reported having a toothache in the past month and had not seen a dentist in the last year. Only 29% of these children had sealants on any molar.

To address this concerning threat to the overall health of children in Kentucky, Dr. James Cecil, D.M.D, M.P.H., Administrator of the Office of Oral Health, within the Department for Public Health, imparts a vision which provides access to care and assurance of services to all children within the Commonwealth.

//2005/ The first part of this vision has been accomplished; a comprehensive survey to establish baseline data for the state. Results of this survey, implemented in 2000, were discussed earlier. The next steps, fluoride varnish program for preschoolers and a sealant program for school-age children both began on July 1, 2003 and are currently underway. A surveillance system is the next target for development to monitor children's oral health issues across the state. Kentucky's FY 04 Oral Health Collaborative Systems Grant has provided funding for this project as well as for the development of a Strategic Plan for Oral Health for the state which will be completed by the end of the state year.

The Strategic Planning Process has been a collaborative effort between the Kentucky Department of Public Health and the University of Kentucky School of Public Health Dentistry. The process began with a selection of over 200 key players throughout the state to be a part of the planning process. This listing was eventually culled down to approximately 125 participants who participated in a six-question electronic survey (a SWAT Analysis) which asked for input on the strengths and weaknesses of the provision of oral health services in Kentucky; identification of additional factors that would have a positive (and negative) impact on the achievement of oral health and a vision (ideal state) for oral health. These questions generated many responses which have been condensed and provided the Oral Health Strategic Planning Executive Committee with a baseline from which to develop draft vision, mission, plus-delta and value statements. In late May, the large group will convene in Lexington for 1.5 days to refine the work previously done by the Executive Committee and to generate specific steps for addressing oral health issues for all Kentuckians. Finally, the plan will be drafted and written by the end of June. The resulting plan will be included as an attachment within the Title V Block Grant for FY 06.

Next, regional dental treatment centers will be established throughout Kentucky to provide service availability for children and adults alike. Several partnerships are already in place to make these centers of care a reality including one in Hazard (Eastern Kentucky) and in Madisonville (Western Kentucky). With improved access to care, specialized programs for all populations will be developed in our state. This series of programs and assessment tools, will have a positive impact on the oral health of Kentucky's children. //2005//

These are just a few examples of the health challenges facing our state. Others, such as obesity in children and childhood injury (particularly motor vehicle injury), are equally important and are discussed within the appropriate performance measures later in the narrative.

Kentucky's Public Health Successes in Maternal and Child Health

While many public health challenges face Kentucky's health providers, there have been some exciting success stories over the past decade in Kentucky.

Kentucky's KIDS NOW Early Childhood Development Initiative has provided millions of dollars for the support of program impacting the early years of a child's life; from preconception to entry into the childcare setting. Performance and outcome measures associated with these programs are being carefully analyzed and already show positive impacts on the well-being of Kentucky children. Details about this nationally acclaimed early childhood initiative and the partnerships that make it work are provided throughout the document.

Additionally, the rate of teen birth has declined from past years (from 35.3 per 1,000 in 1997 for 15-17 year olds to 24.9 in 2002) and is now approaching the national rate for this performance measure. The most substantial declines have been seen throughout Eastern Kentucky counties; where poverty is still a great concern.

Over 85% of women in Kentucky enter prenatal care in the first trimester and have adequate prenatal care, based on the Kotelchuck Index. Additionally, childhood injuries and infant mortality have steadily decreased while access to health care for Kentucky children has steadily increased through the advent of KCHIP, Kentucky's Children's Health Insurance Program.

The Title V Program -- Access, Assurance and Policy Development

Traditionally, the Title V program has focused on providing access to maternal and child health services whether it be through supporting local health departments or through contracts with universities to deliver services within the community setting and on site for the maternal and child health population. Although this continues to be the focus for the Title V programs, a changing health care environment has opened other opportunities to improve the health of women, infants, children and children with special health care needs. Assurance through partnerships, cooperative agreements and contracts will be discussed throughout the FY 05 Title V Annual Report and Application.

Local Health Departments continue to be the arm of the Department for Public Health at the local level. As in past years, the majority of Title V funding is allocated directly to local health departments to support their activities benefiting the maternal and child population. Local health departments conduct community needs assessments on a regular basis which guide their programming priorities while the Department for Public Health provides regulatory guidance and standards of care; in addition to training opportunities and other resources.

In general, the statewide trend is that the direct community services for maternal and child health is occurring more frequently in traditional medical homes than in years past. When this is the case, local health departments assume an assurance role.

What factors are influencing this trend? Improved economy, more public financing (such as KCHIP) and more effective systems utilizing a Primary Care Provider. This is occurring more commonly in the areas of family planning, child preventive and prenatal services. Some rural counties do lack key health providers such as OB/GYNs and Pediatricians. In these cases, local health departments do provide preventive and direct clinical services.

The Kentucky Public Health Practice Reference (PHPR), developed by the Department for Public Health, serves as the guidance for clinically based information to support patient-centered health care provided by local health departments. Additionally, the PHPR provides supportive information to assist the professional in providing services within the community; outside the clinic setting.

Guidelines included in the PHPR will enhance the health care professionals knowledge and understanding of population-focused practice and reflect current information and recognized treatment recommendations from appropriate literature and authorities. These guidelines are the minimum standards of care and may not be reduced. If a local health department desires to provide an enhanced level of care, they may develop local protocol. Additional protocols and guidelines that

are desired at the local level must be jointly developed by nurses, advanced practice nurses, physician assistants and their collaborating physicians, as indicated. The entire PHPR and updates to the document will soon be available on the DPH website at:
[www.http://dphinfobase/table_of_contents.htm](http://dphinfobase/table_of_contents.htm)

All local health departments clinical and administrative operations are reviewed on a regular basis under the Division of Adult and Child Health Improvement's Quality Assurance Review Process. The family planning program, as well as other programs (such as child fatality review, pediatric clinical and lead poisoning prevention) are included in this review process. Using Kentucky's Public Health Practice Reference as the quality assurance standard, a team of registered nurses visits each local health department to conduct a clinical record review and staff interviews. Issues for discussion include barriers to access, continuing education needs and data collection quality. Specific to the family planning program, appropriateness of care and adherence to the federal guidelines is ascertained during this review. Following an exit interview with key staff, a written report is prepared by the team and the local health department responds with a quality improvement plan to address identified issues.

Universities are also important partners with the Department for Public Health in the continuum of care for Kentucky's maternal and child populations. Kentucky's two tertiary centers are the University of Kentucky (Lexington) and the University of Louisville. They, as well as Eastern and Western Kentucky Universities, Pikeville School of Osteopathy and others collaborate on many levels including training for health care providers, research and the provision of resources for providers throughout the state. Details about specific contracts are discussed under Section III, D - State Agency Coordination.

Other Key Partners in Maternal and Child Health

ACHI/Federally Funded Primary Care Centers

Kentucky has thirteen primary care sites that receive federal funding; and these have approximately twenty-six service locations in underserved areas of the state. In addition to offering primary care services, the percentage of other services offered at these locations include: Dental (62%), Enabling (38%), Mental Health/Substance Abuse (46%), OB/GYN (62%), Other Professional Services (46%) and Specialty Care (23%).

Formal linkages and collaborative efforts between primary care centers and local health departments vary throughout the state. Two sites (Lexington-Fayette County and Louisville Metro-Jefferson County) are formally linked with their respective local health departments. In response to the federal expansion of funds for the enhancement of existing centers and the development of new centers, a statewide strategic plan was completed in April of 2003. Fifteen new access sites will be implemented within the first phase of the strategic plan during FY 02 -- 06. Five of these new access points are planned by new organizations and 10 are planned by existing health centers; three expansions of medical capacity are also planned. The Primary Care Association estimates that with this combination of 18 access points, an additional 77,150 new individuals will be served. Finally, 2,240 persons will also be reached through the expansion of services by five existing health centers also within the period. Together, a total of 79,390 individuals will be provided access through this initiative.

Other Agencies and Non-Profits

In addition to governmental linkages, ACHI also collaborates with a number of associations, voluntary organizations and advocacy groups with an interest in maternal and child health.

Pikeville College School of Osteopathic Medicine - utilizing the opportunity to work with this key group of rural medical professionals, the Health Access Branch is providing Oral Health education to faculty, students, interns, and residents of the Pikeville College School of Osteopathic Medicine. In addition, the testing and evaluation of the effectiveness of this training is emphasized, in order that it may be used a model by similar osteopathic medical schools across the nation.

It is expected that this project will facilitate the training of osteopathic physicians to recognize oral health problems in their patients and to make appropriate referrals where appropriate to oral health professionals. The ultimate objective is to improve the oral health status of Kentuckians, especially children.

The March of Dimes Birth Defects Foundation: The March of Dimes is another strong partner of the Department for Public Health. ACH staff participates on the Greater Kentucky Chapter State-Level Program Service Committee and in the allocation of nearly \$130,000 for direct community grants supporting maternal and child health programs at the local level. Additionally, staff work on the local level to implement relevant programs and projects; such as preconceptional planning, prenatal lead poisoning prevention and prematurity/low birthweight awareness and prevention.

Other partners include the Kentucky Perinatal Association, Kentucky Early Childhood Authority, the Migrant Health Coalition, the Kentucky State Coalition of Primary Care and the Kentucky Disabilities Coalition.

Steve Davis, M.D., Director of Adult and Child Health Improvement, believes that "targeting an inch wide and a mile deep" will impact a health issue effectively and quickly. And, that a unified effort across the state by local health departments, universities, hospitals and private providers is the key to solving Kentucky's health challenges for the maternal and child population into the 21st century.

/2005/ The Commission's Role in Assuring the Health and Well-Being of CSHCN

The Commission for Children with Special Health Care Needs has a long history dating back to 1924 when it was created by the State Legislature in response to a request from the Rotary Club to provide treatment to children with orthopedic conditions through itinerant clinics across the state. The focus on community-based systems of care continues today. In addition to being a direct services provider, the Commission has assumed a leadership role in assuring state and local systems of care for children and youth with special health care needs (cyshcn) and in promoting a broader definition of health for CSHCN and their families as defined by the World Health Organization: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." This expanded focus has positioned the Commission to take a leadership role in closing the achievement gap by championing the President's New Freedom Initiative and the No Child Left Behind Act among other state and local agencies, the faith community, and community based organizations on behalf of the Cabinet for Health and Family Services.

As a national leader in developing systems to support the transition of cyshcn to adulthood, Kentucky became the first state to develop a Title V performance measure for transition to adulthood in 1997. The focus of staff has evolved from clinic care to care coordination/case management. The development of personal and family competencies that support successful transition are integral components of care coordination and patients five and older are counseled and assisted in transition to adult health care. Within the past year, the Commission has been primary grant writer for two community-based efforts to secure funding through the Administration for Developmental Disabilities and the Department of Labor for services to children and youth with disabilities and their families through comprehensive one-stop centers. Because schools are often the focal point for children and youth and their families, the Commission has developed a strong and productive relationship with the Division of Exceptional Children Services, Kentucky Department of Education. In doing so, we have taken steps to build an infrastructure at the community level that supports both the child's health and educational needs.

Because of the complexity of their medical needs we sometimes forget that children and youth with special health care needs are first and foremost children and youth. They are subject to the same behavioral health risks as their non-disabled peers. Addressing health promotion and

injury prevention among children and youth with disabilities represents a new challenge to the Commission. "Graduate" surveys of youth exiting the Commission and Shriners Hospital (Lexington) found that youth smoke and drink alcohol at levels of typical youth in Kentucky. The surveys also show that graduates use the emergency room at almost double the rates of typical youth and over 1 in 4 of the visits were due to trauma. Obesity and lack of physical activity among CSHCN are clearly issues that must be addressed through patient education and care coordination and through community and school-based interventions that are done in collaboration with our education and public health partners.

The highly successful implementation of the universal newborn hearing screening program has provided the Commission a foundation for population-based public health practice and the capacity to respond to future opportunities for advancing early and continuous screening. As we prepare for the MCH 5 year needs assessment which will begin in the Fall of 2004, we are realizing additional opportunity to expand our focus using a broader definition of CUSHCN than those enrolled in the Commission's Title V specialty medical services program. The availability of data from the 2001 National Survey of CUSHCN coupled with the Child & Adolescent Health Measurement Initiative provides a platform from which we can now assess the needs of cushcn in Kentucky ages 0-17. Previously, much of our reporting was limited to cushcn enrolled in the Title V specialty medical program, which accounted for less than 10,000-12,000 of the state's estimated 156,000 cushcn.

As the Commission proceeds with the MCH 5-year needs assessment, cultural and linguistic competency will be foremost in our minds. Prevalence statistics from the National Survey indicate that 14.4% of the cushcn in Kentucky are Hispanic; 16.2% are Black; and 20.3% are Multi-racial. Approximately 1 in 3 of Kentucky's cushcn have family household incomes at or below 199% of the Federal Poverty Level. Because cultural competence is a developmental process that evolves over an extended period, the Commission has committed to this process by designating a Title VI coordinator whose job is to assure that policies and structures are developed to assure that the agency works effectively cross-culturally.

The National Survey of Children with Special Health Care Needs can be accessed at www.cshcndata.org. //2005//

B. AGENCY CAPACITY

Assurance for the Health of Kentucky's Women and Children

Kentucky's attention to the needs of its women and children has never been stronger. Prior to the federal legislation that created SCHIP, the Cabinet for Health Services had a small work group that designed a plan about how public health could provide or assure access to quality care for our most vulnerable populations. While this plan was being created, federal funding came through the SCHIP program, which became KCHIP in Kentucky. In 1998, 65 million dollars was designated to support health services through KCHIP and Kentucky has been lauded nationally for its efficient enrollment process and success in identifying children who qualify for this program.

In the 2000 State Legislative Session, a radical new program was created called "KIDS NOW!" This comprehensive plan addresses issues for children from the prenatal period (folic acid supplementation) to birth (home visitation and newborn hearing screening) through the time that they attend childcare. (More discussion about KIDS NOW! is included throughout the narrative). This program added \$ 55 million new dollars to programs centered on children in Kentucky, and in excess

of \$ 30 million dollars was allocated specifically for programs dealing with maternal and child health. Funded through the national Master Tobacco Settlement, Kentucky's legislature passed a bill that allowed 25% of this funding to be directed to very young children and families; thereby assuring significant and ongoing support for this population.

Discussion follows regarding the delivery of care system in Kentucky for the maternal and child population.

***** Capacity - Kentucky Statutes *****

State statutes relevant to Title V program (by program area) authority include:

Maternal Health

KRS 194A.095 Directs that an Office of Women's Health be established within the Cabinet for Health Services.

KRS 214.160 Requires syphilis testing for pregnant women.

Perinatal Health

KRS 211.651 -- KRS 211.670 Authorizes the Birth Surveillance Registry administered by the Division of Adult and Child Health. Allows Birth Surveillance Registry personnel to review and receive records from medical laboratories and general acute-care hospital if voluntarily participating in keeping a listing of both inpatients and outpatients.

KRS 214.155 Authorizes newborn screening for inborn errors of metabolism and other hereditary disorders (currently PKU, congenital hypothyroidism, galactosemia and sickle cell).

HB395 Amend KRS 304.17A-139 to remove the general \$ 4,000 cap on coverage for inherited metabolic diseases and provide for a \$ 25,000 cap on medical formulas and a separate cap of \$ 4,000 on low-protein modified foods for each plan year.

SB55 An act relating to abandoned infants. Amend KRS 311.6526 to require the Emergency Medical Services Program for Children to collaborate with the Cabinet for Families and Children and require guidelines for responding to abandoned infants, including preserving the confidentiality of the parent, and define "newborn infant" as an infant less than seventy-two (72) hours old. Providing implied consent for treatment and confidentiality for the person releasing the infant with the provision unless indicators of child abuse or neglect are present.

//2005/ HB 108 AN ACT relating to the protection of unborn children.

Create a new section of KRS Chapter 507 to include unborn child after viability within the definition of "person" for the purposes of the criminal homicide statues to criminalize fetal homicide; create a new section of KRS Chapter 532 to provide a sentence enhancement for criminally causing a miscarriage or still birth of a fetus before viability. //2005//

Pediatric

//2005/ KRS 200.650 -- KRS 200.676 Establishes First Steps, Kentucky Early Intervention System. //2005//

KRS 211.680 -- Authorizes the Department for Public Health to coordinate efforts to reduce the number of child fatalities through reviews of unexpected child deaths.

KRS 211.900 -- KRS 211.905 Authorizes comprehensive lead poisoning prevention services.

KRS 213.410 Authorizes SIDS services.

KRS 214.034 -- KRS 214.036 Establishes immunization requirements for children.

KRS 214.185 Permits diagnosis and treatment of minors for contraception, sexually transmitted diseases and pregnancy related care without parental consent.

HB353 To allow public and private school students to self-administer asthma medications when the school receives written authorization from the parent and health care provider.

HB398 AN ACT relating to safety education.

Create a new section of KRS Chapter 95A.200 to establish a Safety Education Fund to be administered by the Commission on Fire Protection Personnel Standards and Education to initiate education programs in the public schools and other agencies to reduce and prevent injuries and the loss of life; the commission shall promulgate administrative regulations to establish the criteria for providing funds to initiate injury prevention curricula and training programs throughout the state.

Children with Special Health Care Needs

KRS 194A.030(7) Creates the Commission for Children with Special Health Care Needs

KRS 200.460 -- KRS 200.499 Commission for Children with Special Health Care Needs. Establishes the organization and guidelines for providing services to children with special health care needs.

KRS 200.550 -- KRS 200.560 Provides for the detection and treatment of children and adults with bleeding disorders.

KRS 211.645, 211.647 and 216.2970 Universal Newborn Hearing Screening.

KRS 213.046 When a birth certificate is filed for any birth that occurred outside an institution, the Cabinet for Health Services shall forward information regarding the need for an auditory screening for an infant and a list of options available for obtaining an auditory screening for an infant.

911 KAR 1:070. (Formerly 902 KAR 4:070) Implements the services of the Commission for Children with Special Health Care Needs.

MCH General

KRS 211.180 Gives the Department for Public Health the responsibility for public health, including improving the health of mothers, infants and children.

HB 67 To allow ARNPs and RNS to distribute nonscheduled legend drugs from a Department for Public Health approved list in local health departments.

HB126 Create new section within KRS Chapter 156 to establish a full-time position of education school nurse consultant within the Department of Education and specify employment requirements and job duties to include development of protocols for health procedures, quality improvement measures for schools and local health departments and data collection and reporting.

Capacity: Early Childhood Development - "KIDS NOW!" Early Childhood Development Program

"KIDS NOW!" Early Childhood Program brought \$55 million dollars from the tobacco settlement to Kentucky's maternal and child population through House Bill 706 in 2002. These funds are used in implementing programs such as folic acid education, voluntary home visiting, universal newborn hearing screening, substance abuse treatment for pregnant women and multiple programs enhancing

early child care and education. A table at the end of this section shows current and past funding for programs coordinated or directly linked to the Division of Adult and Child Health. ***//2005/ Early Childhood Development was moved from the Governor's Office to the Kentucky Department for Education. Kim Townley, Ph.D. continues to be the Division's Director. //2005//***

Significant program activities under this initiative have been ongoing for the Commission for Children with Special Health Care Needs and the Division of Adult and Child Health. The programs working to enhance early childcare, health and education have allowed additional opportunities to collaborate with the Division of Child Care on general child development, data collection and management and quality issues. For additional information about "KIDS NOW!", visit their website at <http://www.state.ky.us/agencies/gov/ecd/index.htm>

Capacity: Division of Adult and Child Health Improvement

The Title V Director, Steve Davis, M.D., is the Director of the Division of Adult and Child Health Improvement and has administrative responsibility for a significant number of programs outside of the MCH program area. ***//2005/ Effective March 1, 2004, the Division of Adult and Child Health Improvement became the agency designated by the Cabinet for Health and Family Services to administer the state's Part C (IDEA) early intervention program called First Steps. The new Branch will be called the Early Childhood Development Branch. //2005//***

The Division of Adult and Child Health Improvement (ACHI) has a total of 91 employees. Five branches comprise the Division; Maternal and Child Health, Chronic Disease Prevention & Control, Nutrition Services, Health Care Access, and ***//2005/ Early Childhood Development. The Drug Enforcement Branch is now located in the Office of the Inspector General under the recent state government reorganization. //2005//***

This Division has multiple opportunities to collaborate thereby increasing the potential to have a greater impact on the health care delivery system that affects women and children. Programs such as breast and cervical cancer, school health, WIC, Five-A-Day Campaign, and Healthy People 2010 objectives relative to the Preventive Health Block Grant are housed within the Division. Resources housed within the Division can be reallocated or redirected with greater flexibility as a result of this organizational model.

Discussion follows about service provision from the branches which directly impact maternal and child health; the Maternal and Child Health Branch, Nutrition Services Branch, Chronic Disease Prevention and Control Branch, the Health Access Branch, and the Early Childhood Development Branch.

-Maternal and Child Health Branch: ***//2005/ The Maternal and Child Health Branch (MCH) is divided into two sections, Women's Health and Pediatrics. The Women's Health Section will implement health prevention education and clinical services in the Breast and Cervical Cancer program, family planning and maternity care. Abstinence and teen pregnancy prevention programs are also promoted by this section. The Pediatrics Section includes metabolic screening and genetic and diagnostic services as well as child preventive health screenings (Well Child and EPSDT), child lead poisoning prevention, the Kentucky Birth Surveillance Registry, the Child Fatality Review and injury prevention programs and the Coordinated School Health Initiatives. The Kentucky Birth Surveillance Registry provides critical data and information regarding children born with birth defects. Coordinated School Health Initiatives is a recent addition to the MCH Branch, Pediatric's section and is a collaborative effort with the Kentucky Department for Education. The branch assures quality programs in all areas of MCH programming and policy through coordination, collaboration and technical assistance to partners throughout the state. //2005//***

-Nutrition Services Branch: The Nutrition Services Branch includes five programs; the ACHI Nutrition Program, WIC Program, 5 A Day Program, the Farmers' Market Nutrition Program (FMNP) in

collaboration with the Kentucky Department of Agriculture and the Obesity Component of the Centers' for Disease Control (CDC) Chronic Disease Prevention and Health Promotion Programs Grant.

The ACHI Nutrition Program provides medical nutrition therapy to eligible clients in 110 of 120 counties and community nutrition education services to all counties. The Program goals are to; promote healthy eating that follows national guidance policy, impact policy that improves access to healthy foods, and promote healthy weight among adults and children. The nutritionists provided medical nutrition therapy services to approximately 10,300 unduplicated patients in health departments. Besides providing medical nutrition therapy to patients with problems such as obesity, diabetes and cardiovascular disease, nutritionists conduct in-service education for staff. The community programs use proven strategies such as the 5 A Day Program, Choose 1% or Less Program, weight loss classes, cooking classes, and menus for day care centers and schools.

The federally funded WIC Program sets the standards for nutrition services. WIC's primary focus is to provide nutritious foods, nutrition education and, when appropriate, breastfeeding information and appropriate social and medical referrals for low-income pregnant, breastfeeding and postpartum women, infants, and children who are at nutritional risk. The program is also responsible for promoting breastfeeding, resulting in 31 percent of low-income women breastfeeding.

The Nutrition Services Branch, in collaboration with the Department of Agriculture, administers the WIC Farmers' Market Nutrition Program (FMNP). FMNP provides participants in the WIC Program with coupons to purchase fresh fruits and vegetables at local farmers' markets. Through this program, WIC participants receive the nutritional benefits of fresh fruits and vegetables and nutrition education concerning 5 A Day. Forty-one (41) local agencies/sites, approximately 23,313 WIC participants and approximately 600 farmers received the benefits of this Program.

Additionally, this Branch coordinates the CDC Obesity Prevention Grant, discussed in detail under the "Other Program Activities" section.

-Chronic Disease Prevention and Control Branch: The Chronic Disease Branch is responsible for decreasing the morbidity and mortality from chronic diseases. Emphasis is on prevention and risk factors that can be reduced through healthy lifestyles. The branch puts a significant amount of its effort into decreasing substance abuse including the use of tobacco, alcohol and legal and illegal drugs; increasing physical activity and improving the eating habits of Kentuckians. The branch's programs include cardiovascular health, diabetes, substance abuse prevention, tobacco, health promotion, asthma, arthritis and home health. This branch works closely with the Maternal and Child Health Branch on numerous initiatives including prenatal smoking cessation, maternal diabetes and healthy lifestyles for Kentucky's women of childbearing age and their children.

-Health Care Access Branch: FY 2002 saw the creation of the Health Care Access Branch consisting of the primary care and oral health programs that were formerly part of the Maternal and Child Health Branch. This branch was established to give focus and emphasis to activities conducted by the Division of Adult and Child Health Improvement that address issues of accessibility and availability of essential primary medical and oral health services at the community level.

The Primary Care Program has a cooperative agreement with the federal Department of Health and Human Services (DHHS) to provide current data on health professionals in Kentucky that is used by the Secretary of DHHS in designating Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs) in Kentucky. Branch staff obtains licensure data from the Kentucky Board of Medical Licensure and conducts surveys of local physicians to determine the number of primary care physicians actually practicing in Kentucky counties and the degree to which these physician practices serve the uninsured and underinsured populations.

Following the identification and designation of HPSAs and MUAs, staff of the primary care program participates in several programs aimed at increasing the number of health professionals available to serve these areas including the Conrad State 30 program, the Appalachian Regional Commission J-1

Visa Waiver Program and the National Health Service Corps.

The Division of Adult and Child Health Improvement is a partner with Health Kentucky, a nationally recognized public/private program that seeks to provide health and medical services to Kentuckians with incomes below the federal poverty level who are not eligible for Medicaid and have no other health insurance coverage. Staff of the Health Care Access Branch answers the Kentucky Physicians Care (KPC) hotline to provide information about the program and make referral to volunteer physicians, pharmacists, and other participating health care providers.

The Oral Health Program has attempted to make medical professionals as well as non-professionals aware of the linkages of oral health with general health (i.e., diabetes, heart disease, preterm low birth weight babies, early childhood caries, and others) through disease prevention and health promotion activities. Our vision is that oral health is integral to general health; most oral diseases are highly preventable using evidence-based approaches.

//2005/ - Early Childhood Development Branch: The Early Childhood Development Branch implements statewide services for preventive health in very young children, education to the caretakers of those very young children and direct intervention to children identified as needing developmental and/or social and emotional services. This branch promotes coordination and collaboration between the three major birth to age three programs in the state for both children with and without developmental concerns. This branch oversees "KIDS NOW!" programs, Kentucky's early childhood initiatives that include home visiting through the HANDS program, Healthy Start in child care services, early childhood mental health services and the early intervention Part C (IDEA) program called First Steps for children birth to age three who have a suspected developmental delay or a medical condition known to cause a developmental delay. //2005//

Capacity: Local Health Departments

The degree of coordination and cooperation between ACH and local health departments cannot be overstated. Kentucky has 16 district health departments and 39 independent health departments.

Local health departments are the primary prevention arm for maternal and child health services in Kentucky. Traditionally, this has meant that most of the Title V Block Grant funds have supported direct clinical services in the local health departments. State staff continues to present opportunities for local health departments to partner with new entities and transition into community services as well.

Capacity: Commission for Children with Special Health Care Needs*

****Note: //2005/ Effective March 1, 2004, the Division of Adult and Child Health became the agency designated by the Cabinet for Health and Family Services to administer the state's Part C (IDEA) early intervention program called First Steps. //2005//***

A Memorandum of Agreement between the Commission and the State Division of Disability Services assures that children who apply for SSI benefits receive referral and outreach services.

Families may access Title V/CSHCN services through 14 regional offices across the state. Direct medical services are provided to children with certain conditions, both congenital and acquired. See locations of regional offices and list of conditions treated by the Commission at <http://chs.ky.gov/commissionkids/clinics.htm>. The Commission provides family-centered, community-based care by sending treatment teams including nurses and pediatric specialty physicians at clinic sites in 26 of the state's 120 counties. Clinics for some complex conditions that require multi-disciplinary treatment teams are held only in Louisville and Lexington due to availability of providers. Families in need receive financial support to assist with travel and/or lodging in order to attend these clinics or receive hospital services.

The Commission maintains a local provider network through contracts with approximately 350 pediatric specialty physicians and 150 dentists throughout the state. Other medical and ancillary services e.g., therapists, pharmacists, audiologists are available through contracts with local community providers. The Commission also contracts for foreign and sign-language interpretative services to assure access to care for families of diverse cultures including those with hearing impairments. These services are available in each Commission region. A need for interpretative services is identified during intake and arrangements are made for appropriate service prior to clinic or other Commission appointments.

/2005/ Previously, the Commission had reported on the transfer of the State's early intervention services program, which is partially funded under the Individuals with Education Act (IDEA) Part C. Effective March 1, 2004 this program was transferred from the Commission to the Division of Adult and Child Health. In 2002 in conjunction with the program transfer, the Commission initiated an extensive planning process involving over 70 stakeholders, to study and recommend actions for improving agency capacity to respond to the health and developmental needs of cyshcn. Since then, the Commission has added a developmental transition checklist to the Internet-based case management and reporting system (CUP). Work is now underway to develop a patient and family centered care plan for use by the nurses, social workers and other health care professionals that serve as care coordinators. The care plan will capture child and family outcomes and improve our capacity to measure and monitor the extent to which are delivering comprehensive coordinated care and achieving the other MCHB performance measures.

In 2004 the Commission secured a Family Support 360 Planning Grant from the Administration for Developmental Disabilities to provide services to persons with disabilities in an integrated one-stop setting. Partnering with KY-SPIN, Inc. (KY Special Parent Involvement Network- the state Parent Training Information grantee) and Seven Counties Services, Inc. (the regional mental health/ mental retardation/developmental disabilities agency), the Commission initiated a community planning process in the Louisville Metro to develop a transition and self-determination resource center in the existing network of one-stop health, education, and human services centers known as the Neighborhood Place. As principle investigator on this grant, the Commission has expanded its role from specialty care provider to include community development and integrated systems development. Later this year, the Commission will apply for an implementation grant with the intent of expanding the planning model to other areas of the state. The planning model developed for the Family Support Grant will be used, with minor modification, as the framework for the MCH 5-year needs assessment to be initiated later this year. In conjunction with the needs assessment, we plan to implement a statewide campaign to educate stakeholders at the state and community levels about the needs of cyshcn using the National Survey of CSHCN and other data. Building upon community partnerships formed during the implementation of universal newborn hearing screening and vision screening for children entering school under the KIDS Now initiative, and through our tenure as administrator of the Part C program, our goal is to act as a convener and engage our partners to develop a shared vision and plan for achieving a system of care unique to their community.

The Commission is working to continue to expand the capacity of its health information system to fully support the core functions of public health as relates to cyshcn: to assure early identification and screening leading to diagnosis, treatment, and access to community-based systems of care; to provide comprehensive care coordination with the context of the medical home; to identify and eliminate disparities in health status outcomes; and to support program accountability through the collection, analysis, and reporting of data and progress in meeting performance targets. To this end, grant funds from MCHB for State Systems Development Initiative (SSDI) are currently being used to integrate the UNHS database into the Title V cyshcn care coordination and information system. SSDI funds will then be used over the course of the next two years to support the link between the Title V cyshcn database (including

UNHS) with vital records and other public health data systems maintained by the Cabinet for Health and Family Services.//2005//

Note: Collaborative ventures between the Division of Adult and Child Health Improvement (ACHI) and the following organizations are discussed in detail within Section III E -- State Agency Coordination.

Additional discussion is included within pertinent performance measures and indicators.

1. Commission for Children with Special Health Care Needs
2. Local Health Departments
3. Department for Medicaid Services
4. Department for Mental Health and Mental Retardation
5. Other State Agencies
6. Tertiary Centers (University of Kentucky and University of Louisville)
7. Other Partners (March of Dimes, etc.)

Kentucky School of Public Health

A cooperative venture is being undertaken by Kentucky's leading educational institutions to increase the capacity for public health professionals. The University of Kentucky and the University of Louisville are the cornerstones of the Kentucky School for Public Health. The University of Kentucky School of Public Health is committed to graduate education and offers the Master of Public Health and Doctor of Public Health degrees. Through its Institute for Public Health Research, the University of Louisville offers the Master of Science in Public Health and Doctor of Philosophy degrees. An affiliation agreement between the two institutions outlines a plan to focus on cooperative efforts in teaching, research, and service in public health and to facilitate student matriculation and study at either institution.

Other institutes (such as Eastern Kentucky University in Richmond, Western Kentucky University in Bowling Green and Pikeville College's School of Osteopathy) are working in partnership with UK and UL to make this a truly statewide effort. For more information about the Kentucky School for Public Health, please visit their website at <http://www.mc.uky.edu/kysph/>

Kentucky Public Health Leadership Program

The ability of future public health professionals to positively impact the health of Kentucky's citizens has been greatly enhanced through the development of Kentucky's Public Health Leadership Program.

Employees of the Division of Adult and Child Health Improvement staff, as well as local health department staff, annually attend the year-long Kentucky Public Health Leadership Institute (KPHLI), a cooperative venture between the University of Kentucky (Lexington), the Good Samaritan Foundation, the Kentucky Department for Public Health and the Centers for Disease Control and Prevention.

The Kentucky Public Health Leadership Institute began in March 2000. This multi-disciplinary leadership development opportunity is for individuals involved in Public Health within the state. KPHLI serves as a change catalyst for both leaders and public health entities within the state. The institute's goal is to strengthen Kentucky public health by improving the skills of the professionals who administer state, regional and local public health systems.

The contact person for KPHLI is Cynthia Lamberth, MPH, of the University of Kentucky School of Public Health. Curriculum contents include leadership and teamwork, core public health functions, study pertaining to the ten basic essential services and creating a vision for the future for public health, measuring outcomes, changing strategies within a bureaucratic system and budget/finance. More information about the Kentucky Public Health Leadership Institute is available at: <http://www.mc.uky.edu/kphli>

C. ORGANIZATIONAL STRUCTURE

Office of the Governor

/2005/ Ernie Fletcher, M.D. was elected Governor of the Commonwealth of Kentucky and took the Oath of Office in December 2003. Governor Fletcher has a B.S. from the University of Kentucky College of Engineering and later graduated from the University of Kentucky College of Medicine. Governor Fletcher has also been an Air Force fighter pilot, a state legislator and was United States Congressman before being elected Governor.

Under a statewide government reorganization, the Office for Early Childhood Development, lead by Executive Director Kim Townley, Ph.D, has been relocated to the Kentucky Department for Education. This office coordinates the landmark early childhood development program "KIDS NOW" comprised of 17 initiatives. A model program nationally, "KIDS NOW!" brings together health professionals, early childhood educators, higher education, the business community, foundations, and public and private entities which serve young children and their families from across the state and within multiple state agencies in a united effort to improve the lives of Kentucky's children.

Cabinet for Health and Family Services

One of Governor Fletcher first tasks upon taking office was a reorganization of state government. The Cabinet for Health Services and the Cabinet for Families and Children were consolidated to become the Cabinet for Health and Family Services. The Kentucky Department for Public Health, Division of Adult and Child Health Improvement (ACHI) and The Commission for Children with Special Health Care Needs are included within the Cabinet for Health and Family Services. The Cabinet for Health and Family Services is the state government agency that administers programs to promote the mental and physical health of Kentuckians. The Cabinet includes the following departments: Public Health, Mental Health and Mental Retardation, Medicaid, Disability Determination Services, Human Support Services and Community Based Services. It also includes the Commission for Children with Special Health Care Needs, and the following offices: Ombudsman, Certificate of Need, Inspector General, Legal Services, Fiscal Services, Human Resource Management, Technology, Contract Oversight and Legislative and Public Affairs.

Dr. James Holsinger Jr., M.D. was named secretary of the Cabinet for Health and Family Services by Governor Fletcher. Dr. Holsinger is the former Chancellor of the University of Kentucky Chandler Medical Center. He graduated from Duke University Medical School in 1964 and completed a Ph.D. with a major in anatomy and a minor in physiology at Duke University in 1968. Dr. Holsinger has served in a variety of academic and administrative appointments including time at the University of Nebraska, University of Connecticut, University of Georgia, University of Virginia, and the University of Kentucky. Dr. Holsinger also served for 26 years in the Department of Veterans Affairs and was appointed in 1990 by President George Bush as Chief Chief Medical Director for the Veterans Health Administration.

Delanor Manson has been appointed Deputy Secretary for CHFS. Ms. Manson is a registered nurse licensed in Kentucky, California and New Mexico, a certified health care quality professional and a U.S. Navy Reservist. She most recently was employed as a senior healthcare consultant with Smith Seckman Reid, Inc. of Nashville and previously was senior vice president for accreditation and regulatory management for META Associates of Louisville, a health care program management company. She has nearly 30 years' experience in health care education, marketing and business development as well as practical patient care. Ms. Manson received her nursing degree from the University of Kentucky and holds a master's

degree in healthcare administration from Webster University.

As Deputy Secretary of CHFS, Ms. Manson said she will focus on supporting cabinet initiatives to fulfill Gov. Fletcher's goals to strengthen the state's public and private health care systems and the families they serve.

Mark Birdwhistell is the Cabinet Undersecretary for Health Services. Mr. Birdwhistell was the chief executive officer of CHA Health, a Lexington managed care organization that covered 200,000 members. He had served as CEO since 1998. Mr. Birdwhistell previously held positions with the University of Kentucky Hospital and the state Department for Medicaid Services. Mr. Birdwhistell is a graduate of Georgetown College and has a master's in public administration from UK. He is a past president of the Kentucky Association of Health Plans and serves on advisory boards for the Martin School of Public Policy and Administration at UK. Mr. Birdwhistell will be one of four under secretaries and will oversee Medicaid, Public Health, Mental Health and Mental Retardation and Disability Determination Services.

Rebecca Cecil has been appointed Deputy Undersecretary for Health. Ms. Cecil, a licensed pharmacist, received her degree from the University of Kentucky's School of Pharmacy. During her 14-year tenure with state government, she has served as the Director of Licensing and Regulation in the CHFS Office of the Inspector General and assistant to both the Secretary of Health Services and the Commissioner of the Department for Mental Health and Mental Retardation Services. As Deputy Undersecretary for Health, Ms. Cecil will assist in the oversight and administration of Public Health, Mental Health and Mental Retardation Services, Medicaid and other health services provided to CHFS clients.

Please note that an organizational chart for CHFS is attached. //2005//

Department for Public Health

The Department for Public Health (DPH) is the only agency in Kentucky responsible for developing and operating all public health programs for the people of the Commonwealth. Kentucky Revised Statute 194.030 created DPH to "develop and operate all programs of the cabinet that provide health services and all programs for the prevention, detection, care, and treatment of physical disability, illness, and disease." DPH has a staff of 383 (as of June, 2004) at the state level divided among five divisions described below:

- Division of Adult and Child Health Improvement (ACHI) promotes maternal, child and family health by developing systems of care and by promoting and providing preventive health services to at risk populations. (more detail below)
- Division of Epidemiology and Health Policy is responsible for communicable disease prevention and control, disease surveillance and investigation, injury prevention and research, maintenance of vital statistics and health data, including hospital discharge data and county health profiles. This division also publishes various health planning documents including the Kentucky Public Health Improvement Plan and Healthy Kentuckians 2010.
- The Division of Laboratory Services provides analysis and quality control for health department laboratories and reference services to laboratories. The central lab also conducts metabolic screening for all newborns in the state.
- The Division of Public Health Protection and Safety protects Kentuckians from unsafe consumer products, lead hazards, radiation and other toxic exposure, unsanitary milk, adulterating and misbranded foods, unsanitary public facilities, and malfunctioning sewage systems.
- The Division of Administration and Financial Management develops and oversees the Department for Public Health's budget as well as local health department's fiscal planning, allocations and payments, and their administrative and management practices. The division also manages departmental procurement/contracts, information technology and administrative support to local health

departments in all 120 counties of the Commonwealth.

Division of Adult and Child Health Improvement

The Division of Adult and Child Health Improvement includes Maternal and Child Health (MCH), Chronic Disease Prevention & Control, Nutrition Services, Health Care Access and ***/2005/ Early Childhood Development. The Drug Enforcement Branch is now located in the Office of the Inspector General under the recent state government reorganization.***

//2005// James S. Davis, M.D. is the Director of the Division of Adult and Child Health Improvement.

The Maternal and Child Health (MCH) Branch activities, set forth under the Title V program, are managed by Linda Lancaster, Branch manager and section supervisors for teams including: Pediatrics and Women's Health. More information about programs within the Maternal and Child Health Branch were provided earlier in the narrative.

Children with Special Health Care Needs

Kentucky's "KIDS NOW!" initiative gave the Commission the charge to implement a statewide Universal Newborn Hearing Screening (UNHS). State tobacco settlement funds totaling \$1.7 million were allocated for state fiscal years 2001 and 2002 to support the implementation of this initiative. The mandate to implement UNHS necessitated the addition of new staff members and a change in organizational structure.

The Commission's executive office, division directors, and statewide administrative staff are located in the central office in Louisville. The three Nurse Service Administrators live and maintain offices in the regions they manage. This level of regional, community-based management allows timely supervision and intervention as issues arise; identification of emerging issues that may impact the agency and population served; and reinforcement of program objectives on a consistent, statewide basis.

The merger of Kentucky's Part C and Title V/CSHCN programs occurred just as the state was beginning to experience the effects of a budget crisis that continues to restrict staffing capacity and program development. The Kentucky CSHCN was officially reorganized in October 2001 to include the state's early intervention program (First Steps). The former Divisions of Medical Services and Care Coordination were abolished. The Medical Director, Dr. J. William Holmes was assigned medical oversight for both the CSHCN's Title V and Part C programs. New program divisions were created: 1) Health and Development; 2) Administrative Service ; and 3) Quality Outcomes Management.*See attached Organization Chart. The division of the Commission's local statewide offices into three distinct regions with Nurse Service Administrators as regional managers was maintained within the Division of Health and Development.

The Commission's Executive Director, Medical Director, and Directors of the Divisions of Administrative Services, Health and Development and Quality and Outcomes are appointed by the Governor, as are members of the Board of Commissioners, and the Hemophilia Advisory Committee. The Commission's Executive Director with approval of the Board of Commissioners appoints members of the Medical Advisory Committee. The primary role of the Board of Commissioners is to provide oversight and approval of the executive director's actions. The Board meets quarterly with the Executive Director and senior management staff to review program status, consult and advise on programmatic concerns, and take voting action as may be required on certain issues or business such as appointments to the Medical staff.

/2005/ Effective June 16, 2004 under the newly re-organized Cabinet for Health and Family Services, the Commission reports to the Undersecretary for Children and Family Services, Eugene H. Foster, Ed.D. Dr. Foster has extensive experience in the delivery of care and the organization of community based systems of care for children and youth with special needs and their families. Additionally, he brings a wealth of experience and expertise in strategic

planning, staff development, and community capacity building for systems change. In addition to the Commission, Dr. Foster oversees the Department for Community Based Services (DCBS). DCBS administers an array of income assistance programs, including TANF and Food Stamps; determines eligibility for Medicaid/SCHIP and the Kentucky Physicians Care Program; and is responsible for child and adult protective services, foster care (including medically fragile foster care) and adoptions. DCBS has a local office in each of Kentucky's 120 counties. The Louisville DCBS office(together with the Jefferson County Public Schools, Louisville Metro Health Department and Human Services Department; and Seven Counties Services) created the Neighborhood Place one-stop centers--which are the focal point of the Commission's Family Support 360 grant. Many of the Commission staff that work in the district offices already have strong relationships with their local DCBS counterparts. As the services offered by DCBS are critical to community systems of care, we envision that these relationships will contribute to the strength of our MCH 5-year needs assessment.

At the present time there has been no discussion of re-organizing the Commission.

D. OTHER MCH CAPACITY

Senior Management

Director - Division of Adult and Child Health

Dr. James S. (Steve) Davis did his undergraduate studies at Morehead State University receiving a Bachelor of Science degree in Biology. He received his M.D. degree from the University of Kentucky and completed his internship and residency in Pediatrics at the University of Kentucky Chandler Medical Center.

Currently, Dr. Davis is responsible for overall direction of the Division of Adult and Child Health Improvement, Department for Public Health, including medical policy development for Maternal and Child Health (MCH), Kentucky's Early Intervention System (First Steps), Chronic Disease Prevention, WIC and Nutrition, Primary Care, Oral Health, and Home Health services. Duties include: managing a budget of \$200 million, supervising 90+ staff members overseeing the development of grants and contracts, working closely with local health departments, universities, state agencies, legislators, and the public, represents the Division with professional medical associations, private physicians, and a variety of task forces and interagency planning groups. The position requires independent medical judgment for development of clinical standards, medical policy, and consultation on individual patients.

Prior to his appointment as Division of Adult and Child Health Improvement Director, Dr. Davis was a practicing pediatrician. He practiced first in Glasgow, Kentucky. He then established a large pediatric medical practice in Pikeville, Kentucky, which provided comprehensive pediatric care to approximately 16,000 children. He recruited five pediatricians and established evening and outreach clinics to improve access to care. He worked with Pikeville Methodist Hospital to establish a Level II Neonatal Intensive Care Unit and a Pediatric Transitional Care Unit for critically ill children. He also served as a teaching preceptor for several colleges and universities.

Dr. Davis provides leadership to the medical profession by service on numerous boards and committees. He is the Chair of the March of Dimes Prematurity Campaign, the Kentucky Folic Acid Partnership, Co-Chair of the State Health Care Decision Advisory Committee and Kentucky's Interagency Coordinating Council for Early Intervention: First Steps Program. Dr. Davis serves on the Executive Committee of the Kentucky Pediatric Society, Kentucky Perinatal Association and on the Advisory Committee of the Kentucky OB-GYN Society. Dr. Davis is a frequent presenter to task forces, conferences, and schools on issues as diverse as Health Policy Management, Teen Pregnancy Prevention, Common Childhood Injury Prevention, Drug Diversion and the Health Status of Kentuckians.

In 1998, Dr. Davis received the University of Kentucky College of Medicine Distinguished Alumnus

Award. In 2003 he was inducted into the Alumni Hall of Fame at Morehead State University.

Branch Manager, Maternal and Child Health

Leading this branch since September of 2002, Linda Lancaster has been with the DPH since 1988; working with Kentucky's Early Intervention Program (First Steps), Kentucky's Birth Surveillance Registry, State Folic Acid Supplementation Program, Adult Preventive and Arthritis programs. Ms. Lancaster has an Associate Degree in Nursing from the University of Tennessee School of Nursing, a Bachelor of Science Degree in Health Education from Peabody College at Vanderbilt University and a MPA from Kentucky State University School of Public Administration.

Branch Manager, Nutrition Services

Frances M. Hawkins manages the Nutrition Services Branch. A state public health employee in Kentucky since 1980, Ms. Hawkins coordinates the Nutrition Services Branch, which administers the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the Adult and Child Health (ACH) Nutrition Program, the Five A Day Program, the Farmers' Market Nutrition Program (FMNP) in collaboration with the Kentucky Department of Agriculture and the Obesity Component of the Centers' for Disease Control Chronic Disease Prevention and Health Promotion Programs Grant. Ms. Hawkins received her early training at Indiana University of Pennsylvania and her Master's degree at the University of Kentucky in 1979. She has managed the Nutrition Services Branch since 1996 and is a registered, licensed dietitian.

Branch Manager - Health Care Access Branch

John Hensley has been an employee of Kentucky State Government for over twenty-one years. He began his career with the Department for Education and soon moved to the Cabinet for Families and Children where he worked for sixteen years. Moving up within the Cabinet, he started as a staff member of the Family Service Office and after several years was promoted to the position of Family Services Office Supervisor. In 2000, he moved to the Department for Public Health where he was a Program Development and Evaluation Specialist for the Cardiovascular Health Program for two years before transferring to the Health Care Access Branch to administer Kentucky's J-1 Visa Waiver Program. He was promoted to Branch Manager in October of 2003. Mr. Hensley received a degree in Sociology from Morehead State University in 1976.

Branch Manager - Chronic Disease Prevention & Control

Curt Rowe has worked in the area of public and private not-for-profit health care endeavors for the past thirty years. Earning his undergraduate degree in business administration at Berea College, he went on to earn his Master's of Public Health degree at the University of North Carolina in 1970. In his professional roles, Mr. Rowe has supervised employees in various departments of private, not-for-profit hospitals, in health promotion/disease prevention initiatives, in grant-funded initiatives, and in numerous appointed work groups.

Acting Branch Manager - Early Childhood Development

Germain O'Connell has a bachelor's in Social Work from the University of Kentucky (1979). Working her entire career in the field of disabilities with both children and adults, Ms. O'Connell was a key staff member of Kentucky's First Steps program (working in development, implementation and management) for ten years under its' previous home with the Department of Mental Health/Mental Retardation. With this program now relocated to the Department for Public Health under the Early Childhood Development Branch, Ms. O'Connell was appointed as Acting Branch Manager from her previous position of Section Supervisor of the Early Childhood Development Section under the Maternal and Child Health Branch. Her experience and interest in the area of developmental delays and disabilities will provide many benefits to the program.

Other Key Program Staff

James C. Cecil is the Administrator of the Office of Oral Health for the Commonwealth of Kentucky, under the Health Care Access Branch of Adult and Child Health. Prior to his appointment, Dr. Cecil was a faculty member in the Division of Dental Public Health, Department of Oral Health Science in

the College of Dentistry at the University of Kentucky. He has been a faculty member since his return to Kentucky in 1996, where he completed a distinguished career with the United States Navy Dental Corps. His research and service projects relate to access to oral health care where he is actively involved with the development of preventive dental outreach programs that service Appalachia, Central and Western Kentucky. Dr. Cecil received his Doctor of Dental Medicine degree from the University of Kentucky in 1970 and his Masters in Public Health degree from the School of Public Health at the University of Michigan in 1976.

Tracey D. Jewell is the lead maternal and child epidemiologist for the MCH Branch. Ms. Jewell earned her Master's of Public Health at the University of Alabama Birmingham School of Public Health in 1998. She joined the staff at the DPH in February of 1999 and came to the MCH Branch in January of 2001 to assume her present position.

Commission for Children with Special Health Care Needs - Senior Management Staff

Executive Director - Eric Friedlander has been Executive Director of the Commission since June 2000. Mr. Friedlander is a graduate of Antioch College with a B.S. in Economics and has served 16 years in KY state government with experience in administration of health and human service programs. Before coming to Commission, Eric served as manager of Statewide Family Resource and Youth Services Centers Program -- a school based health and human service program designed to remove barriers to children's learning and as manager of the Budget and Policy Branch of the office of Program Support for the Cabinet for Health Services.

Medical Director - J. William Holmes has been medical director at the Commission since November 1993. He has a bachelor's degree in philosophy from Vanderbilt University and an M.D. from the University of Louisville. He has completed training in Pediatrics at the University of Louisville and Neurology/Pediatric Neurology at the University of Kentucky. He was on the faculty of the Departments of Pediatrics and Neurology at UL for 13 years and still holds a clinical appointment. He works with the pediatric specialists throughout the state to assure that the Commission has properly credentialed physicians and dentists delivering services in the Commission clinics. In addition to his consultative and advisory role for Title V/CSHCN services, Dr. Holmes also serves as a reviewer and advisor for First Steps.

Director of the Division of Administrative Services- Beverly R. Hampton has been Director of Administrative Services at the Commission since August 2000. ***/2005/ Ms. Hampton retired from the Commission on August 1, 2004. Her position remains unfilled. Responsibility for CYSHCN portion of the Title V MCH Block Grant was assigned to Theresa Glore. Ms. Glore has a Masters of Science Degree in Community Development, with a focus on community health systems development. As a former employee of the Department for Public Health she was: staff member in primary care and health systems development; manager of HIV prevention and services, including development of systems of care under the Ryan White AIDS grant; manager of health education and state tobacco control contact. Prior to coming to the Commission in October 2000, she served as an assistant to the Director for Local Health Department Operations and as manager of the Procurement Branch. She has a certificate in Health Care Negotiation and Mediation from Harvard School of Public Health and did post-graduate study at Antioch University in conflict resolution.//2005//***

Director of the Division of Quality and Outcomes - Anja Peersen has been a Division Director at the Commission since February of 2000. She received her B.S.N. from Georgetown University and her M.S.N. and a graduate certificate in Interdisciplinary Services and Leadership from the University of Kentucky. She is also certified as a Professional in Healthcare Quality (CPHQ). Ms. Peersen began working for the Commission in 1996. She served as the Program Coordinator for the Healthy & Ready to Work Projects until 2000. Ms. Peersen is currently responsible for providing quality oversight to the programs at the Commission including the Title V, Part C, and UNHS programs.

/2005/ Statewide Staff (including Family Professionals) The Commission has a designated

Information Systems (IS) Branch with a manager and three key personnel and one contract consultant who are working to develop the Computer Utilization Project (CUP), a custom, web-based data management and warehouse system. /2005/ The Cabinet has notified us of the intent to centralize IT services, but as of this date, we do not have specific details. //2005//

Merger with Part C and subsequent re-organization provided the agency the opportunity to create a new parent/education liaison position. An existing staff member Linda Miller who had previously worked in the Intake Division was selected for the position. Ms. Miller is focusing on building partnerships with the state's various family-professional organizations and with the Dept. for Ed., Div. of Exceptional Children to enhance transitions planning and services for cshcn.

/2005/ The Commission has 119 state employees in clinical positions across the state. Other services on the Title V/CSHCN side of the Commission remain essentially the same as reported in the last two years. In addition to a full time physician medical director based in the central Louisville region, other filled positions across the state include: 55 RNs, 10 social workers, 6 speech pathologists, 15 audiologists, 1 occupational therapist, 1 physical therapist, and 1 dietician. //2005//

E. STATE AGENCY COORDINATION

Collaboration: Adult and Child Health Improvement / Commission for Children with Special Health Care Needs

The Directors of these two organizations remain in close contact despite the physical distance between the agencies. They, as well as the Title V Administrator and the Director of Administrative Services, maintain excellent and close working relationships; continually building bridges between the two agencies.

/2005/Cooperative ventures between ACHI and the Commission include: Folic Acid Supplementation, Kentucky Birth Surveillance Registry, State Systems Development Initiative (SSDI grant), fluoride varnish & screening. A representative from ACHI is an ex-officio member of the Commission Board. //2005//

The Commission also provides services to children identified with Sickle Cell Disease under the Kentucky Newborn Screening Program. More information about the referral system for the NBS program is provided under National Performance Measure Number 1 in Section IV.

Collaboration - Adult and Child Health Improvement / Local Health Departments

The arm of the Department for Public Health, local health departments are facing new challenges in service delivery. There are three health care delivery system changes that are currently impacting local health departments are; 1) Medicaid cost-based reimbursement phase out; 2) private providers providing medical homes via Medicaid Managed Care and the KenPAC physician case management program and finally; 3) the reduction in the number of Medicaid patients so that those local health departments still providing direct clinical services have fewer opportunities to generate reimbursement from Medicaid.

In general, children and pregnant women in Kentucky are well supported through the KCHIP and Medicaid insurance systems. The service gap identified is for the adult males and non-pregnant females as well as for undocumented immigrants of all ages. And it is the latter group whose increasing numbers stretch the safety net system. Many local health departments are using Title V funding to provide prenatal services to this population.

Collaboration: Adult and Child Health Improvement / CCSHCN / Department for Medicaid Services

The Division for Adult and Child Health Improvement has a long history of cooperation with the Department for Medicaid Services. Kentucky's CHIP program (KCHIP) is also coordinated through this department as is KenPAC, Kentucky's Managed Care Program.

KCHIP: Kentucky implemented the KCHIP program in multiple phases. The first phase began July 1, 1998, as an extension of Medicaid coverage to children between the ages of 14 to 18 who were in families at or below 100% of the Federal Poverty Level (FPL). The second phase of KCHIP began on July 1, 1999. Medicaid was expanded to cover eligible children from age one through 18 years who did not already have health insurance and whose family income fell at or below 150% FPL. The third phase began in November 1999 as separate insurance program. This phase covers children whose family incomes are 151% FPL and up to 200%. The separate insurance program offers the same benefits as Medicaid, except for non-emergency transportation and Early Periodic Screening Diagnosis and Treatment (EPSDT) special services.

Eligibility is determined by the Department for Community Based Services (DCBS). KCHIP children use the same health care providers as Medicaid and are served through the same service delivery systems as Medicaid.

A map within the appendices shows the counties where KCHIP services for children are covered through Passport Health Plan. Children residing in other counties not shown are served through KenPAC, a Primary Care Case Management (PCCM) program.

KCHIP members enrolled are required to select a Primary Care Physician (PC). PCPs or Primary Care Case Managers are responsible for the coordination of medical services for children enrolled in KCHIP. The purpose for these medical homes is to provide each child with a health care professional who understands the unique needs of the child.

KCHIP enrollment data as of March 2001 - 54,183 - Cumulative Enrollment Data - 77,532
KCHIP enrollment data as of March 2002 - 51,368 - Cumulative Enrollment Data - 133,635
KCHIP enrollment data as of March 2003* - 50,531 - Cumulative Enrollment Data - 161,959

***/2005/ KCHIP enrollment data - 48,776** - Cumulative Enrollment Data - 187,126
** as of March, 2004 //2005//***

*Phase I children ages 14 - 18 up to 100% FPL are now covered by Medicaid's Title XIX - basically enrollment has stayed the same.

Kenpac - Implemented in 1985, the Kentucky Patient Access and Care (KenPAC) Program is a primary care case management program that increases access to primary and preventive health services and coordinates other Medicaid covered health care and related services for Medicaid members eligible to participate in the program. A pediatrician, internist, family doctor, general practitioner, OB/GYN, rural health clinic, primary care center or nurse practitioner acts as the primary care provider (PCP) for Medicaid members enrolled in KenPAC. Kentuckians who receive financial assistance through the Kentucky Transitional Assistance Program (K-TAP), which was formerly Aid to Families with Dependent Children (AFDC) and adults aged 19 and older who receive Supplemental Security Income (SSI), are enrolled in the KenPAC program.

In the month of March 2004, KenPAC served approximately 346,115 enrollees (adults and children) in 104 counties.

In 2001, the KenPAC program added a care coordination support function. The program is staffed entirely by experienced registered nurses that are located around the Commonwealth in areas with high Medicaid population densities. The KenPac care coordinators serve as a liaison between Medicaid and the KenPAC providers. Additionally, on a case-by-case basis, these nurses are available to assist with health care service coordination for KenPAC recipients with unique health problems.

In April, 2003 KenPAC Care Coordination began two six month pilot projects targeting members with large claims, for treatment of congestive heart failure and prescription drugs. Working closely with the member's KenPAC primary care provider, the pilot projects are intended to study a sample population with the intent to reduce costs and to improve the quality of health care.

Memorandums of Agreement (MOA's) - ACHI and Medicaid:

The Division of Adult and Child Health Improvement, as the state Title V agent, has a long history of working cooperatively with the Department for Medicaid Services. This relationship continues through several Interagency Agreements that are renewed annually.

One of these agreements covers preventive health services delivered to Medicaid recipients by local health departments and reimbursed by the Department for Medicaid Services.

Another interagency agreement provides Medicaid reimbursement for early intervention services for infants and toddlers who are determined eligible for First Steps, Kentucky's Early Intervention System, authorized by the Individuals with Disabilities Education Act.

A third agreement is in place between the Department for Public Health, Department for Medicaid Services and Department for Community Based Services. This agreement provides Medicaid reimbursement for targeted case management for Medicaid patients (including children in custody or at risk of being in custody of the state and adults in need of protective services) and for rehabilitative services for Medicaid-eligible children in custody or at risk of being in custody of the state.

The Department for Public Health, Department for Medicaid Services, Department for Community Based Services and Department for Mental Health/Mental Retardation Services also have an interagency agreement for provision of community-based mental health services to children who are in custody or under supervision of the state, or at risk of being in custody of the state; and have just been discharged from a psychiatric facility or at risk of institutionalization in a psychiatric facility.

A fifth interagency agreement is in place to provide Medicaid coverage for targeted case management services to pregnant women, parents and children served by HANDS, the Health Access Nurturing and Development Services Program.

Finally, the Medicaid Services Presumptive Eligibility Program for Pregnant Women is in place and will allow pregnant women to receive prenatal care through Medicaid for up to 90 days while their eligibility for full Medicaid benefits is determined.

Memorandums of Agreement (MOA's) - CSHCN and Medicaid:

In addition to the MOA with ACHI, the Commission also maintains a separate MOA with the Department for Medicaid Services to enable the Commission to provide therapeutic remedial services for applicable Medicaid eligible children enrolled for Title V/CSHCN services. This agreement references the applicable federal and state statutes or regulations and assure that services are provided in accordance with the Title XIX State Plan and EPSDT special services as required by OBRA 89. This MOA is renewed annually.

Collaboration: Adult and Child Health Improvement / Cabinet for Mental Health and Mental Retardation

As part of the KIDS NOW Early Childhood Development Initiative, the Kentucky Division of Substance Abuse, Cabinet for Mental Health and Mental Retardation, is working in partnership with the Department for Public Health in a statewide effort aimed at increasing the health of all Kentucky babies by decreasing the use of alcohol, tobacco, and other drugs during pregnancy. ***/2005/ To date, 80 health departments across the state have a Memorandum of Understanding (MOU) with a regional Comp Care Center to address prevention and treatment of substance abuse in***

pregnant women. Eleven (11) of the forty (40) health departments who do not have a MOU with the Comp Care Centers are working in partnership to develop a MOU to address this important issue.

Also to date, health departments have screened 6,000 pregnant women for alcohol, tobacco, and other drugs using the 4 P's Plus research-based screening tool. By using this tool, women who fall into lower level risk groups can be referred for prevention services, while those in the high risk category can be referred for a fuller substance abuse assessment to the Comp Care system. As a result of this collaboration, thousands of pregnant women struggling with substance abuse issues in Kentucky are being reached. The Comp Care Centers working under the KIDS NOW ECD Initiative have provided substance abuse prevention and /or treatment services to 2,537 pregnant women this fiscal year (end of third quarter report).

Additionally, a collaborative agreement is in place between these agencies to provide mental health services for childbirth to five, primarily in the child care setting (Healthy Start in Childcare) and the Early Childhood Mental Health Program.

Addressing the problem of substance abuse by Kentucky citizens is one of Governor Fletcher's primary health initiatives. The ability of the Department for Public Health to partner with substance abuse professionals will be enhanced as changes occur with the reorganization of state government under his leadership in mid-June of 2004.

Currently, the Division of Substance Abuse is divided into two branches; Substance Abuse Treatment and Substance Abuse Prevention. The Substance Abuse Prevention Branch will be transferred to the Division of Adult and Child Health Improvement in June of 2004. Having substance abuse prevention staff accessible to many of our programs will facilitate partnerships and enhance collaboration. More details about specific program changes will be discussed with the FY06 report. //2005//

Collaboration: Adult and Child Health Improvement / Other State Agencies

In an attempt to assure health access, interventions and positive outcomes, the Division of ACHI participates in a high degree of coordination and collaboration with other state human service agencies.

-ACHI/Department of Education: /2005/ In 2003 Kentucky was selected as one of eighteen states to receive a Centers for Disease Prevention & Control - Division of Adolescent School Health (CDC-DASH) Coordinated School Health (CSH) Infrastructure grant. The Kentucky Department of Education (KDE) and the Kentucky Department for Public Health (KDPH) partner together to develop, implement and evaluate a coordinated school health program at the state level. The grant award is for \$ 415,000 with \$ 100,000 allocated to the Department for Public Health to fund a full-time coordinator, travel and supplies. Additionally, 2.5 FTE positions have been established within the Department for Education to support coordinated school health activities.

Through this state infrastructure, schools and school districts, with assistance from local health departments and other partners, will create and/or strengthen local CSH Programs. CSH consists of an eight-component national model that recognizes how health, wellness, environment and learning are related. This model is an organized set of policies, procedures, and activities designed to promote and sustain the health of students and staff. The eight components include health education, physical education, health services, nutrition services, counseling/psychological services/social services, health school environment, health promotion for staff and family/community involvement. Many other programs within the Division are linked with this project, specifically through a CSH Interagency committee, which includes representatives from Tobacco, Asthma, Oral Health, HIV/AIDS, Well-Child, Abstinence Education, Diabetes, Nutrition/Obesity, Cardiovascular Health and Physical Activity.

***A coordinated approach to school health improves students' health and their capacity to learn through the support of families, schools, and communities united efforts. A very central theme of CSH is keeping students in school, maintaining health over time, and reinforcing positive healthy behaviors throughout the school day. This provides a clear understanding for the student that good health and learning go hand in hand. CSH offers students the information and skills they need to make good choices in life. More information about this program nationally can be found at the following website:
<http://www.cdc.gov/nccdphp/dash/SHI/index.htm>***

Another key partner, Foundation for a Healthy Kentucky (<http://www.healthyky.org/>), has supported school-based projects through funding of community grants to expand, replicate or enhance Coordinated School Health Programs in Kentucky communities.

For more information about what Kentucky is doing in the area of Coordinated School Health, please contact Victoria Greenwell (KDPH) at 502-564-2154, ext. 3588. //2005//

Many other coordinated school-based activities are underway in Kentucky. Information about specific activities are integrated throughout the narrative; particularly under the area of nutrition and physical activity.

-The Department for Public Health has an active collaboration with the Kentucky Dental Association, the Kentucky Dental Hygiene Association, the Kentucky Dental Health Coalition, the dental schools at the University of Kentucky and the University of Louisville, other state and federal agencies, and Kentucky schools of dental hygiene and dental assisting.

Collaboration: CCHSCN/Other State Agencies

Besides key partnerships with ACH and Medicaid, the Commission for Children with Special Health Care Needs has historically maintained and built new partnerships to enhance the system of care for CYSHCN. In the past year the Commission has worked with the Cabinet for Families and Children to identify Title V/CYSHCN enrollees who are residing in foster care and to share program information that will assure coordination of services for children in foster care.

//2005/The Commission maintains a strong relationship with the KY Department of Education, with the Executive Director serving on the State Advisory Panel for Exceptional Students. A MOU between CSHCN and DOE calls for exploring avenues to link transition related data sets to measure and monitor student progress. The state agency for protection & advocacy, developmental disabilities council, and the university center for excellence in addition to the departments for community based services, vocational rehabilitation, and employment services are partnering with the Commission in the Family Support 360 Planning Grant. The Commission serves on the Department for Mental Health's Co-Occurring Disorders Workgroup, which is studying the need for appropriate behavioral supports for the growing number of CYSHCN presenting with dual diagnosis. A representative of the Commission serves on the state early intervention Interagency Coordinating Council. The Commission also partners extensively with the two state medical schools and their teaching hospitals for specialty care for CYSHCN enrolled in the Title V medical services program.//2005//

Collaboration: Adult and Child Health Improvement / Tertiary Centers

The Division of Adult and Child Health Improvement has contracts with both the University of Louisville and the University of Kentucky for tertiary activities in the areas of genetic services, neonatal care, metabolic services, sickle cell and developmental services. The tertiary centers also provide invaluable consultation and educational offerings to ACHI and hundreds of providers across the state.

-University of Louisville (Louisville, Kentucky)

Community Development Evaluation Services: Community Development Evaluation Services are provided to the Western half of Kentucky through the U of L Child Evaluation Center. They provide 325 multi-disciplinary tertiary evaluations and 260 single-discipline evaluations to children birth to sixteen to determine complex developmental disorders, program eligibility and service recommendations as well as support and educational services to families and health providers. Evaluations are done both at the University's Child Evaluation Center and through a series of traveling clinics across the western half of the state.

High Risk Infant Follow-up Project: The Neonatal Follow-Up Clinic provides developmental screening assessments for high-risk and premature infants for the Western half of Kentucky. The staff provides center based multi-disciplinary neuro-developmental screening to interpret diagnoses to families; identify intervention needs, and initiate specialty referrals. These evaluations are done at both the University's Neonatal Clinic in Louisville and at regional neuro-developmental screening clinics housed in western Kentucky hospitals. In addition, the staff provides technical assistance and education to Pediatricians and other health care professionals throughout the state on how to manage the needs of the premature, high-risk infant they are serving in their local communities.

Other Contracts Impacting Maternal and Child Health with the University of Louisville: These include metabolic screening and case management for children with identified conditions; genetics referral and outreach, maternal mortality, nutrition education for providers of high-risk women; physician and public health nurse continuing education and oral health survey implementation and data analysis.

-University of Kentucky (Lexington, Kentucky)

Intensive Infant Care Project: The Infant Care Project provides 175 multi-disciplinary developmental assessments to acutely ill children to interpret findings to families; identify intervention needs and to initiate specialty referrals. These services are provided to children admitted to the NICU at the University Hospital during the course of their treatment. The professionals at the NICU serving these children also provide on-going training and consultation to hospitals, Pediatricians and local health care providers, in the eastern part of the state, to stabilize these acutely ill children and to assure the continuity of their care once they return to their local community. In addition, the Project coordinates with the Kentucky Birth Surveillance Registry to track outcomes and to design quality improvement initiatives within the NICU. The Director of the Kentucky Birth Surveillance Registry is an employee of the University of Kentucky, assigned to Frankfort.

Kentucky Injury Prevention and Research Center The University of Kentucky Injury Prevention and Research Center (KIPRC) is contracted annually by ACH to provide information, resources and support for injury prevention programs to the local health department systems. They provide support to communities interested in the formation of injury prevention groups at the local level, linking partners and facilitating the process of committee formation. KIPRC also supports the local health departments in their work with Family Resource Centers, health educators and school health nurses. Finally, they provide on-going training to health professionals throughout the Commonwealth, including physicians, nurses, health educators and others.

Young Parents Program: The University of Kentucky's Young Parents Program works to provide quality prenatal care to pregnant adolescents and to identify and address high-risk behaviors in this population. Details about this contact are provided under National Performance Measure Number 8.

Other Contracts Impacting Maternal and Child Health with the University of Kentucky: These include a strong metabolic and pediatric genetics referral and outreach clinic program, the Regional Pediatrics Program evaluation (support of complex medical programs for rural primary care physicians); support for local staff of the KIDS NOW Early Childhood Mental Health Program by the Dept. of Psychiatry and others.

F. HEALTH SYSTEMS CAPACITY INDICATORS

Health Systems Capacity Indicator # 01

The rate of children hospitalized for asthma (per 10,000 children less than five years of age).

Data for this measure improved significantly between FY1998 and FY1999. A new vendor for hospital billing data (CompData) was awarded the state contract in 2000. Data from FY1999 is far more accurate than in previous years when only a few of the larger Kentucky hospitals reported inpatient cases. Kentucky has incomplete data for this measure because no emergency room data is collected by the Department for Public Health; only inpatient data is available at present.

Identified asthma cases for 2001 increased from the previous year. 2000 rates show 44.9 per 10,000 while 2001 increased to 60.8 per 10,000. Data for FY02 showed no change with a rate of 60.8 per 10,000 children hospitalized for asthma. In FY03, a significant increase was shown with the new rate of 69.2. Because of the rising rates, a great deal of work in the area of asthma has recently occurred within the Department for Public Health.

The Chronic Disease Prevention and Control Branch, along with other important partners in Kentucky, applied to the CDC for a Public Health Prevention Specialist, to be located within the branch and to carry out activities specifically related to asthma. The Prevention Specialist was assigned to work in Kentucky August 2003 to September 2005. Additionally, the Kentucky Asthma Partnership was established to coordinate asthma activities across Kentucky. The four primary partners are the American Lung Association of Kentucky, the University of Kentucky, the University of Louisville, and the Kentucky Department for Public Health. Other members include healthcare systems, clinicians, local health departments, local asthma coalitions, Medicaid, KDE, environmental health, and citizens' advocacy groups.

//2005/ The Chronic Disease Prevention and Control Branch submitted a grant application to CDC for funding to build an asthma program, to develop a surveillance system for asthma, and to develop a statewide asthma strategic plan. Additionally, the Kentucky Asthma Partnership developed a burden document to describe asthma in Kentucky and provide recommendations for next steps to address asthma in Kentucky. This document is attached for review. Activities in 2005 would include those required by the CDC grant, which include establishing an asthma program at the Kentucky Department for Public Health, developing a statewide surveillance system, and developing a statewide asthma plan. //2005//

Health System Capacity Indicator # 02*

The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen.

Ninety-five percent of Medicaid enrollees in Kentucky received at least one initial periodic screen in 1999, in 2000, 81.1% and in 2002, 91% received EPSDT screenings. This indicator declined to 81.3% in 2002* and declined again in 2003 to 80.3%.

* During 2002 the mail-in recertification form was replaced by face-to face interviews for recertification, which resulted in a lower number of recipients applying for benefits. Numbers are beginning to stabilize in 2003 as people adapt to the new system.

Health System Capacity Indicator #03

The percent of State Children's Health Insurance Program (CHIP) enrollees whose age is less than one year who received at least one periodic screen.

Again, a substantial increase has been seen between 2000 and 2001. Seventy-nine percent of CHIP enrollees whose age is less than one year have received at least one periodic screen as compared with 40.9% in 2000. In 2002, however, a decrease was seen in this measure, as it dropped to

61%. ***//2005/ In 2003, numbers stabilized and increased to 83.8%. //2005//***

During 2002 the mail-in recertification form was replaced by face-to face interviews for recertification, which resulted in a lower number of recipients applying for CHIP benefits. Numbers are beginning to stabilize in 2003 as people adapt to the new system.

Health System Capacity Indicator #04

The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

//2005/ Kentucky's women are receiving adequate prenatal care as based on calculations using the Kotelchuck index. In 2000, 80.6 percent of women of childbearing age in Kentucky received adequate prenatal care and in 2001, this number rose slightly to 80.8 percent. Data for this measure continues to increase steadily, with preliminary data showing that in 2002, 81.2% of women received adequate prenatal care, based upon the Kotelchuck Index. //2005//

Health System Capacity Indicator #05

Comparison of health system capacity indicators for Medicaid, non-Medicaid, and for all MCH populations in the State. Data for this Health System Capacity Indicator is not available - linkage not achieved as of summer 2003.

Health System Capacity Indicator #06

Medicaid/Chip Eligibility Levels (Form 18). Please see data included within the HSCI section for levels for children and pregnant women.

Health System Capacity Indicator #07*

The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

1999 was the first year for reporting for this indicator, which showed that 51.9% percent of EPSDT eligible children aged 6 through 9 years, received dental services during the year. In 2000, this indicator increased from 51.9% to 52.4%. And another increase was seen in 2001; from 52.4% to 53.5%. Totals declined in 2002* to 36.4% due, in part, to data import issues. ***//2005/ Numbers stabilized in 2003 and increased 43%. //2005//***

* During 2002 the mail-in recertification form was replaced by face-to face interviews for recertification, which resulted in a lower number of recipients applying for CHIP benefits. Numbers are beginning to stabilize in 2003 as people adapt to the new system.

Health System Capacity Indicator #08

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

Between October 1, 2001 and September 30, 2002 the Commission served a total of 4,190 SSI eligible children. This represents non-duplicated children receiving services in the Disabled Children's Program, the SSI/Children's Support Services Program, or the Title V/CSHCN medical program. Currently the Commission is unable to report valid information on services to SSI eligible children enrolled in First Steps.

For many years, the Commission administered the SSI/Disabled Children's Program (DCP) that provided a broad array of early intervention support and medically necessary services to SSI recipient

children aged birth through three. DCP was closed effective June 30, 2002 and the Commission had planned to continue providing limited medical support services beyond those that could be provided under Medicaid or other resources for SSI eligible children ages birth to 16 under a new program the SSI/Children's Support Services Program (SSI/CSS). Although SSI/CSS was established in the fall of 2002 and a few applicants received services through May 2003, the increasing budgetary constraints lead the Commission to make the difficult decision to limit activities on behalf of SSI eligible children to only those services that are mandated for state Title V/CSHCN programs.

Effective July 1, 2003, the Commission will no longer offer separate programming for children receiving SSI benefits. Applications for services under the SSI/ Children's Support Services Program (formerly SSI/Disabled Children's Program) will not be accepted after May 30, 2003. The Commission will continue to document services to SSI eligible children and youth who qualify for services in the Title V/Children with Special Health Care Needs medical program and will work with the data repository for First Steps children at the University of Louisville to strengthen capacity to track SSI eligibility of children receiving FS early intervention services.

The Commission will also continue to partner with the Social Security Administration and Disability Determinations Services to provide outreach and referral information to families who apply for SSI disability benefits for children or youth under age 16. Families of young SSI recipients and youth under age 16 who receive SSI benefits may contact the Commission at 1-800-232-1160 (or by email from the agency website: CASHCHWebPage@mail.state.ky.us)for assistance in locating resources to meet medical or rehabilitative needs that are not covered under Title XIX (Medicaid).

//2005/ The Commission served 9.19% (1,828) of children and youth under the age of 16 who receive SSI benefits in Kentucky. This number is significantly lower than in previous years due to the discontinuation (as a result of state revenue shortages)of the Disabled Children's Program that provided additional services to this population.//2005//

Health System Capacity Indicator #09 A

The ability of States to assure that the Maternal and Child Health program and Title V agency have access to policy and program relevant information and data.

The Division of Adult and Child Health Improvement and the Commission for Children with Special Health Care Needs will both address data capacity issues within this section.

Division of Adult and Child Health Improvement/Maternal and Child Health Branch:

Currently, the MCH Branch has the ability to access many types of maternal and child health data through the work of our lead MCH Epidemiologist, Tracey Jewell, MPH. Ms. Jewell works with MCH Branch staff, analyzing vital statistics data, service data (through the Patient Services Report System - local health department service/payment data), and other information as needed.

Vital Statistics live birth certificates are linked on an annual basis to death certificates. The Maternal and Child Health Epidemiologist has direct access to all electronic files regarding vital events for Kentucky. The birth and death records are linked through the process of running a SAS program that links death certificates to birth certificates based on pre-defined variables and criteria. This process creates a temporary SAS dataset from which detailed analysis can be performed on linked records.

//2005/ Using the State System Development Initiative Grant (SSDI), linkages will begin for birth and death vital records in 2004. The Kentucky Department for Public Health is partnering with the University of Louisville School of Public Health and Information Sciences to examine current needs for linkages and to link data sets identified by program staff. The University of Louisville will also assist CHFS IT Staff in a technical assessment of the FOCUS technology platform in order to determine its capacity to be used for the MCH SSDI grant for linkages described above. While beginning with birth and death records, other systems targeted for

future linkages include Medicaid eligibles and Newborn Screening records (Metabolic and Hearing). //2005//

In 2000, hospital discharge survey data was available through the Kentucky Department for Public Health's Health Policy Branch. UNISYS had been the vendor for the prior contract period but lost the contract to CompData in 2000. The relationship with CompData during the early period of the new contract has been excellent with more complete and timely data submission.

The Kentucky Birth Surveillance System is now fully functional. Additional discussion about the KBSR and resulting data is included with the first narrative section "State Overview".

Currently Kentucky does not provide a new mothers survey such as PRAMS. Some information regarding pregnancy is collected using the annual BRFSS.

Health Systems Capacity Measures # 09B and 09C - Data Capacity

Division of Adult and Child Health:

//2005/ The Youth Behavioral Risk Survey is coordinated by the Kentucky Department of Education in cooperation with the Department for Public Health. Participation for the YRBS increased in 2003 and the resulting data was weighted and will be published. For more information about Kentucky's data, please see the CDC website at: <http://www.cdc.gov/HealthyYouth/yrbs/> //2005//

The ability of States to determine the percent of adolescents in grades 9 through 12 who report using tobacco products in the past month.

This data is based on the Youth Risk Behavioral Survey, completed every other year in Kentucky. In 1997, 47 percent of those surveyed reported using tobacco products during the past month. In 1999, a slight increase to 48.1% was reported. In 2003, 33% of participants reported smoking cigarettes and 14% reported using smokeless tobacco during the past month.

To meet this new health challenge, The KDPH through the Tobacco Use Prevention and Cessation Program and the Oral Health Program has developed the Kentucky Quit Spit Program. The Kentucky Quit Spit Program provides spit tobacco prevention education and cessation information to each of Kentucky's Local Health Departments, Family Resource and Youth Services Center's, and Regional Prevention Centers that make up almost 500 public health agencies in the Commonwealth. This design has enhanced the existing local coalitions effectiveness in helping meet our statewide goals.

The Oral Cancer Self Screening Kit Project is the newest health promotion initiative of the Kentucky Quit Spit Program. The Oral Cancer Self Screening Kit Project focuses on meeting the Healthy Kentuckians 2010 Objectives for oral cancer reduction by using the recommended implementation strategies. The Oral Cancer Self Screening Kit Project long-term objectives are to increase the public's awareness, knowledge, and understanding of oral cancer prevention, increase oral cancer exams, and access to timely diagnosis and treatment as needed.

The Kentucky WIC Program has participated in the Pediatric Nutrition Surveillance System (PedNSS) for 29 years. Data on birthweight, short stature, underweight, overweight and anemia is entered into the system for each child that is certified for the Program. This data is collected by the Patient Services Reporting System (PSRS), identified by clinic site and then submitted to the Centers for Disease Control and Prevention (CDC) for analysis. Reports are produced that summarize the data on a nationwide, statewide and clinic basis. The reports are sent to each appropriate WIC Coordinator. The Program is currently working with CDC to transmit the data electronically and receive the data back electronically. This will result in a shorter turnaround time for the data being returned to the clinic.

Commission for Children with Special Health Care Needs:

The Commission continued development of a custom data system Computer Utilization Project (CUP). To maintain confidentiality of protected health information in compliance with the Health Insurance Portability and Accountability Act (HIPAA), identifying information has been encrypted for electronic transportation and security profiles established to provide access only to authorized individuals. A system audit trail monitors access to information.

CUP features completed during 2002 included the transfer and expansion of our patient encounter system to track patient clinic and non-clinic services, expansion of the social history section to include additional information about education and English fluency, and complete merger of the Hemophilia database into CUP. We began work on a new transitions component that includes a checklist of age appropriate skills that care-coordinators can use to electronically chart the transition accomplishments of individual c/yschn while tracking the overall progress of our population. The checklist is based on the age of the child and will display a list of recommended topics of discussion to the care coordination team. (Another enhancement to CUP during 2002 is a tracking feature for in house and outside appointments.) The Commission's data system has had improvements both in quality and capacity during the past few years thereby allowing us to do meaningful comparisons horizontally and longitudinally regarding the young people in our system and the services provided to them.

//2005/The Commission is using funds allocated under the SSDI grant to integrate the universal newborn hearing screening (UNHS) database into CUP. This will support the linkage between UNHS data and birth records. The development of this capacity is a priority so that we are prepared for the time when KDPH (which administers vital records) and the Cabinet are ready to proceed with the data linkage.

Once the UNHS system is fully integrated into CUP, the Commission will focus on developing the systems capacity for web-based entry of the Hearing Screening Report Form by the birthing hospital. A longer-term goal, but no less important, is the development of web-based reporting functions for audiology providers to notify the Commission when infants receive the recommended diagnostic follow-up evaluation. //2005//

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

During the 2000 State Legislative Session, a radical new program called "KIDS NOW!" was introduced. "KIDS NOW!" is a comprehensive plan that addresses issues for children from the prenatal period (folic acid supplementation) to birth (home visitation and newborn hearing screening) to the time that they attend childcare.

This program added \$ 55 million new dollars to programs centered on children in Kentucky, and in excess of \$ 30 million dollars was allocated specifically for programs dealing with maternal and child health. Funded through the national Master Tobacco Settlement, Kentucky's legislature passed a bill that allowed 25% of this funding to be directed to children and families; thereby assuring significant and ongoing support for this population. Outcome Measures for KIDS NOW! are many of the current MCH Block Grant Performance Measures, including early entry into prenatal care, immunization status, low birthweight, births to teens and hearing screening.

Evidence-based data analysis is an integral part of Kentucky's MCH program evaluation process, and the Title V Block Grant National and State Performance Measures are critical to that process. A concerted effort was made to provide detailed program information for each activity that addresses a national or state performance measure. Due to limited space, however, some details were not included.

Both the Commission for Children with Special Health Care Needs and the Department for Public Health welcome questions from readers. Contact information for the main offices of both agencies are listed below. Upon receipt of your call, you will be referred to the appropriate program person.

Kentucky Department for Public Health, Division of Adult and Child Health Improvement
502-564-4830

Kentucky Commission for Children with Special Health Care Needs 502-595-4459

B. STATE PRIORITIES

The Division of Adult and Child Health Improvement and the Commission for Children with Special Health Care Needs will discuss the identification of their priorities separately within this section.

Division of Adult and Child Health Improvement - Ongoing Priorities

Kentucky's State MCH Priorities are many and broad in scope but all focus on improving the health and well being of Kentucky's population. Kentucky faces numerous health challenges over the next decade. Obesity, smoking (prenatally and throughout the population), diabetes, asthma, low birth weight and prematurity, congenital anomalies and the ratio between white and black infant mortality are all listed as top maternal and child health issues. Issues like oral health, asthma, childhood lead poisoning prevention, injury prevention and mental health for our youngest citizens are new statewide programs that Kentucky is currently addressing aggressively.

State program staff have developed partnerships with local health departments, other state agencies and university staff to become the main driving force in the identification of priorities in maternal and child health. These groups, with the addition of consumers of the services, comprise many advisory committees and ad-hoc committees. Our local health departments provide the "front-line" of defense against emerging health issues at the community level and are in constant communication with state staff. Additional information on health trends is obtained through resources nationally and from other states. Universities provide other resources including, but not limited to, analysis, research and training capabilities in various program areas.

Vital statistics data is used to support many of the maternal and child health performance measures. While Vital Statistics data has inherent flaws, it is considered to be our most accurate source of MCH data. BRFSS and YRBSS Survey data are available with sample sizes large enough to infer findings to the larger Kentucky population. Other data systems, such as PRAMS (Pregnancy Risk Assessment Monitoring Survey) do not currently exist in the state but are being explored for future use. Additionally, the Youth Tobacco Survey administered to high school students added height and weight questions to estimate BMI among youth.

The Kentucky Birth Surveillance Registry (KBSR), primarily a passive surveillance system with targeted active surveillance contains highly accurate data. This system provides critical epidemiological data on children born with birth defects. Conditions targeted are abstracted from hospital medical records by the KBSR staff comprised of a Certified Genetic Counselor and a Registered Nurse. This system has received CDC funding for the past two grant cycles and received a "B" grade from a national review of all birth surveillance systems in the nation. Very few systems received such a high grade, particularly for those that have only been in existence for a few years.

Now fully operational, the Kentucky Birth Surveillance Registry routinely monitors selected congenital anomalies and is also available for cluster investigations throughout the state. ***/2005/ Kentucky is in the process of working with other states on two grant opportunities for the purpose of enhancing capacity in Kentucky to address prevention, screening, diagnosis and treatment of genetic conditions.***

A neural tube surveillance system monitors the rate of NTDs in Kentucky, which has declined dramatically through the combined effort of the fortification of bread and Kentucky's local health department supplementation program to increase the number of women taking folic acid in their communities. This is a primary example of a success story that Kentucky hopes to emulate to other programs and health conditions.

Kentucky has obtained two federal grants, the State Systems Development Initiative grant and the Early Childhood Comprehensive Systems grant to study system infrastructures through data integration and linkages.

The Early Childhood Comprehensive Systems grant will examine current services and identify potential service gaps within five areas Early Childhood Development; Health Insurance/Medical Home; Mental Health/Social-Emotional Development; Early Care and Education Child Care and Parent Education and Family Support. Each subcommittee will meet to discuss issues and provide recommendations. The recommendations will then be discussed statewide in ten local community forums. The information will also be used in the Title V/ MCHB 5 year needs assessment. //2005//

Commission for Children with Special Health Care Needs - Ongoing Priorities

/2005/ A strategic planning retreat was last held in April 2001 to plan for the merger of the early intervention services program with the Commission's Title V medical services program. Now that the early intervention program has been transferred to the Division Adult & Child Health Improvement, a second strategic planning retreat will be held in September 2004 to chart the agency's future direction. Participants in the retreat, which will be facilitated by the Eastern Kentucky University Training Resource Center, will include the commission board, parents and other stakeholders, cabinet level staff, and the agency's executive and management staff. The strategic planning retreat will assure that Commission programs are aligned with Governor Ernie Fletcher's health and education initiatives and his vision for state government. The

retreat also will mark the beginning of the MCH 5-year needs assessment and provide the basis for the Commission's state plan as required by KRS Chapter 48, which stipulates each cabinet submit a four-year strategic plan to the state budget director, the secretary of the executive cabinet and the legislature with each biennial budget request.

The mission of the Commission is to plan, develop, provide and evaluate the public statewide system of care for children with developmental delays and special health care needs. During the coming year, the Commission will address program priorities at each level of core public health practice using the construct of the MCHB pyramid. A discussion of each follows, starting at the base.

Infrastructure Building Services:

-In conjunction with the MCHB needs assessment, the Commission has identified as a priority the building of capacity at the state and districts for analytic assessment, evaluation and planning and quality improvement. (NP # 5)

A turnkey presentation will be developed and staff and parents trained to educate stakeholders about the needs of cyshcn and their families using data from the National Survey of Children with Special Health Care Needs, the 6 MCH performance measures, State Youth Risk Behavior Survey, US Census data, and other data relevant to the health and well-being of children and youth with special needs and their families.

Using elements of the community engagement and planning model developed for the Family Support 360 Grant in the Louisville Metro, stakeholders will be engaged at the state and district level to participate in the needs assessment and planning process to identify strategies for strengthening systems of care for cyshcn and their families. (NP # 2, 3, 4, 5, 6)

-The Commission will partner with the Division Adult & Child Health Improvement in supporting the linkage of public health information systems, including the Universal Newborn Hearing Screening database to vital records, early intervention, Medicaid, etc. to: monitor and report annually on access to care and health status and outcomes among CYSHCN who have been historically underserved, including racial and ethnic minorities and those living in poverty; provide a data foundation for the five-year Title V needs assessment; support the identification of areas for improvement and priorities for resource allocation; and the ongoing collection, analysis & reporting of Title V performance measures and outcomes. (SSDI grant funds will be used to fund this initiative.) (NP# 5, 12)

-The Commission will develop an application for funding from the Champions for Progress Center to financially support family participation at all levels of policy and procedure development, including the Title V MCH 5-year needs assessment at the state and district level through stipends and payments for respite care/child care, transportation, meals and lodging. Funds will also be used to support the replication of educational materials such as posters and CD-ROMs to widely disseminate data from the National Survey of Children with Special Health Care Needs. (NP #2)

Population-Based Services:

-The Commission is finalizing the transfer of the UNHS database into the Commission's web-based care coordination and health information system (CUP). A parallel activity has been the development of systems capacity for web-based entry of the Hearing Screen Report Form by birthing hospitals. Once these two systems development initiatives are completed, the Commission will develop web-based reporting for audiology providers to notify the Commission when infants receive the recommended diagnostic follow-up evaluation. This system will be available for use with other newborn screening programs and for screening programs requiring referral for diagnostic follow-up, treatment, and coordination of care. (NP #

12)

Enabling Services:

-Care coordination is provided to all children and youth enrolled in the Commission Title V specialty medical services program. All care coordination is provided in concert with the medical home. Identification of a standardized care plan appropriate to cyshcn is now underway, with several models under consideration for use by all health care professionals who provide care in our Title V medical program. The plan, which supports families and youth as full partners in decision-making, will lead to the development of child/youth and family specific outcomes and lend itself to measuring progress in meeting these outcomes. It will be a very useful addition to the computerized transition checklist that was implemented system-wide during the current performance period. (NP # 2, 3,4,5,6)

Direct Care:

-Due to the continued presence of medically underserved areas and areas in which there is limited or no access to specialty care, the Commission must continue its role as direct services provider and payor of specialty medical care for cyshcn. The Commission's medical director works with the medical advisory committee and the three regional nurse managers to assess the demand for services and provider availability to respond to the needs. The medical director and regional managers work with local and regionally-based providers to address the need through a variety of practice options, including (but not limited to) specialty clinics provided by the Commission with contract physicians who reside in the area, but prefer to see patients in our clinics; physicians who travel to the area and provide services in Commission clinics; clinics for cyshcn in private physician offices; or patients seen in private physician offices. As indicated in a point-in-time survey on May 21, 2004, the Commission staffs a total of 106 clinics statewide serving 8,944 children and youth. (However, this is subject to change at any time subject to the availability and practice preferences of our contract physicians.) The leading number of children and youth were seen in (not in numerical order): eye, orthopedic, neurology/epilepsy and neurosurgical, otology, and cardiology clinics. A large number of children are also served through asthma, cystic fibrosis, craniofacial anomalies, and myelomenigocele clinics. (NP # 3,4,5)

The MCH 5-year needs assessment will assess the continuing demand for primary & specialty medical care and the availability of qualified health providers to meet this demand. Of concern, is the increasing number of physicians who contract with the Commission who are retiring. The medical director and medical advisory committee will study and make recommendations for how we can address this growing concern, including potential partnerships with graduate medical education programs and residency programs and the use of practice incentives. (NP # 3,4,5) //2005//

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

a. Last Year's Accomplishments

General Program Information : Newborn Screening in Kentucky

Newborn screening tests are performed by the Kentucky Department for Public Health, Division of Laboratory Services. Follow-up for positive screens is coordinated by the program administrator of the newborn screening program in the Division of Adult and Child Health. Additionally, contracts exist with both the University of Kentucky (UK) and the University of Louisville Medical Centers to provide medical consultation. As well as providing a confirmatory diagnosis of the screening result and medical management, the university medical centers engage in medical education and training throughout the state. Formula, and now food products will also be provided for individuals with certain newborn metabolic condition including PKU. The Commission for Children with Special Health Care Needs provides outreach and case management services for children with positive sickle cell disease results.

Commission for Children with Special Health Care Needs

The Commission initiated an outreach and follow-up care program for sickle cell in 1995. When an infant is identified through newborn screening for potential sickle cell disease, the Sickle Cell Program's nurse contacts the family and the child's primary care physician within 72 hrs. The child is scheduled for confirmatory testing (electrophoresis) and placed on prophylaxis penicillin to help prevent infection, which is the number one cause of death among children with sickle cell disease. If the test confirms sickle cell, the program nurse makes a home visit to begin counseling and education with the family and assist them to schedule an appointment with a hematologist at either the University of Kentucky or the University of Louisville.

A monthly sickle cell clinic is held at UK and a weekly clinic in Louisville. The Sickle Cell Program nurses participate in these clinics and are available to assist patients and families as necessary. The role of the Sickle Cell Program nurse is to provide outreach, education including reproductive health information and care coordination for patients, families, health care professionals and the public statewide. Currently 30-60 children and their families are seen monthly in either a clinic or home visit by a care coordinator. The program's goals center around partnership with families and their health providers resulting in: 1) reduced morbidity and mortality among infants with sickle cell disease; 2) parents of children with sickle cell disease know their genetic status and are able to make informed choices regarding future pregnancies; 3) children and youth acquire the knowledge and skills required to manage their disease, understand the genetics of the disease and are able to transition to adult health care and make informed decisions about their health

b. Current Activities

In 2002, 96.2% of Kentucky births received a newborn screening.

In order to improve service delivery, several new projects are currently underway within the Newborn Screening Program (NBS). First, a meeting of the business partners including the two tertiary centers, the Kentucky State Lab and the Department for Public Health met to discuss issues important to the NBS system. These include the need for test expansion and equipment (such as a Mass Tandem Spectrometer) for the lab. Also discussed was the plan to reconvene the New Born Screening Advisory Committee beginning in Summer 2004.

Members of the NBS Advisory Committee will include private insurers, consumers, other state agencies/programs (such as Medicaid, CSHCN and WIC), pharmacies and providers (local and contractors such as UK and UL). Topics for discussion include education for consumers and providers (particularly physicians and pharmacies), data needs related to the NBS program, and increased consumer participation throughout the NBS continuum.

Finally, a new data system for the Newborn Screening program is being developed within the Maternal and Child Health Branch. The Laboratory Information Management System (LIMS) is a in-house data system that will help assure accurate data collection and reporting for the program and allow communication between the state laboratory and the Newborn Screening follow-up staff that are located in the Division of Adult and Child Health Improvement. Specifications for this system are currently under development.

c. Plan for the Coming Year

//2005/ Education is the primary goal for FY 05. A new brochure has been developed to inform parents of the importance of having a newborn screening test performed on their child, along with information and resources on supplemental screening for disorders not currently included on Kentucky's screening panel. This brochure will be distributed statewide to local health departments, Lamaze instructors, OBGYN's, pediatricians, and other health professionals. It will also be incorporated into the information packets provided to families in the early childhood programs such as HANDS, Prenatal, and Family Planning.

A training curriculum is being developed with sessions designed to train and inform Durable Medical Equipment (DME) providers on ordering, billing and processing metabolic food and formula for children affected with a metabolic disorder such as PKU. There is much hesitation to assist these metabolic patients because of confusion and misunderstandings by the DME/pharmacies and it is hoped these trainings will be designed to provide guidelines and contact information to individuals that can provide assistance.

During the 2001 Legislative Session, expansion for the newborn screening program was mandated under SB31, an act related to newborn screening. Newborn screening will expand, as funding is available, to include but not be limited to, medium-chain acyl-CoA dehydrogenase deficiency (MCAD), very long-chain acyl-CoA deficiency (LVCAD), short-chain acyl-CoA dehydrogenase deficiency (SCAD), maple syrup urine disease, congenital adrenal hyperplasia, biotinidase disorder, and cystic fibrosis. The Department for Public Health shall apply for any federal grants available through the Public Health Service Act to expand or to improve programs to provide screening, counseling, testing, or specialty services for newborns or children at risk for heritable disorders. The effectiveness of newborn screening and associated services will be evaluated. //2005//

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

a. Last Year's Accomplishments

A survey of Commission families conducted by the Interdisciplinary Human Development Institute, University of Kentucky, and PiNK (the state Family Voices affiliate) during the summer of 2003 reported that 98.4% of respondents receiving services from the Commission said they were satisfied with the services they were receiving.

-There are now two parents of cyshcn serving on the Board of Commissioners; efforts are

underway to replace a youth who resigned due to illness.

-A developmental transition checklist was added to CUP (the Title V web-based care coordination and information system) to serve as an assessment and counseling tool for families/youth. The checklist covers the knowledge, attitudes, and behaviors that lead to competency in directing personal and family healthcare and provides a means for measuring family and youth participation in the care they receive. Performance data for FY 03 are not complete as use was limited to pilot sites during most of the period.

-Budgetary constraints forced cancellation of contracts with two family advocacy organizations, KY-SPIN and PiNK. In anticipation of the funding cuts, CSHCN initiated a planning process (BLT - building linkages for transition) with KY SPIN and other partners to explore funding opportunities. This became the basis for the STRONG Partnership (Strengthening Transition Resources & Opportunities in Neighborhoods Grant)- a Family Support 360 Planning Grant from the Administration for Developmental Disabilities to develop a transition resource center in Louisville Metro's one-stop centers. The Commission is the grant's principal investigator. Two project coordinators were hired to implement the grant. One is a family advocate employed by KY-SPIN. The other is employed by the Community Mental Health/Mental Retardation Board.

-State general funds were awarded to each of the state's 15 District Early Intervention Councils (DEIC) to support parent participation and involvement at the regional and state levels in regards to early intervention services delivery.

-Linda Miller was appointed in 2002 to coordinate family participation in policy and program development. She is continuing to develop the role, to identify and recruit family leaders, and to network and collaborate with other family advocates. She is active in UP in KY (United Partners in Kentucky), a functional non-compensated partnership to support family-agency collaboration and sharing of expertise and public advocacy for children and youth with special health care needs and taken a leadership role in developing the UP in KY web site that includes an extensive array of resources for families and information about public policy initiatives impacting cshcn and their families.

b. Current Activities

A staff member has been designated to support Title VI compliance.

- KY-SPIN family representatives are co-located in CSHCN offices statewide on a regular basis. KY-SPIN reports include identification of issues and recommendations for improving service delivery.

-Regional nurse administrators are developing a care plan to be used by all health care professionals who provide Title V medical services. The plan mandates participation of family and youth/child in the identification of person and family-centered priorities and outcomes. It expands agency capacity to monitor staff performance, document outcomes, etc. and reinforce families and youth as full partners in decision-making.

The care plan is intended to address a concern documented by an external evaluator in the final report for our HRTW transition grant (1999-2003):

"The Commission pays for services so we tend to want control over scheduling, etc. We must learn to teach families how to work with the system to get the services we pay for and communicate with us about what they got."

It should also address this observation reported by a respondent to the Commission staff survey on transition:

"We need to allow families more control and to make choices so they can be more independent and teach their teens to be more independent and to work with a variety of resources. We still allow or encourage families to rely on us (professionals) too much. Care coordination is often nurturing and controlling rather than teaching families how to do for themselves."

c. Plan for the Coming Year

-Continue the above.

-Implement a family satisfaction survey in conjunction with the MCH 5-year needs assessment and thereafter on a regular basis.

-Each district office will assess the degree that they incorporate cultural and linguistic competence into their programs using the framework and principles developed by the National Center for Cultural Competence and the self-assessment questionnaire developed by the Center, also in conjunction with the MCH 5-year needs assessment. Partner agencies will be encouraged to do the same.

-Staff from each region in collaboration with families and other stakeholders will conduct an area-specific needs assessment. The needs assessment, coupled with findings from the family satisfaction survey and the cultural competence self-assessment will provide the basis for development of a local plan, which identifies priorities and performance indicators/performance outcomes to be targeted during the next 3-5 years for each of the 6 MCHB performance measures.

Performance Measure 03: The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)

a. Last Year's Accomplishments

-95.2% of children & youth enrolled in the Title V medical program had a medical home.

-Entities that enter into a personal services contract with CCSHCN to provide medical services and/or care coordination to cyshcn are required to coordinate care with the medical home as a condition of their contract.

-CCSHCN entered into contract with the University of Kentucky Division of Pediatric Hematology/Oncology on behalf of the university's hemophilia treatment center (UKHTC) to provide outpatient pharmacy services for managing utilization and dispensing clotting factor under the Public Health Services discount pricing program to children and youth who are enrolled in the CCSHCN Hemophilia Program. The pharmacy management program is intended to optimize patient health, while minimizing the need for factor and managing its use. It will provide an avenue for educating patients and their primary care physicians about the latest clinical practices and other important treatment issues. By introducing pharmacy management and supporting the UKHTC's participation in the 340B program, CCSHCN expects to realize better disease management and health outcomes as well as reduced program costs. The program will be evaluated with consideration given to expanding it to other areas of disease/pharmacy management for cyshcn as a potential quality and cost containment initiative.

-Staff made direct contact with the Area Health Education Centers serving their service areas.

The AHEC's serve as a critical link to many primary care practitioners and to graduate medical education programs that secure placements for medical students, residents, and nursing and allied health students. In the future, this relationship may position us to expand our role in assuring access to systems of care, including the medical home, for all cyshcn and not just those served through the Title V specialty medical program. CCSHCN is approved by the Kentucky Board of Nursing to provide nursing continuing education units. We will explore the opportunity to partner with the AHEC's to provide community-based education and training for health practitioners, with a focus on the medical home; comprehensive, coordinated systems of care for cyshcn; and youth transition.

b. Current Activities

-CCSHCN Title V care coordinators record each enrollees' medical home in our web-based case management and reporting system. If no medical home is identified, the care coordinator works with the family and youth to identify a medical home and to establish a link with the medical home.

-Care coordinators are required, and performance is monitored through annual chart audits, to assure that the medical home receives clinic notes within 5 days a child or youth being seen in a CCSHCN clinic.

-Staff maintains direct contact with federally qualified health centers and school nurses who serve cyshcn within their service areas to support coordinated, comprehensive care.

-Referrals are monitored through reports produced by case management and reporting system. District staff contacts primary care physicians who are not referring cyshcn to the Title V program and those new to the area.

- Kentucky Patient Access and Care (KenPAC) nurse case managers are co-located in several CCSHCN district offices. KenPac is a primary care case management program providing a "medical home" and a "primary care provider" to all KenPAC enrollees who are Medicaid-eligible based on Transitional Assistance for Needy Families and adult Supplemental Security Income (SSI). The main goals of the program are to increase primary and preventive services, coordinate use of other health care services including inpatient hospital and outpatient care, thereby improving quality and health outcomes, and controlling overall costs to the Medicaid program.

-CCSHCN Medical Director, who also sees cyshcn enrolled in our Title V medical program, and the nurse coordinator for our Elizabethtown office are on the board of Passport Health Plan, the state's single Medicaid Managed Care entity.

-CCSHCN Medical Advisory Group, which includes a pediatrician who is a recent past president of Kentucky Medical Association, meets quarterly.

-Several Commission offices are located in close proximity to local health departments and/or primary care centers. Several provide clinic space for specialty care such as early intervention intensive evaluations, neonatal follow-up and outreach by the university medical centers, etc.

c. Plan for the Coming Year

-95.2% of children & youth enrolled in the Title V medical program had a medical home, conversely the percentage of cyschn that report having a personal doctor or nurse in the National survey was much lower (12.6% KY/ 11.0 % US). To increase awareness, CCSCHN staff, with the assistance of KY-SPIN, will develop an article presenting National survey data and the 6 MCHB performance measures for publication in state family practice and pediatric

journals. The article will invite their participation in the MCH 5-yr needs assessment.

- Staff will prepare a turnkey presentation for use by state and regional staff and board members on National Survey and the 6 MCHB performance measures for local presentation to medical professionals, public policy makers, families, and other constituents.

-A provider survey will be conducted as a component of the MCH 5-year needs assessment.

-A family survey will be conducted to target families of cyshcn who do not access Title V services to assess their knowledge and satisfaction re: the medical home and to solicit ways in which care can be improved within the context of the medical home. KY-SPIN, PiNK, our education partners, local health departments, etc. will be solicited to assist us in distributing the survey (which will also be posted on the Internet and "advertised" through list serves.) The goal is to capture more specific information than that gained through the IHDI/PiNK survey of families.

-Through the MCH 5 yr needs assessment and the cultural competence self-assessment, district office staff at all levels and to the extent possible, their medical partners, will discuss with families of cyschn the attributes of family-centered care and how it can be incorporated into a variety of practice settings.

KY-SPIN notes as a result of their visits to our district offices and clinics:

"I don't think many of the staff [CCSHCN] know much about the needs of these families, they know the medical needs, but few know how all the other needs play off one another and the direct impact the 'big picture' has on health, education, and just about everything. I think we have made lots of progress ...[however] We still have a long way to go?"

-Continue development of systems capacity through funds from the MCHB grant for State Systems Development Initiative (SSDI) to link the Title V information system (including the Universal Newborn Hearing Screening records) with birth records, the birth surveillance registry, early intervention, etc. to evaluate access to care, utilization of services, and health care outcomes.

-Study availability and access by cyshcn to primary care and specialty care in conjunction with the 5 yr needs assessment. Convene a taskforce to work with representatives from undergraduate and graduate medical education programs to strengthen systems of care and assure that future demand is met for primary care and specialty care physicians and other health professionals.

Performance Measure 04: The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)

a. Last Year's Accomplishments

Per 2001 National Survey of Children with Special Health Care Needs:

-6.4% of cyshcn in Kentucky (5.2% US) are uninsured

-11.5 %of cyshcn in Kentucky (11.6% US) were without insurance at some point during the past year

-38.1% of cyshcn in Kentucky (33.8 % US) between the ages 0-17 are insured with coverage that is not adequate

-Among cyshcn enrolled in the Title V medical program, 66.3% (0-18) and 64.3% (0-21) have

adequate insurance if one considers that children and youth with Medicaid as a payor source have adequate insurance to pay for the services they need.

-Conversely, one in three cyschn served by the Title V medical program do not have adequate private and/or public insurance to pay for the services they need.

The number of cyschn without adequate private and/or public insurance to pay for the services they need is expected to increase. Evidence also suggests that many families are having difficulty in meeting out-of-pocket expenses. The Kentucky Long Term Policy Research Center reports that "families are scrambling to reconstruct budgets that will enable them to meet the cost of health insurance, which, if available, now rivals that of housing for some (2003)." The Center reports in its 2004 report on health care in Kentucky that "Cost, access, and the quality of health care, which relates to both cost and access, have proven to be the perennial public policy concerns. Continued slow job growth has worsened the situation, curtailing revenues that might finance remedies at the state and federal level and increasing the number of citizens of all ages who need help with meeting the cost of health care."

-Surveys of graduates exiting the Commission program between the ages of 18-21 indicate that 35% have no health insurance compared with 27% of youth age 18-24 in Kentucky. Similarly, a number of parents with no insurance or inadequate insurance are unemployed or under-employed.

As employment and earnings have been demonstrated to be a strong predictor of health insurance coverage, CSHCN staff was the lead writer in a grant for funds from the US Department of Labor to improve access to youth with special health care needs and families of cyschn to services offered by one-stop employment and training centers in the Louisville Metro. The proposed scope of work was developed collaboratively with the local Workforce Investment Board, Department for Vocational Rehabilitation, and Center for Accessible Living (which has a federal grant to provide benefits counseling services for SSI/SSDI recipients.) We will not know about the status of the proposal's funding under later this year.

b. Current Activities

-The current process for determining eligibility for Title V medical services includes documentation of insurance/Medicaid status and an annual financial update. In addition to reviewing third party resources, covered benefits in existing policies are reviewed. Families and youth living independently receive assistance in applying for Medicaid, KCHIP (SCHIP), and SSI.

-The intake branch manager and several members of her staff have extensive expertise in health insurance matters as former managers and/or employees of major insurance providers. They are available to assist families and care coordinators in dealing with insurance issues.

-Family education includes accessing financial resources and working with 3rd party payors to coordinate benefits and advocate for coverage.

c. Plan for the Coming Year

In addition to continuing the above,

-Governor Fletcher, a physician and former member of US Congress, is committed to improving the health of Kentuckians, however, he notes:

"We are sorely lacking in public education on healthy habits of living. We need to promote preventive medicine. These issues are especially important to me-which is why we will

modernize Medicaid to make it easier to access, and to empower people to take control of their own healthcare."

To this end, the CSHCN will continue to take an active role through care coordination and family/patient education to re-enforce personal responsibility and self-care and appropriate use of health care resources, including the use of preventive care.

- Through funds allocated to CSHCN from the MCHB grant for State Systems Development Initiative (SSDI), we are working to develop an interface with Medicaid files, which will allow us to evaluate utilization and highlight areas in which we can be more proactive in working with families to ensure utilization of preventive services (such as EPSDT), better management of chronic conditions and prevention of secondary conditions, and support appropriate use of medical transportation, emergency room services, and in-patient hospitalization.

-The MCH 5-yr needs assessment will attempt to further document the extent to which children and youth with special health care needs, including those who are not enrolled in the Title V medical program, have adequate private and/or public insurance to pay for the services they need through parent surveys, focus groups, key informant interviews, and provider surveys.

Performance Measure 05: Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)

a. Last Year's Accomplishments

CCSHCN, PINK (KY Family Voices affiliate), the Owensboro Down Syndrome Association, and KY-SPIN collaborated with the UK Interdisciplinary Human Development Institute to disseminate the Consumer and Family Satisfaction Survey through July 31, 2003 (of which IHDI is the author). Over 1,400 survey questionnaires were distributed to CSHCN offices with 36.4% (n=510) returned. The survey instrument was also widely publicized through electronic list serves targeting families of cyshcn with 136 electronic surveys completed.

Findings from among all respondents (not just families served by the Commission):
61% of respondents reported that a family member had a physical disability
7% reported that their family member had a mental disability
24% reported both a physical and mental disability

Concerning unmet needs, families responded:

Urban Rural

Health care 15.1% 22.4%

Education 12.3% 21.0%

Recreation 20.5% 13.6%

Transportation 13.7% 10.3%

Employment 15.1% 6.3%

Housing 8.2% 5.3%

Respite 2.7% 2.0%

Other 5.5% 7.2%

No current unmet 6.8% 12.5%

needs

Commission results regarding unmet needs aligned closely with the total responses (21.3% reported health care needs; 18.4% reported education needs; 13% reported no current needs) (In comparison, National survey data indicate that 14.8% of KY cyshcn (17.7% US) had 1 or

more unmet needs for specific health care services)

Respondents reporting a greater number of unmet service needs were more likely to be less satisfied with their services as a whole

Consumers who reported having the opportunity to organize and direct services were more likely to be satisfied

Although not statistically significant, an independent T-test revealed that consumers in urban settings were slightly more satisfied with their overall services than were consumers in rural areas

98.4% of those reporting that they received services through CCSHCN said they were satisfied with the services they were receiving from the Commission.

Data from the CCSHCN care coordination and reporting system CUP indicate that approximately 23% of families who receive care coordination, requested assistance with accessing community resources and additional specialty health care. (This number may increase in future periods as the data are limited to offices piloting the new developmental transition checklist in CUP.)

b. Current Activities

-Community outreach is incorporated into position descriptions and performance evaluations. Comments from the staff survey indicate attitudes are changing about the role of the Title V cysnch agency from a clinic to care coordination/systems of care model:

"The Commission focus on building systems of care is at both the state and local levels - from the top down and the bottom up. We've learned that care coordination for children and youth with special health care needs and their families must support access to community-based services and supports that address the social, emotional, and mental health and well-being of the child and youth and their family as well as the tradition array of health and human services."

-The executive director was appointed to the State Department of Education's Special Education Advisory Committee; the Commission is also represented on the State Interagency Coordinating Council; KIDS Now Partnership for early childhood; the State Co-Occurring Disorders systems development workgroup, State Interagency Transition Workgroup, etc. and a number of other state and local taskforces and committees. Active participation is occurring at the district level including District Early Intervention Councils.

-Western KY Program Coordinators developed the Care Coordinator Guide to the Transition Checklist, which incorporates Bright Futures and other developmental assets. The three volumes, which supplement the transition checklists, offer guidance and information for health professionals and families and youth on a comprehensive array of resources supporting social and physical health and development. It is expected to be a great resource for use in building local systems of care as it identifies the comprehensive array of services and supports that should be available and accessible to families. There has been great local interest among our partner agencies in obtaining copies of these guides.

The Commission is the principle investigator in partnership with KY-SPIN and the regional mental health agency, Seven Counties Services, in a planning grant for the development of a disability resource center in Louisville Metro's Neighborhood Place one-stop centers. Supported by a Family 360 Grant from the Administration for Developmental Disabilities, the centers house staff from the Jefferson County Public Schools, Louisville Metro Health Department, Louisville Metro Human Services Department, and the State Department for

Community Based Services (TANF, food stamps, Medicaid eligibility, etc.) Three of the eight Neighborhood Place centers are participating in the pilot because they serve communities with a higher number of racial/ethnic/cultural minorities. Through the community planning process, we are developing a framework for expanding the one-stop development process to other areas of the state and for use in the MCH 5-yr needs assessment.

c. Plan for the Coming Year

- See above

- Implementation of a care plan is expected to further enhance our performance in this area.

-We plan to expand the one-stop planning model to other areas of the state in conjunction with the MCH block grant 5 year needs assessment.

-Conduct family surveys, focus groups, key informant interviews, and provider surveys, etc. in conjunction with the 5 year needs assessment.

-Use the cultural and linguistic competency framework developed by the National Center for Cultural Competence to assess the extent to which community systems of care honor and embrace different cultures in conjunction with the MCH 5 year needs assessment; staff in each district office will use the self-assessment developed by the Center to assess the extent to which they, too, are culturally and linguistically competent and identify specific priorities and outcomes specific to their office.

-Pursue Memoranda of Understanding with partner agencies/organizations, regardless of whether money is exchanged, to include specific actions that each party will take to assure that systems of care are organized so that families can use them easily and the identification of quantitative and qualitative indicators for monitoring and reporting performance.

-Continue to foster attitudes among staff that lead them to see how they, as public health professionals, can contribute to ensuring that systems of care for cyschn and their families are organized so that families can use them easily. As noted in the staff survey:

"When I first came to the Commission, we were one of Kentucky's best secrets. Since then we've made a lot of progress in integrating our personnel into the community through committees, workshops, boards, and partnerships. We are sharing resources, organizing services, and connecting with families in a very big way and at the same time building systems of care for children and youth with special health care needs and their families."

Performance Measure 06: The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)

a. Last Year's Accomplishments

Over the past decade, Commission staff has worked tirelessly to develop an infrastructure that supports successful transition from the time children and families make contact with the Commission until they are discharged or reach their 21st birthdays. This effort has been generously supported by MCHB, most recently through a Healthy & Ready to Work grant which expired September 30, 2003. Transition activities have been incorporated into the overall Title V specialty medical and care coordination program. Staff now has greater focus on teaching youth skills in self-care and condition management. Findings from a staff survey conducted to evaluate the impact of the transition program indicate that:

91% of Commission staff report that they now make a great conscious effort to focus on transition issues.

Staff perceives that young people with disabilities are taking more responsibility for their health care and having less difficulty transitioning to adult health care (86% of youth responding to the graduate survey of youth exiting the Title V medical program report having a family doctor or clinic to go to).

Collaboration among agencies is perceived to be much better; physicians are more knowledgeable and active in discussing transition issues - although still not as much as desired.

Graduates are still not working at levels of young people without disabilities, but they indicate they want to work.

29% of graduates have no health insurance; we still have significant work to be done in helping young people and their families to maintain insurance through family, employer, higher education, and/or Medicaid.

Family educational and socioeconomic levels greatly influence expectations and opportunities for youth with special health care needs; families served by the Commission have low educational achievement, high rates of disability, and are poor.

The need for raising expectations and providing services and supports that result in educational attainment, employment, and access to quality health care is not limited to youth with special health care needs - it also applies to many poor families and families in which the parents are undereducated.

b. Current Activities

-The developmental transition checklist is used by all care coordination staff to identify and assist youth and their families in developing the personal and family competencies (attitudes, skills, and behaviors) which will support self-determination lead to successful transition.

-Central office has senior level staff assigned to coordinate transition-related programming and services and to serve as a resource to staff and other state and local partners.

-CCSHCN is the Title V partner in the MCHB funded National Healthy & Ready to Work Center.

-Each CCSHCN office has a designated transition coordinator, referred to as the "TEACH liaison."

-Requests for proposals and personal services contracts now require each contracting entity to describe how they will address youth transition and the other 5 MCHB performance measures as a condition of their contract.

-CCSHCN continues to partner with transition liaisons from the state's special education cooperatives to identify collaborative strategies for strengthening transition, including Disability Mentoring Day, which has been a huge success in most regions of the state:

National Disability Mentoring Day is a big event in Hazard. CCSHCN staff have secured the participation of a very diverse and locally powerful planning group, including local elected officers, school administrators, small and large employers and other community partners. The

members of the partnership, which have seen first hand the potential that youth with special health care needs represent to the area's labor force, return year after year to volunteer as mentors. And through word of mouth, the number of employers signing up to be mentors increases year after year. Last year, there were more employers signed up to be mentors than there were youth. The mayor proclaims the day as Hazard's Disability Mentoring Day, the school system provides transportation, and the rest of the community kicks in to make it happen. Other counties in the region are now participating and cyshcn in the region have a vast network of very powerful and influential supporters championing their success.

-CCSHCN continues to build upon the success of the Paducah office in providing a forum for teens with disabilities to serve the community, experience new opportunities, and above all to have fun. In most regions of the state, CCSHCN is actively supporting youth participation in local boys and girls organizations, including Girl Scouts, community-based adaptive recreation programs, camps, etc.; assisting other organizations to expand their services or create new opportunities for youth to volunteer, learn, and have fun (such as the Louisville Youth Group which is a collaborative venture between CCSHCN, the Center for Accessible Living, and Metro Parks Department).

c. Plan for the Coming Year

- Continue the above.

-Develop a Memorandum of Understanding with the State Department of Education which identifies specific actions that each will take to promote transition of children and youth with special health care needs, assist local education agencies in bridging the achievement gap, and support the identification and inclusion of health-related issues in the student's IEP and Individualized Graduation Plan.

- Support Governor Fletcher's JOBS for Kentucky initiative by working with vocational rehabilitation, accessible living centers, Workforce Investment boards, and business initiatives to link youth with special health care needs and their families to local employment and training resources, literacy and GED programs, and other local services and supports such as the state's child care resource and referrals centers.

-Be open to opportunities for enriching the lives of cyshcn. The following is an example of one such effort in our Owensboro office:

Special education students from Ohio County Middle & High Schools and Henderson County High School accepted the challenge of organizing and assembling over 800 pages of transition checklists and supporting documentation into three volumes. Each student played an important role. They had to be fast and accurate. Instructions were followed, important tasks accomplished, and deadlines met. Over 100 sets of manuals were assembled --one for each CCSHCN care coordinator. Students experienced the strong sense of personal power, purpose, and worth that comes from a job done well and the knowledge that you are helping others. CCSHCN staff had the opportunity to see these students in a new light--as partners and collaborators. At the end, the students, their parents and teachers and CCSHCN staff celebrated their success with a pizza party. Certificates of merit were distributed, and each student was recognized individually for his/her contributions to a very important product that will be of benefit to many children and youth and their families.

Another outcome that we experienced as a result of our transition program is beautifully expressed in a letter to a local newspaper written by the parent of a girl in the Girl Scout Troop 1509, which is sponsored by the Louisville CCSHCN office:

"... we the parents are very proud of them [the troop]- I look at my daughter every day and think to myself that there is nothing in this world they can't do or accomplish what they want to be in life, just because of their special needs. They just work a little harder each day to prove themselves in this world."

It goes without saying, that we hope to see many of these same outcomes or similar outcomes on a regular basis as a result of our transition program. The youth served through our Title V program represent in no small part the future of our Commonwealth, and we are honored to support them in their transition to adulthood.

Performance Measure 07: Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

a. Last Year's Accomplishments

Last Year's Accomplishments:

General Program Information - Immunizations in Kentucky

Within the Department for Public Health, the Division of Epidemiology is the lead division for the immunization program. Programs operated by the Title V agency and local health departments routinely assess immunization status. Immunizations are provided through the local health departments and supplied through the Department for Public Health. Recent legislation fully funded the cost of vaccines for underinsured children. This program expansion is one of the items within the early childhood development program.

Data for this measure is provided by the CDC's National Immunization Survey (NIS). The NIS has been conducted annually since 1994 by the National Immunization Program and is used to obtain national, state, and selected urban area estimates of vaccination coverage rates for US children between the ages of 19 and 35 months. The NIS is a random digit dialing telephone survey of households with age-eligible children followed by a mail survey of the children's vaccination providers to validate immunization information. National vaccination rates are based on the entire survey sample of more than 30,000 completed interviews. The sample size for each state is considerably smaller and for this reason has a much larger confidence interval.

A child's immunization status is assessed and referrals are made at many points within the health, education and social service delivery system. Specific programs within the Maternal and Child Health Branch that effect this measure within preventive and primary services for children include the following: Regional Pediatrics Program; Child and Youth Project; Well Child Program; Health Access, Nurturing Development Services (HANDS); WIC; and Healthy Lifestyle Education.

b. Current Activities

Current Activities:

The purchase of vaccines to cover the underinsured population of children, who are non-Medicaid and non-KCHIP eligible, will increase access to immunizations. This program was fully implemented in August of 2000. Two million dollars has been added to the proposed FY 04-05 biennial budget. Approximately 7,500 underinsured children have been immunized during FY 03-04.

In 2002, the immunization rate for this measure in Kentucky was 72.3 + or - 6.4 percent. The national average for 2002 was 74.8 + or - 1.0 percent.

Victor M. Negron, Program Manager of Kentucky's Immunization Program, explained why immunization numbers have declined slightly in Kentucky over the past few years. Immunization grant 317 funding and state general funding for program operations or vaccine purchases (for other underinsured children) has been decreasing over the past several years. Additionally, some vaccines have been in short supply from vaccine manufacturers.

The Kentucky Immunization Program distributed a significant amount of vaccine for administration to children from birth through 18 years of age. Transaction data for 2002 shows that 617,063 vaccine doses were distributed to public providers and 235,218 vaccine doses were distributed to private providers, for administration to Kentucky children.

c. Plan for the Coming Year

Plan for the Coming Year:

//2005/ Once again, \$ 2 million has been allocated by the KIDS NOW Early Childhood Initiative to support Kentucky's immunization program. Activities for Fy 04-05 will be similar to those listed in the previous sections. //2005//

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

a. Last Year's Accomplishments

Performance Measure 08:

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

Last Year's Accomplishments:

General Program Information - Teen Birth Rate/Family Planning Services

Data for 2002 indicates a rate of births for teens at 24.9/1000, which is a continuation of the downward trend from 1999 rate of births for teens at 30.2/1000. Kentucky has experienced a drop in the number of teen births in this age group. The rate for 18-19 year olds fluctuates annually.

A full array of reproductive healthcare services for individuals of all ages is available through federal Title X funds allocated to local health departments. Services include client education, counseling, history, physical assessment and laboratory testing, fertility regulation, infertility services, pregnancy diagnosis and counseling, adolescent services, gynecologist services and sexually transmitted disease testing and treatment. 114,458 women, men, and adolescents were served through the Title X program in calendar year 2003.

These services provide primary and preventive health intervention services for adolescents. Additionally, the preventive and primary services for adolescents that effect this measure include: the School Health and Adolescent Preventive Health Services, Family Planning for Teens, Teen Pregnancy Prevention, Abstinence and Healthy Lifestyle Education.

b. Current Activities

Current Activities:

The rate of births per 1,000 adolescents continues to decline in 2002. The rate of births (provisional as of 5/02) to teens 15 to 17 years old decreased from 30.2 in 1999 to 24.9 in 2002. This is still, however, above the national rate of 24.7 per 1000 for this age group. Births to younger adolescents (<15) remained steady at 0.8 per 1000 while the rate of births in 2002

to 18-19 adolescents declined , down from 93.0 in 1999 to 82.0 (Kentucky Vital Statistics 2002).

The teen birth rate per 1,000 adolescents is experiencing another decline in 2002. Provisional data indicates that the rate may fall below 25., current data shows that in the 15 to 17 year age group, births were 24.9 per 1,000. Births for under-15 remain steady and 18 to 19 year olds also declined, from 91.1 in 2000 to 82.0 in 2002. These numbers may change, as birth files are not complete for 2002.

Kentucky is expected to receive \$ 5,271,181 in federal Title X funding for Fiscal Year 2005. The majority of this funding is allocated to local health departments to assure access to family planning throughout Kentucky's 120 counties. Additionally, local health departments may opt to use a portion of their federal Title V Block Grant allocation to support family planning program efforts in their community. All Title X delegate agencies must have a sliding fee scale based upon federal poverty guidelines and must offer all methods of FDA approved contraceptives, including emergency contraceptive pills. Title X funding does not fund abortions.

The Title X program provides regional training opportunities through Emory University School of Medicine, Department of Gynecology and Obstetrics, Regional Training Center. Approximately 14 courses are offered annually, and include topics applicable to family planning and beneficial to many other program staff. An annual needs assessment is completed by local health department family planning staff and courses for the upcoming year are selected based upon the survey results.

A collaboration of the Kentucky Department for Public Health, the Department of Mental Health/Mental Retardation, the Office of Women's Mental and Physical Health, the Kentucky Domestic Violence Association, the Kentucky Association of Sexual Assault Programs, and the Madison County Health Department offered four regional trainings on domestic violence and sexual assault for local health department professionals in June, 2004. The purpose of the trainings was to heighten awareness and understanding of the impact of these social issues, provide education on the health risk assessment screening and documentation tools, and provide community resource and referral information. Over 125 local health department staff attended these trainings. Continued future collaborative efforts are planned to evaluate prevention efforts and disseminate effective strategies to state and local partners to address the issue of violence against women.

c. Plan for the Coming Year

Plan for the Coming Year:

/2005/ Kentucky will continue to have significant numbers of adolescents participating in Postponing Sexual Involvement (approximately 40,000 in 2003) and Reducing the Risk (approximately 16,565 in 2003). Currently, the Teen Outreach Program (TOP) is being conducted in 5 counties with approximately 600 students, this program involves life skills instruction with community service and has been identified as one of the most promising programs to enhance school performance while reducing teen pregnancy.

Under the funding of the Abstinence Education Initiative, 77 counties are running pre-teen PSI classes, representing 80 schools and reaching 13,000 children. In addition, 35 counties also received funding to provide abstinence activities, which vary from classroom training to teen centers and service-learning projects. ACH continues to provide support and to participate in the statewide Kentucky Teen Pregnancy Coalition and to provide technical support to local county coalitions. The Kentucky Teen Pregnancy Coalition will sponsor their annual conference in October, 2004.

The University of Kentucky's Young Parent Program assists young mothers as they deal

with stressors in their lives and teaches them skills to optimize future health outcomes of both mothers and their children. In 2003, 882 patients (562 adolescents and 320 infants) benefited from this program. This program also works in middle schools to identify and address high-risk behavior issues in late childhood and early adolescent years. During FY03, 621 adolescents were served by the school-based component of this program.

All of these initiatives are expected to continue during FY05. //2005//

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

a. Last Year's Accomplishments

In 2001, the Kentucky Children's Oral Health Survey was completed and preliminary data showed that 20% of third graders examined had sealants. The Kentucky Department for Public Health is guiding an effort to develop an oral health status surveillance system for Kentucky, which will be operational during 2003-2004. This will be funded through the Oral Health Collaborative Systems Grant, provided to states by MCHB/HRSA. As part of the surveillance system, sentinel schools will be used to measure the proportion of third grade school children who have received protective sealants on at least one permanent molar tooth.

The Oral Health team, led by James Cecil, D.M.D., M.P.H., has extensive plans for Kentucky. These include the aforementioned Oral Health Surveillance System and working with Medicaid to increase the number of dentists in rural areas and the number of children with Medicaid or KCHIP that routinely access dental care.

Nearly one-third of a sample of 2-4 year olds identified by Kentucky's Children's Oral Health Survey was found to be affected by Severe Early Childhood Caries (ECC) and 9% needed urgent care for decay. A summary of pertinent data follows:

- * Two to four year old children:
- * 47% had early childhood caries (ECC)
- * 31% had severe early childhood caries (S-ECC)
- * 59% got sweets/snacks daily
- * 44% had "bad bottle behaviors"
- * 39% had never been to a dentist
- * 35% of parents had not seen a dentist in the last year
- * 39% had Medicaid; 15% had KCHIP; 29% had private dental insurance

- * School children (3rd and 6th Graders):
- * 57% had caries experience; 29% had visible decay (untreated disease)
- * 51% reported bleeding gums; 15% had signs of gingival inflammation
- * 20% reported having a toothache in the past month
- * >20% had not seen a dentist in the last year
- * 29% had sealants on any molar
- * Problems most severe in the Eastern region of the state

Since 2001, Kentucky has used the data from the 2001 Children's Oral Health Survey of 29% as its total for children in Kentucky who have sealants on any molar. Activities are currently underway to develop an on-going Children's Oral Health Surveillance System which would continually monitor children's oral health (including sealant prevalence).

Until this system is developed, no other statistically significant method exists for measuring

sealant prevalence.

b. Current Activities

The 2003-2004 fiscal year was an exciting one for Kentucky's Oral Health Program. First, Kentucky was awarded an Oral Health Collaboration Systems Grant (MCHB/HRSA) which enabled the beginning of a Strategic Planning Process for the state. A detailed description of the Strategic Planning Process has been included within the Kentucky State Overview Section of the Title V.

Kids Smiles Fluoride Varnish Program started in July 2003 as a part of the KIDS NOW Early Childhood Initiative. The purpose of Kids Smiles is: To prevent early childhood caries (ECC) through: (1) targeted early screening, (2) oral health education of caregivers, (3) application of a fluoride varnish to primary teeth (baby) if necessary, and (4) proper referral to a dentist if appropriate for care. Funding for KIDS SMILES in Kentucky's biennium budget \$ 250,000 each year for two years.

Nearly 9000 children have been provided oral health screenings and applications of fluoride in local health departments during the first three quarters of FY 04.

Provided training at sixteen sites to approximately 700 health department nurses and other providers. Training evaluations indicated training was excellent, timely and appropriate for non-dental professionals.

Oral Health Staff provided over 12,000 pre-packed fluoride varnish kits (free of charge) to participating local health departments. A database for monthly tracking and reporting of local health department applications of fluoride varnish as been developed and a contract has been established with the Commission for Children with Special Health Care Needs to apply fluoride varnish to children (birth to five) under their care beginning Spring 2004. Outcome evaluation to be conducted beginning FY 04/05.

With additional funding from KIDS NOW, sealant programs were started in 18 local health departments. In collaboration with local dental hygienists and dentists as well as community schools, local health departments were provided with funding to purchase portable dental exam equipment. These partners worked together to provide screenings and sealants on Kentucky 2nd, 3rd and 6th graders throughout the Commonwealth. Parents were informed on the program through informed consent signature forms.

In Kentucky, dentists must first screen the child and record which teeth are in need of sealants (Kentucky dental hygienists are under indirect supervision). In some cases, sealants are immediately provided by dentists or hygienists and in other communities, dental hygienists return to the school at another time to provide the sealants. Some local health departments have added dental professionals to their staff to increase the number of preventive dental services that they can provide.

c. Plan for the Coming Year

/2005/ Kentucky's Sealant Program will continue with 23 local health departments participating in 2004/2005. Funding for on-going support for the Sealant Program is provided by KIDS NOW Early Childhood Development Program.

The Kentucky Children's Oral Health Surveillance System will continue with the screenings beginning at Kentucky schools in Fall of 2004 and will be on-going on an annual basis; rotating approximately one third of the random sample of schools off each year and replacing these with new schools. The surveillance system will screen 3rd graders and 9th graders. The surveillance system is a cooperative effort between the Department for Public Health and the University of Kentucky School of Dentistry and is funding by the Oral Health Collaborative Systems Grant, Maternal and Child Health Bureau, HRSA. //2005//

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

a. Last Year's Accomplishments

General Program Information - Motor Vehicle Deaths

In 2002, the rate of deaths to children decreased from 5.3/100,000 (2001) to 3.9/100,000. This reflects the continuation of the downward trend for the past two years.

It is believed that a variety of preventive and primary services for children programs have contributed to this decline. The Child and Youth Project, the Well Child Program, the HANDS program, WIC, Child Fatality Review, Injury Prevention, Child Safety Seats, Child Abuse and Neglect and the Healthy Lifestyle Education program are included.

Two specific efforts by the Maternal and Child Health Branch include the Kentucky Safe Kids Coalition and prevention measures identified through the Child Fatality Review Program. During 1999, the Kentucky Safe Kids Coalition received grant funds to assist in fully implementing the "Buckle That Child" program. This program operates an 800 number for citizens to report other Kentucky drivers by license number who are noted driving without the child or children in their car buckled up. Information on the importance of securing children and wearing seat belts is mailed to that driver. This grant provides safety seats as a resource for low income families in hopes that law enforcement will ticket and judges will fine which has at times been lax because of the economic burden on families. The second effort was the receipt of a mini van from the General Motors and National Safe Kids Campaign partnership that is fully equipped to perform safety seat checkups. Partnering with the Department for Transportation, Governor's Drive Smart Program has allowed these efforts to be implemented.

Local Safe Kids Coalitions throughout the Commonwealth provide regular child passenger safety events provided by grant funding from the National Safe Kids Organization. The KSP and the Department of Transportation has applied for a NHTSA grant to provide car seat and booster seats for Kentucky and KIPRC (Kentucky Injury Prevention Research Center) received a grant to purchase high back boosters for the Commonwealth.

This measure saw a slight increase in 2000; rising from 5.8 deaths per 100,000 children to 6.4 deaths. This increase represents six additional deaths within the age group over totals for 1999 (43 deaths).

A decline occurred for this measure in 2001, 5.3 deaths to children aged 1 - 14 were caused by motor vehicle accidents.

b. Current Activities

Support for the development of injury prevention coalitions and child fatality review teams assisted by the local health departments and at the state level continue.

Additionally, the Division of Adult and Child Health supports the Pediatric and Adolescent Injury Prevention Program at the University of Kentucky. ACH also partners with the Kentucky's Drive Smart Team to provide child safety seat checkups and other safe driving initiatives contribute to the Division's efforts to reduce deaths to children aged 1 - 14 and beyond (the Child Fatality Review System tracks all children's deaths from birth to age 17).

c. Plan for the Coming Year

//2005/ Activities for the coming year will be for Kentucky to continue to work with our current partners to seek improvement in this performance measure.

More about Kentucky's Child Fatality Review Teams and Safety Programs are included under the State Performance Measure discussion. //2005//

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

a. Last Year's Accomplishments

Performance Measure 11:

Percentage of mothers who breastfeed their infants at hospital discharge.

Last Year's Accomplishments:

General Program Information-Breastfeeding

//2002/ Data The percentage of women choosing to breast feed continues to rise steadily, reaching a new high in 2002 at 56.5%, an increase from 54.2% of the previous year.

Last Year's Accomplishment:

The Loving Support Grant Trainings were completed statewide in November 2003. Every agency in the state received the training and returned to their agency to train the entire staff on breastfeeding promotion. This task was to be accomplished by April 30, 2004. All agencies were provided with 3 breastfeeding videos, the book Medications and Mothers Milk, and Loving Support posters and information. Community partners were invited to the training and provided the same materials. Radio PSAs across the state promoted breastfeeding and support for working moms. Single User Electric Breast Pumps were ordered and distributed to each agency. The number distributed was based on the number of breastfeeding women enrolled in the WIC Program.

b. Current Activities

Current Activities:

2003 The percentage of breastfeeding continues to increase; the percentage of WIC moms choosing to breast feed has increased from 25.7% to 34.75%.

The Steering Team of public and private partners, developed from the Loving Support Grant, continues to meet and set policies for breastfeeding education and promotion for the state. Currently, they are developing education and promotion materials, creating a unique breastfeeding logo, developing a Breastfeeding Resource Guide for local health departments

and local health providers and developing a Worksite Program to recognize businesses that support breastfeeding moms.

Ten Breastfeeding Grantees provide additional support for breastfeeding in their area of the state. They provide education and trainings to health care providers, develop creative billboards promoting breastfeeding and provide mobile breastfeeding rooms for families who attend outdoor fairs and festivals. The mobile units offer a clean safe place to nurse and change infants. The grantee located in Louisville initiated and organized the Rock and Relax Room at the Kentucky State Fair for the past 13 years. The Lexington Grantee has been elected to serve as President of the International Lactation Improvement Coalition for the year July 2004 through July 2005. The grantees have established Breastfeeding Coalitions in their area, which offer continuing education credits and provide the members with education and updated policy.

c. Plan for the Coming Year

//2005/ The Nutrition Services Branch and the University of Kentucky Medical Center are planning a Breastfeeding Conference for September 15, 2004. The conference will target physicians, nurses, dietitians and other public and private health care providers. One of the conference speakers will provide information concerning the link between chronic disease and breastfeeding.

The National Ad Council and the Office for Women's Health have created a Breastfeeding Ad Campaign that is set to launch this year. The State WIC Staff and the Breastfeeding Grantees and Steering Team will help promote the media campaign across the state.

Funding from the Centers for Disease Control Obesity Grant will be used to provide materials and education on breastfeeding role to reduce obesity and chronic disease across Kentucky.

Promotions planned for World Breastfeeding Week August 1-7, 2004 include Governor's proclamation, news release and materials mailed to the health departments. //2005//

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

a. Last Year's Accomplishments

The Universal Newborn Hearing Screening staff have provided numerous presentations to a variety of audiences focused on dissemination of information about the Commission's program, collaboration with the medical home, coordination of services from the hospital hearing screening through diagnostic audiology to warranted early intervention services, and educating future pediatricians, general practitioners and audiologists.

The presentations included:

-May 23,2003 - A collaborative presentation with the American Academy of Pediatrics, Chapter Champion for Newborn Hearing Screening, Dr., Dan Stewart, at Kosair Children's hospital Grand Rounds. The audience included practicing physicians, residents and first and second year medical students, audiologists and speech-language pathologists. This was the first Telehealth Network presentation in the state of Kentucky and was simultaneously broadcast statewide with the ability for statewide participants to interact with the presenters.

-Nov. 2003 - Infant Toddler Institute. Multiple presentations were provided by UNHS staff as requested by the oversight committee for the conference. The audience included Part C providers, nurses, parents, audiologists, speech-language pathologists; day care and pre-school staff. Topics presented included Overview of Audiology; What to do, when working with a child identified as Deaf or Hard of Hearing; Brain Development in the First Year of Life; and Learning to Sign.

-May 20, 2004 - Presentation to the Au.D. class at the University of Louisville. Second and third year students in Audiology were given a historic review of Universal Newborn Hearing Screening, State and National guidelines pertaining to the screening, evaluation and warranted intervention and recommended reporting procedures; and audiological and brain development in the infant through age 1 year.

-Led the development of a series of Risk Presentations for Low Incidence Impairments including Deaf and Hard of Hearing, Blind and Deaf/Blind with community partners. The series is to be presented to second year medical students at both the University of Louisville and the University of Kentucky. To date, the Power Point draft presentations have been presented to U of K students in the Department of Special Education. UNHS staff is presenting the Risk Factors related to Deaf and Hard of Hearing series.

b. Current Activities

The Commission is finalizing the transfer of the UNHS database into the Commission's web-based care coordination and health information system (CUP). A parallel activity underway is the developmental of systems capacity for web-based entry of the Hearing Screen Report Form by birthing hospitals. Once these systems are fully operational, the Commission plans to develop web-based reporting for audiology providers to notify the Commission when infants receive the recommended diagnostic follow-up evaluation.

c. Plan for the Coming Year

Continue the above.

In 2003, 50,643 infants were screened prior to discharge from hospitals required to perform and report newborn hearing screening. During the same period, there were 51,008 live births reported by those hospitals mandated to provide a report on all newborns prior to discharge. The percentage screened was 99.28% of all live births at hospitals that have at least 40 births per year and are required to perform and report newborn hearing screening.

It is not anticipated that the performance indicator will rise above 99% for those newborns who are required to be screened due to some families choosing not to have the screening and more frequently because hospital screening equipment may not be functioning prior to the infant's discharge.

If newborns that are not required to be screened are included in the denominator, the target performance indicator is not expected to exceed 94%. Between 1999 and 2003, hearing screening reports were provided for an average of 89.96% of all live births; the percentage in 2002 was 91.52% and the provisional percentage in 2003 was 93.71% of all live births.

a. Last Year's Accomplishments

General Program Information - Uninsured Children in Kentucky

The rate of children in Kentucky without health insurance continues to decrease. In 1998, it was estimated that 13.3% of Kentucky's children were uninsured. In 1999 this estimate decreased to 9.9%. Over the next few years, the estimate for uninsured children continued to decline, to 6.9 in 2001 and 6.5 in 2002. 2003 remains at 6.5 using the U.S. Census Bureau estimation. Translating this into numbers of children, 67,470 Kentucky children were uninsured in 2003, as compared to 101,000 in 1999.

A small portion of the decrease in the number of uninsured children can be explained by a slight drop in the total population ages 18 and under as estimated by the U.S. Census Bureau. The majority of the decrease, however, is the result of a larger share of Kentucky's children having health insurance.

Although it is likely that a number of factors contributed to this decrease in the rate of uninsured children, these results suggest that the Kentucky Children's Health Insurance Program (KCHIP) is having an effect on the number of uninsured children. All uninsured children under age 19 in families with incomes below 200% of the Federal Poverty Guidelines are now eligible for health insurance coverage either through KCHIP or Medicaid.

Kentucky implemented the KCHIP program in multiple phases. The first phase began July 1, 1998, as an extension of Medicaid coverage to children 14 through 18 years of age who were in families at or below 100% of the Federal Poverty Level (FPL). The second phase of KCHIP began on July 1, 1999. Medicaid was expanded to cover eligible children from age one through 18 years who did not already have health insurance and whose family income fell at or below 150% FPL. The third phase began in November 1999 as separate insurance program. This phase covers children whose family incomes are 151% FPL and up to 200%. The separate insurance program offers the same benefits as Medicaid, except for non-emergency transportation and Early Periodic Screening Diagnosis and Treatment (EPSDT) special services. Eligibility is determined by the Department for Community Based Services (DCBS). KCHIP children use the same health care providers as Medicaid and are served through the same service delivery systems as Medicaid.

KCHIP members enrolled in either Passport or KenPAC are required to select a Primary Care Physician (PC). PCPs or Primary Care Case Managers are responsible for the coordination of medical services for children enrolled in KCHIP. The purpose for these medical homes is to provide each child with a health care professional who understands the unique needs of the child.

b. Current Activities

Eligibility is determined by the Department for Community Based Services (DCBS). KCHIP children use the same health care providers as Medicaid and are served through the same service delivery systems as Medicaid.

A map within the appendices shows the counties where KCHIP services for children are covered through Passport Health Plan. Children residing in other counties not shown are served through KenPAC, a Primary Care Case Management (PCCM) program.

KCHIP members enrolled in either Passport or KenPAC are required to select a Primary Care Physician (PC). PCPs or Primary Care Case Managers are responsible for the coordination of medical services for children enrolled in KCHIP. The purpose for these medical homes is to provide each child with a health care professional who understands the unique needs of the

child.

The Division of Adult and Child Health Improvement through partnership with the Division of Local Health Operations and the Department for Medicaid Services have been working to provide outreach, education and referral for the Kentucky Children's Health Insurance Program. Results have been promising. All uninsured children under age 19 in families with incomes below 200% of the Federal Poverty Guidelines are eligible for health insurance coverage either through KCHIP or Medicaid.

Current KCHIP enrollment data as of March 2001 - 54,183.
Cumulative Enrollment Data -- 77,532

Current KCHIP enrollment data as of March 2002 -- 51,368
Cumulative Enrollment Data -- 133,635

Current KCHIP enrollment data as of March 2003 -- 50,531*
Cumulative Enrollment Data -- 161,959

*Phase I children ages 14 -- 18 up to 100% FPL are now covered by Medicaid's Title XIX -- basically enrollment has stayed the same.

c. Plan for the Coming Year

Plan for the Coming Year:

//2005/Activities under this measure for FY05 will be similar to those described in previous sections. //2005//

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

a. Last Year's Accomplishments

Last Year's Accomplishments:

Medicaid and KCHIP eligibility guidelines state that any child age 18 and under is eligible for either KCHIP or Medicaid if their family income is below 200% of the federal poverty guidelines. Using these criteria to define the eligible population, it is estimated that there were approximately 508,000 children eligible for one of these programs. This includes all children below 200% of poverty regardless of their insurance status; that is, some will be enrolled in Medicaid or KCHIP, some will be uninsured and some will have a private insurance policy. The data used from this estimate comes from the Current Population Survey and the Kentucky Health Insurance Survey. - Mike Clark, Ph.D.

As discussed under Performance Measure 13, significant outreach efforts are made to get children enrolled in the Medicaid Program and these have been successful. Efforts to increase Medicaid providers are also ongoing and should ease with the fee-for-service model used by the KenPAC program. Currently KenPAC serves approximately 254,000 enrollees in 102 Kentucky counties. There are about 1,500 physicians at nearly 1000 clinic and office sites participating in the program in Kentucky and bordering states.

Data from 1998 (50.9 %) is questionable, as it varies substantially from 1997 (81.4%) and 1999 (82.9%) and there is no documentation to provide details about data for this year.

In 2000, 68.1 percent of children potentially eligible for Medicaid actually received a service. In 2001 and 2002, the total for this measure continued to increase (77.2% and 75.4% respectively) and in 2003, enjoyed a substantial increase, to 90.7%. Data for this measure has been supplied by Lisa Lee of the Department for Medicaid Services.

b. Current Activities

Current Activities:

Kentucky's State Systems Development Initiative (SSDI) Grant is currently funding Kentucky's initial effort in linking various MCH data sets. While birth and death records will be the first sets linked, the linkage of Medicaid eligible data to both birth and death records will be a high priority. With this information, we can identify children who should be receiving services but who may not currently be in the system.

Many of the programs within the ACH Division currently import Medicaid data and link with records in their respective databases. But no truly integrated electronic linkage system exists between Medicaid and MCH Data systems.

c. Plan for the Coming Year

Plan for the Coming Year:

Please see above.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

a. Last Year's Accomplishments

General Information: Low Birth Weight

General risk factors for very low birth weight and low birth weight include poor nutrition, smoking, substance abuse, infections, lack of oral health and lack of access to prenatal care. Maternal risk factors include diabetes, hypertension, anemia, pulmonary disease, cardiac disease, infections (vaginal and periodontal), chronic lead exposure and abnormal reproductive anatomy.

Several Kentucky programs under the KIDS NOW! Early Childhood Initiative address the risk factors of low and very low birth weight. The HANDS home visiting program will allow more first-time mothers to access prenatal care and services that will enhance their birth outcomes. Kentucky's Folic Acid Campaign will increase the number of women of childbearing age who regularly ingest folic acid and will decrease the number of infants born with neural tube defects.

Substance abuse prevention and treatment for pregnant and postpartum women are now covered through Medicaid. Local health departments and comprehensive care centers are now teaming up to identify substance-abusing prenatal patients early in the pregnancy. Other programs that positively impact this problem include tobacco cessation in the maternal population, WIC, teen pregnancy prevention, family planning, and prenatal.

Additionally, data provided by the Kentucky Birth Surveillance Registry and its' referrals to services for those families identified as having a child affected by a congenital anomaly will also impact the number of low and very low birth weight births in Kentucky. Finally, Kentucky's

network of genetic outreach clinics throughout the state continue to bring excellent genetic evaluation services to patients referred by local health departments and private providers. A state genetics plan and several statewide meetings for those interested in furthering genetic services within Kentucky have occurred during the past year as the Division for Adult and Child Health received a State Genetics Grant from HRSA in 2000, totaling \$ 75,000 for each of two years.

Data for 1999 shows a decline from the previous year; from 1.7 in 1998 to 1.5 in 1999.

b. Current Activities

Current Activities:

//2005/ Data for 2000 and 2001 remains steady for the measure at 1.5 percent. There was a slight increase in very low birth weight to 1.7% in 2002.

In CY 02, a contrast group of first-time parents not participating in the voluntary home visitation program, HANDS, was compared with participating families. The HANDS program saw 13% fewer low birth weight infants and 29% fewer very low birth infants. //2005//

To "jump-start" local efforts to combat the problem of low birthweight, this measure was one of three maternal and child health measures selected for programmatic emphasis during the FY04 budget year in cooperation with local health departments. Activities were recommended known to reduce low birthweight, such as presentation of prenatal classes for families. These were listed and local health departments select appropriate activities for their community from this listing, using Title V funding to underwrite the activities.

As discussed within the State Overview section of this narrative, the problems of both prematurity and low birthweight are being aggressively addressed in Kentucky. In June of 2003, funding was allocated by the Greater Kentucky Chapter of the March of Dimes to support the Kentucky Perinatal Association (KPA) Conference presentation of "Summit on Prematurity; Caring for Our Smallest Citizens".

This conference is traditionally attended by those working in the field of perinatology and is an excellent opportunity to reach physicians and neonatal nurses from across the state. Topics such as "Managing High Risk Pregnancies to Prevent Prematurity" by John O'Brien, M.D., "Focus on Prematurity in the Commonwealth of Kentucky" by James S. Davis, M.D. and "Premature Birth - The Answers Can't Come Soon Enough" by Karla Damus, Ph.D, M.S.P.H., R.N. (March of Dimes National Foundation), and "Update on New Aggressive Therapies in Nutrition for Preterm Infants" by David H. Adamkin, M.D. were included within the Summit Agenda.

In June of 2004 the KPA annual meeting: Summit on Prematurity, will focus on two major aspects of health care practice as it relates to prematurity: care of the mother during pregnancy and care of the mother and infant in the event of premature birth

c. Plan for the Coming Year

Plan for the Coming Year:

The March of Dimes in collaboration with the Department for Public Health has partnered with other state professional and community stakeholders to establish a Kentucky Prematurity Steering Committee (KPSC) which met initially in August 2003 and again in May of 2004 to promote statewide community partnerships and to assure continued and strengthened

preconceptional and prenatal health education in Kentucky to reduce the rate of preterm births. The March of Dimes is sponsoring a one-day Preterm Birth Summit for the fall of 2004 targeting health care professionals. Health professionals will have the opportunity to learn more about the causes of prematurity, the impact on children born prematurely, and prevention/intervention activities.

Programs such as HANDS will continue to work to assure that women receive early and adequate prenatal care. Kentucky's Substance Abuse Cessation Program is operational; more information about this program is included within the performance measure addressing early prenatal care.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

a. Last Year's Accomplishments

Data from 1999 shows a decline in the rate of suicides among youth (15-19) for the fourth year. The rate for 1999 is 7.5, down from 8.4 in 1998 and 1997 and 11.1 in 1996. While the number of suicides among youth is down, programs are being developed to address this very important mental health issue. The Stop Youth Suicide Campaign, chaired by Hatim A. Omar, M.D., of the University of Kentucky Medical Center in Lexington Kentucky is one such example. The Stop Youth Suicide public awareness campaign will take place in central Kentucky for twelve consecutive months, beginning in October of 2000.

Activities include monthly educational communications with youth and those serving youth including government agencies, schools, the faith community and health care providers; broadcasting interviews on local television and radio stations with people whose lives have been affected by suicide; information for youth, parents, citizens and health professionals about risk factor identification associated with suicide referral information for support services.

The rate (per 100,000) of suicide deaths among youth aged 15 to 19 increased slightly in 2000. The rate increased from 7.5 in 1999 to 8.7 in 2000. This represents three additional suicides within the age group.

Over the five-year period between 1996 and 2000, suicide deaths for this age group in Kentucky have decreased slightly, with the highest level in 1996 (11.1) and the lowest in 1999 at 7.5.

b. Current Activities

Data for 2001 indicates a slight decrease in adolescent suicide; from 8.7 in 2000 to 6.1 in 2001, however the rate increased slightly in 2002 to 6.8/100,000. Death files for 2001 have not been closed to date, so this rate may change.

c. Plan for the Coming Year

/2005/ Kentucky, through the leadership of the Department for Mental Health and Mental Retardation, is in the process of developing a Suicide Prevention Plan. The planning committee began meeting in March 2002, and eight members attended the SPAN Conference in Washington, D.C. in July of 2002. Committee attendance is strong; with an average of 40 individuals at each of the five meetings held to date. Initially, plans from other states were reviewed, and goals related to awareness, training/education and surveillance were developed.

An executive summary of the draft plan for suicide prevention is currently in process and will be presented to the Commonwealth of Kentucky in 2004. The Nursing Director and the coordinator of the Kentucky Child Fatality Review and Injury Prevention Program for the Department for Public Health participate on the planning group. Formal goals adopted by the group are:

- 1. To increase public awareness of suicide as a preventable public health problem**
- 2. To identify and coordinate resources, intervention options, and training opportunities within the state.**
- 3. To evaluate the methodology and impact of the group's efforts and the available resources.**

Senate Bill 148 was passed in the 2004 legislation session, that authorizes the Kentucky Suicide Prevention Planning Group as an official work group for suicide prevention. The authorization recognition was acknowledged by Kentucky Governor Fletcher. //2005//

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

a. Last Year's Accomplishments

Performance Measure 17:

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

Last Year's Accomplishments:

General Information: Neonatal Regional Care Delivery

Four Kentucky hospitals qualify as Level III Neonatal Hospital facilities, the University of Kentucky, University of Louisville, Norton/Kosair (Louisville) and Suburban (Louisville). A total of 117 beds are licensed for care under the Level III designation. Additionally, 221 beds are licensed for care under the Level II designation; these hospitals are distributed throughout the state while the Level III hospitals cluster in the two major population centers; Louisville and Lexington.

Special Care Neonatal beds are licensed acute care beds located in hospital neonatal units that provide care and treatment of newborn infants through the age of 28 days, and longer if necessary.

The number of Level III Neonatal beds is determined by a calculation based on the total annual births in the state while the number of Level II Neonatal beds is based by a calculation using the number of total annual births to an area development district.

The Cabinet for Health and Family Services may determine that more Level III beds are necessary in order to allow for the presence of hospitals that provide a higher intensity of neonatal care than that provided by most hospitals due to a high percentage of neonatal patient referrals for specialized services such as open-heart surgery, transplants, etc.

The Certificate of Needs office within the Department for Public Health is responsible for working with local hospitals and keeping standards consistent with the Guidelines for Perinatal Care, Third Edition, published jointly by the American Academy of Pediatrics and the American

College of Obstetrics and Gynecology.

In 2002, 68.0 percent of very low birth weight infants were delivered at hospitals licensed as Level III facilities in Kentucky. This was an increase over 59.9 percent in 2001.

b. Current Activities

Current Activities:

68.0 percent of very low birth-weight infants were born at either Level III or Level II nurseries in 2002.

Level II nurseries are being utilized more to care for at-risk infants since these nurseries are more geographically distributed across the state than Level III nurseries. Also, as more neonatologists are being trained, these professionals are going to rural Level II nurseries to care for these infants. Several local hospitals have excellent neonatal units that meet the need of women giving birth to very low birth weight infants in their areas.

c. Plan for the Coming Year

Plan for the Coming Year:

//2005/ Title V Director, Steve Davis, MD, continues to monitor this measure and to work cooperatively with local hospitals to assure for the care of these newborns. Due to the rural nature of many Kentucky counties, Level II hospitals will continue to support this process by delivering some of Kentucky's at-risk infants with selected conditions.

The Certificate of Needs office within the Department for Public Health is responsible for working with local hospitals and keeping standards consistent with the Guidelines for Perinatal Care, Third Edition, published jointly by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology. //2005//

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

a. Last Year's Accomplishments

Performance Measure 18:

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

Last Year's Accomplishments:

Preliminary data for 2001 and 2002 indicates a slight increase has been achieved (85.7%) in this performance measure. Data for 2000 and for 1999 indicated a very slight increase was achieved in this performance measure. In 2000 and 1999, 85.6 percent of Kentucky mothers received prenatal care in the first trimester as compared to 85.5 percent in 1998, 85 percent in 1997, and 83.8 percent in 1996.

At the local level, all health departments have been certified in the Medicaid Presumptive Eligibility (PE) process to enable them to assist prenatal patients, who are eligible, to access temporary prenatal benefits at the time of the positive pregnancy test. PE is an eligibility tool adopted by Kentucky's Department for Medicaid Services to expedite a pregnant woman's access to needed outpatient prenatal services while their application for full Medicaid benefits

is being processed.

Local health department staff continue to provide counseling to pregnant women on the importance of early entry into prenatal care at the time of their positive pregnancy test, and appropriate referrals such as first time pregnant moms to the HANDS Program. In addition, local health department staff will make an appointment, or a referral for the pregnant women, to initiate early entry into prenatal care, as well as, assisting Medicaid eligible pregnant women to access services.

Some local health departments have paid for prenatal services, out of their community funds, for the uninsured pregnant women (i.e., the undocumented Hispanic population). This financial burden has been greater in some counties than in others. The Division of Adult and Child Health has attempted to alleviate some of this financial burden by allocating additional specified funds to the health departments.

Kentucky's population has a high prevalence of smokers; in 2001, Kentucky led the nation in the total percentage of smokers (30.9%). Data from the Behavioral Risk Factor Survey (BRFSS) for 2001 found that 35.8% of women between the age of 18 - 44 smoke in our state. Data from the Kentucky Vital Statistics indicates a prevalence of 23.4% of women smoking during pregnancy and preliminary data for 2001 indicates no change. Preliminary data for 2002 from the Kentucky Vital Statistic files indicates a slight increase in women smoking during pregnancy (24.0%). Adverse health outcomes for the infants of pregnant women who smoke have been well documented; they include higher rates of SIDS and low-birth weight, just to name a few.

In response to this significant public health problem, Kentucky has implemented many programs to encourage all women of childbearing age, and the general population, to stop smoking. On a local level all health departments offer client smoking cessation interventions. The Tobacco Prevention and Cessation Program is focusing on reducing

b. Current Activities

Current Activities:

Preliminary data for this measure has remained steady for 2002, with 85.7% of Kentucky's women receiving prenatal care in the first trimester. The percent of women receiving early prenatal care has increased steadily over the past five years. Funding from the Title V Block Grant, allocated to local health departments as unrestricted monies (to be used to support Title V Performance Measures) is often used to support prenatal services for local health department clientele.

As part of the Governor's KIDS NOW ECD Initiative, the Kentucky Division of Substance Abuse, Cabinet for Mental Health and Mental Retardation, is working in partnership with the Department for Public Health to support a statewide effort aimed at increasing the health of all Kentucky babies by decreasing the use of alcohol, tobacco, and other drugs during pregnancy.

Components that comprise this initiative include:

- A Medicaid Benefit package providing a full continuum substance abuse prevention and treatment services to Medicaid-eligible women who are pregnant or postpartum up to 60 days.
- Substance abuse prevention and treatment services for non-Medicaid eligible pregnant women and women with dependent children.
- Outreach efforts aimed at better identifying pregnant and postpartum women in need of substance abuse prevention or treatment, and engaging in those services

- Collaborative efforts between local agencies and within the Mental Health prevention and treatment systems to help provide a full continuum of care to pregnant women in need of all types of services.

In the first two quarters of FY02, 169 pregnant women have been screened or referred, 225 have been assessed and 285 have entered prevention or treatment services as a result of this initiative. Additionally, funding for methadone treatment and transportation for narcotic addicted pregnant women (including oxycontin) is provided. Individual incentives are offered for delivering a healthy baby and for remaining in the program.

Data through the third quarter of FY03 (based upon the state fiscal year of July 1st through June 30th) is: 5405 pregnant women screened or referred; 574 pregnant women receiving an assessment and 2104 pregnant women actually entered prevention or treatment services following a screening or assessment by the KIDS NOW project.

Data through the third quarter of FY04 is: over 6,000 pregnant women have been screened for substance abuse in health departments across the state using a research-based screening tool specifically designed for screening pregnant women for substance abuse risk in pregnancy (The 4P's Plus was developed by Dr. Ira Chasnoff of the Children's Research Triangle in Chicago. The screening tool asks about Present use, Past use, Parents use and Partners use.)

The KIDS NOW Substance Abuse and Pregnancy Initiative staff across the state has provided a substance abuse prevention and/or treatment service to 2,537 pregnant women.

c. Plan for the Coming Year

Plan for the Coming Year:

//2005/ Continue utilizing the Presumptive Eligibility process to enable pregnant women to access prenatal care timely to enhance birth outcomes.

The number of Local Health Departments participating in the substance abuse cessation initiative has increased substantially in the past year (80 health departments have memorandum of Understanding (MOU) with their regional Comprehensive Care Centers to address prevention and treatment of substance abuse in pregnant women). Eleven of the forty health departments who do not have an MOU with their regional Comprehensive Care Center are working on the development of an MOU. According to the KIDS NOW Early Childhood Initiative Summary dated March 2004, over 2,500 pregnant women have received treatment and over 6,000 pregnant women have received prevention services from this program to date in 2004.

An article entitled "Smoking During Pregnancy in Kentucky; Placing Children At Risk", was written by DPH epidemiologists Tracey Jewell, MPH and Sara Robeson, MA, MSPH. In this article the prevalence of smoking in Kentucky's women of childbearing age was examined in detail, examining vital records and BRFSS data from the last decade. The relationship between smoking and adverse health outcomes for infants was examined, including the occurrence of low birth weight and SIDS deaths, using vital statistics data. The article was published in Kentucky's monthly publication, Epidemiologic Notes and Reports in July of 2003, which is widely read by local health department personnel, private providers and others. (The study is included as an attachment to this section.) In FY05 an update on this article will be done by Tracey Jewell and Sara Robeson for Epidemiologic Notes and Reports. //2005//

FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

General Instructions/Notes:

List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.				
1. NBS Business Partner meeting to identify key issues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. NBS Advisory Committee development and regular meetings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Consumer Involvement - Parent and Adult Consumers throughout all aspects of the NBS program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. New data system for NBS program within Department for Public Health.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)				
1. Collaborate with statewide parent organizations to provide in-put to program planning and outreach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Family members and Title V/CSHCN recipients serve on agency Board and various advisory committees.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Parent-professional serves as family participation/liaison on staff of Title V/CSHCN agency.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. KY-SPIN family representatives are co-located in CSHCN offices; identify issues & provide recommendations for improving service delivery	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Implement the requirement that all care coordination staff complete a care plan with the active participation of CYSHCN and their family.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Implement a family satisfaction survey in conjunction with the 5-yr MCH needs assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. All CSHCN offices will assess the degree that they incorporate cultural				

& linguistic competence into their programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)				
1. Data system tracks % of CSCHN enrollees with active PCP(95.36% in FY02)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Clinic notes sent to physician of record within 5 days of enrollees visit to Title V/CSHCN clinic	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Outreach targeted to physicians identified as not referring to Title V/CSHCN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Prepare journal articles and turnkey presentation to disseminate SLAITS data targeted physicians and other health, education, and human services providers as well as families and the community at-large.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Conduct a provider survey as a component of the MCH 5-yr needs assessment; analyze availability & accessibility to primary care and specialty care and attitudes about family-centered care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Conduct a family survey targeting families of CYSHCN who do not access Title V services to assess their access to a medical home and their satisfaction with care received	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Structure opportunities for dialogue between families and health practitioners to discuss what constitutes family-centered care and how it can be incorporated into a variety of practice settings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Provide medical specialty care in collaboration with the child's medical home	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)				
1. Title V/CSHCN financial eligibility considers existence of 3rd party resources and covered benefits.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Data system tracks % of enrollees with source of payment. (91.18% in FY02)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Care Coordinators trouble shoot coverage issues with 3rd party payors.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Workshops train families to work with 3rd party payors to coordinate benefits/advocate for coverage.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Re-enforce personal responsibility and self-care and appropriate use of health care resources, including use of preventive care through care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

coordination & family education				
6. Use SSDI grant funds to link with Medicaid to evaluate utilization and highlight areas in which we can be more proactive in working with families to support appropriate utilization of resources and manage chronic conditions	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Conduct focus groups, key informant interviews, etc in conjunction with the MCH 5-yr needs assessment to document the extent to which CYSHCN not enrolled in the Title V medical program have adequate public/private insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)				
1. Care coordinators develop care plans in concert with the CYSHCN and family; identify child/family priorities, strategies, and outcomes; monitor and report on outcomes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Collaborate with parent-professional organizations and independent living centers	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Maintain program 800 telephone # with Consumer Call Line option	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Extend to other areas of the state the one-stop planning model developed for the Louisville Metro through the ADD Family Support 360 Grant for a transition resource center	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Conduct focus groups, key informant interviews, etc. in conjunction with the MCH 5-yr needs assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Pursue Memoranda of Understanding with partner agencies/organizations to include specific actions that will be taken to improve access to services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Conduct self-assessment to determine the extent to which CSHCN offices are culturally and linguistically competent; each office will develop an action plan w/ 2-3 strategies for improving competency	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. Transition developmental checklist is used in conjunction with the care plan to identify youth's priorities, strategies, and desired outcomes for transition; progress & outcomes are monitored and reported	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

2. State staff provide transition leadership: program planning, technical assistance to regional staff and partner agencies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Each CCSHCN office has a transition liaisons who provides local leadership for transition services and support to CYSHCN and their families	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. CCSHCN is a Title V Partner in the National Healthy & Ready to Work Center	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Requests for proposals & personal services contracts require each entity to describe how they will address youth transition & the other 5 MCHB performance measures	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Active partnerships maintained with education partners and other partners to support disability mentoring day and other transition related programming	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7. Maintain active partnerships with local agencies/organizations to support inclusion of CYSHCN in civic organizations, events, and to contribute to the community	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
8. Memorandum of Agreement is developed with KY Dept of Education to specify actions CCSHCN will take to assist local ed agencies in bridging the achievement gap among CYSHCN	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.				
1. Purchase of vaccines to cover the underinsured children, non-Medicaid and non-KCHIP.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Continued financial support for immunization purchases from KIDS NOW (\$ 2 million in FY04)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continued program activity by the Division of Epidemiology Vaccine Program	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				

1. Continuation of Postponing Sexual Involvement and Reducing the Risk programs by LHD personnel.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Continued support of Abstinence Education Initiative by local health department personnel.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Continued funding for TOP (Teen Outreach Program) in selected counties by local health departments.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Continued training opportunities through Title X Family Planning Funding Support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. Protective sealents for Kentucky third graders.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Collaboration with Medicaid to increase the number of dentists working in rural Kentucky.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continued analysis of Children's Oral Health Survey data.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Development of an Oral Health Surveillance System.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. Continuation of Kentucky Safe Kids Coalition and local State Kids Coalitions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Enhancement of Child Fatality Review Program to increase local review teams.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Injury prevention training within HANDS Home Visitation Curriculum.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Collaboration with Kentucky Injury Prevention Research Center at the University of Kentucky.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Participation in Governor's Drive Smart Team (safety seat checkups and other safe driving initiative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

6. Publication of annual Child Fatality Review Report.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. Support of WIC Breastfeeding Grantees for breastfeeding promotion in their communities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Breastfeeding Coalition building.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Training to local hospitals and providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Promotion of August World Breastfeeding Week 2004.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Participation in National Breast Feeding Campaign for 2003 and 2004.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. Implementation of UNHS Program administered by state Title V/CSHCN agency.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Technical assistance to all birthing hospitals regarding UNHS compliance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. UNHS staff provides CEU presentations/training for hospital personnel.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Stakeholders advisory committee assists in outreach and systems planning.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Database established to monitor and track # of newborn infants tested, results, and follow-up.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

13) Percent of children without health insurance.				
1. Collaboration with Medicaid/KCHIP program initiatives.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Linkage of Medicaid Data by Oral Health Program to identify children eligible but not accessing care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continued support locally for Medicaid/CHIP enrollment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. Linkage of Medicaid Data by Oral Health Program to identify children eligible but not accessing care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Collaborate with Medicaid to access needed data for other MCH programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
15) The percent of very low birth weight infants among all live births.				
1. Emphasis on low birthweight/prematurity during LHD budget process.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Collaboration with Kentucky Perinatal Association and the March of Dimes Birth Defects Foundation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continuation of Substance Abuse Cessation project funding through KIDS NOW.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Continued work with youth through programs such as PSI and Abstinence Education.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Folic Acid Supplementation through local health departments and community campaigns.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

6. Continued support of Kentucky Birth Surveillance Registry to identify congenital anomalies.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7. Contracting through tertiary centers for state-wide genetic clinics.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Leadership in the development of a Prematurity Campaign Committee with the March of Dimes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Smoking cessation initiatives in all local health departments.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. Collaboration with the DMH/MR to develop a Suicide Prevention Plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Increased public awareness of suicide.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Identification and Coordination of Resources.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Identification of intervention options and training resources.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Enhance the Children's Mental Health Initiative within KIDS NOW.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. Oversight by the Certificate of Need Office and adherence of standards of care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. On-going training for health professionals working with neonates.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				

1. Support of maternity/prenatal services by LHD through Title V funding.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Expansion of prenatal substance abuse cessation program at local health departments.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Presumptive Medicaid eligibility for pregnant women.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Collaboration between Comprehensive Care Centers (Kentucky's mental health providers) and LHD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Smoking cessation initiatives in all local health departments.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *State Performance Measure #1: Percent of women between the ages of 18 and 44 reporting through the KBRFS to take folic acid regularly.*

a. Last Year's Accomplishments

Folic Acid - General Information

The importance of folic acid is stressed for both primary and preventive services for women and infants for children via Family Planning Services, Nutrition Services, Adult Health, WIC, Genetics, Healthy Lifestyle Education and the Birth Surveillance Registry. The Folic Acid Module was included in the Kentucky Behavior Risk Factor Survey for 1997, 1999 and 2000.

The Division of Adult and Child Health engages in a folic acid campaign with the March of Dimes Birth Defects Foundation and forty-five interested partners through activities of the Kentucky Folic Acid Partnership. Additionally, free folic acid supplementation and counseling for low-income women of childbearing years is provided as a component of KIDS NOW! Kentucky's Early Childhood Development Initiative, and was included as part of the early childhood development package passed during the 2000 legislative session. The supplement program is provided through every county health department in Kentucky.

During 1999, 39.3 percent of women were taking folic acid regularly, an increase from 36.2 percent in 1997. 2000 BRFSS data shows that 41.8% of Kentucky women of childbearing age are currently taking folic acid regularly. In 2001, 39.6% of women were reached with the folic acid message in 2002, 40.4%. No data was available for 2003 as this question was not included in the survey.

In FY02, 110,623 women have received folic acid supplements and nutritional counseling. 862,500 Kentuckians were reached with the folic acid message through community and professional events and thousands more through radio, TV and news articles. During the week of Mother's Day, restaurants statewide distributed 400,000 tray liners with the folic acid message.

b. Current Activities

During FY03, in addition to the 125 county local health departments, folic acid tablets and counseling are now being provided at six state universities. 85,736 women have received folic acid tablets and counseling. 32,403 participants were reached in 395 statewide folic acid

activities from July 2002 - July 2003 through the efforts of the Folic Acid Partnership.

As of January 2004, the Kentucky Folic Acid Partnership has 75 individual members representing 66 agencies, organizations, and businesses. 45,887 women have received folic acid services from July-December 2003 and a CDC folic acid module was added to the 2004 BRFSS to report knowledge of benefits and consumption of folic acid among Kentucky women 18-44.

Given the success of the Folic Acid Workgroup, the group decided to expand their vision from folic acid awareness and consumption to the reduction of preterm births. As referenced in the opening section of the Title V Block Grant Narrative, preterm and low-birthweight births are quickly increasing in Kentucky as they are throughout the nation. The March of Dimes Birth Defects Foundation has been a supportive partner throughout the folic acid campaign and are now placing a new emphasis on preterm and low birthweight births. This group is now spearheading the Prematurity Campaign, chaired by Steve Davis, MD; Director of the Adult and Child Health Division within the Department for Public Health.

Neural tube defects (NTDs) are ascertained through multiple data sources in Kentucky utilizing active and passive case ascertainment. The rate for all NTDs including spina bifida, anencephaly and encephaloceles was 12.7/10,000 live births and stillbirths in 1996. A decline in NTDs occurred until 1999 when the rate was 5.7/10,000 live births and stillbirths. An increase was noted in 2000 to a rate of 9.2/10,000 live births and stillbirths. In 2001, the rate declined to 5.3/10,000 live births and stillbirths. Overall, from 1996 to 2001 there has been a 57% reduction in the number of children in Kentucky affected by these serious birth defects. Preliminary data for 2002 shows a slight increase in the rate to 5.9/10,000 live births and stillbirths. Geographical mapping of this data has revealed the highest rates to be present in the southeastern areas of Kentucky (see attached maps). For more information, call Joyce Robl, Administrator for the Kentucky Birth Surveillance Registry at 502-564-2154.

c. Plan for the Coming Year

In 2005, the BRFSS will again include folic acid supplementation information. Kentucky will continue to work with local health department partners to provide folic acid tablets and awareness/education to all women of childbearing age in the Commonwealth. Additionally, the partnership will continue between the Kentucky Birth Surveillance Registry, (the sole source of data acquisition for neural tube defects and many other types of birth defects in Kentucky) and the Kentucky Folic Acid Supplementation Program, under the leadership of Sandy Cleveland, R.N.

Finally, the Prematurity Prevention Committee will continue meeting and expanding their vision to the reduction of preterm births in Kentucky. Specific plans by the group to address this issue will be detailed in the FY06 Title V Report.

State Performance Measure 2: *State Performance Measure #2: Percent of counties with comprehensive child safety education and injury prevention programs in place.*

a. Last Year's Accomplishments

Percent of counties with comprehensive child safety education and injury prevention programs in place.

Last Years Accomplishments:

The word "comprehensive" safety education has been re-defined as a plan that concentrates

solely on unintentional injury and conducts multifaceted injury prevention activities emphasizing problems afflicting high-risk populations in the area. This will be achieved by teaching from curricula for the particular audience and the injury cause such as Safe Communities, Safe Sitters, Risk Watch, Buckle Up, and CPR.

All 120 local health departments in Kentucky have some form of child safety education and injury prevention program. With an emphasis on population-based services at the local health department level, it is anticipated that the FY 2004 will reflect a slight decrease in counties (down from 111 at 92%, to about 97 at 81%) that are offering child safety education and injury prevention programs on a comprehensive basis. This is in part due to the change in the definition of "comprehensive". Traditionally this has been done via services provided within the health department as patients received preventive health services. As the demand for preventive health services at the local clinical site health departments decreases, new opportunities are available for population based injury prevention efforts that can reach the entire community. Within the past year, significant strides have been made to increase the variety of injury prevention programs offered by Kentucky's local health departments.

During FY99, 91 counties had injury prevention programs that were considered comprehensive. During FY00, this number increased to 107. In 2001, 111 of Kentucky's 120 counties had comprehensive injury prevention programs (92.5%). In 2002 and 2003, this declined slightly to 80.8%. Planners feel that this decline was not due to a change in program offerings at the community level but to a change in the definition of "comprehensive". (see next section for changes to the program)

b. Current Activities

Marcia A. Burklow, MSPH, is the coordinator for the Child Fatality and Injury Prevention Program in Kentucky. Joining the MCH Branch staff in February of 2002, Ms. Burklow holds an MSPH degree from the University of North Carolina (Chapel Hill, N.C.) and has significant experience at the state level. She has worked in the areas of Licensing and Regulation, Emergency Medical Services and now brings innovative ideas to the MCH Branch as Coordinator of the Child Fatality and Injury Prevention Program. The Child Fatality and Injury Prevention Program tracks children from birth through age 17 although data for this document reflects multiple age ranges.

c. Plan for the Coming Year

//2005/ Several new activities, implemented by Ms. Burklow under this program should positively impact the number of child fatalities over the next years. Discussion of these activities is provided under State Performance Measure Number 7 (Percent of counties who review child deaths with a local multidisciplinary investigation team.)

//2005//

State Performance Measure 3: *State Performance Measure #3: Rate of substantiated incidence of child abuse, neglect or dependency.*

a. Last Year's Accomplishments

The rate of substantiated incidence of child abuse, neglect or dependency has dropped dramatically from past years; in 1998 the rate per 1000 children was 28.7 and in 1999 was 22.5. Data for 2000 (21.9) and 2001 (19.9) continued the trend.

The home visitation efforts have been demonstrated in other states to have an impact on the incidence of child abuse and neglect. Partnerships with the Cabinet for Families and Children

to increase home visitation services and information on the importance of early brain development should assist in meeting this measure. The child fatality review system has strong support at both the community and state level for expertise in this area. All parenting components in local health department services stress the expectations for normal child growth and development and resources available to families

This information is obtained from the Cabinet for Families and Children. Initial results shown by HANDS show lower cases of physical abuse and neglect of babies. Non-HANDS families exhibit 58% more child abuse and 62% more neglect than families participating in HANDS.

b. Current Activities

In 2002 and 2003, new lows are being experienced for this measure. 2002 showed another decline to 18.2% and 2003 dropped to 17.7%.

Current activities mirror those described in the previous section. HANDS is now operational in all 120 Kentucky counties.

c. Plan for the Coming Year

Future activities will mirror those described in the previous section. HANDS is now operational in all 120 Kentucky counties and it's success is expected to continue and to be more evident as data from the programs initial years becomes available to us.

More discussion about HANDS is included under the next state performance measure.

According to the KIDS NOW Early Childhood Initiative Summary dated March 2004, families who participated in HANDS exhibit less child abuse (58% less) and less neglect (62% less) than the control group of families who were eligible but did not participate.

State Performance Measure 4: State Performance Measure #5: Families receiving support services/parenting assistance through HANDS (Health Access Nurturing Development Services) home visiting support program.

a. Last Year's Accomplishments

General Information - HANDS

The HANDS program is coordinated by the Division of Adult and Child Health under the Department for Public Health. The purpose of this program is to provide home visitation to overburdened first-time families to assist them in meeting the challenges of parenting beginning prenatally and continuing during the child's first two years of life. Anticipated results are to achieve positive pregnancy outcomes, to improve the health and developmental outcomes for children, to have children in healthy and safe homes and to reduce the likelihood of child abuse and neglect over the long term. HANDS began in eleven pilot counties in December of 1998 and in the spring of 1999, four additional counties were added. In FY 01, an additional thirty-two counties were added bringing the total participating counties to forty-seven. FY02 brought about 54 additional new counties totaling 101 participating counties and in FY03, statewide coverage of all 120 Kentucky counties was achieved. A brief description of the HANDS enrollment process follows.

Step 1: HANDS Referral Record Screen: completed on mothers of all first-time families. The screen can be completed at different community sites such as a local health department, hospitals, physician offices, etc. The screen indicates stress factors such as unemployment,

inadequate income, unstable housing, limited parental education, isolation, history of substance abuse, poor prenatal care and maternal depression. All first time mothers with a positive screen will be offered a family assessment referred to as the Parent Survey.

Step 2: Parent Survey: will assess the family by looking at both the mother and the father and focusing on their family history. A registered nurse, social worker, or other professionals who have additional training on assessments will complete the Parent Survey. All first-time mothers/fathers with a positive assessment will be offered the home visitation services of HANDS. For an assessment to be positive a parent/partner must score 25 or higher.

Step 3: Entering the HANDS Program: first time families accepting the HANDS program will have a trained Home Visitor providing home visiting services based on family need until the child is age two. During the prenatal period the visits will focus medically on the need for prenatal care, fetal development, avoiding alcohol, smoking, and drugs and on the social model of reducing the stressors in the home before the infant is born. After delivery the focus for the infant will be health care, medical home, child growth and development, immunization, screening for possible developmental delays, anticipatory guidance. In addition, the social model of encouraging parents to become responsible and self-sufficient for their family and promoting parent child interaction will be emphasized through a parenting curriculum.

b. Current Activities

Our annual performance target will be to reach 50 percent of all first-time Kentucky families. All teens with a negative screen or assessment will be offered a once a month home visitation program commonly referred to as "low-intensive track of HANDS" and formerly known as Resource Persons.

Evaluation Services For HANDS is being provided by Resources for Education, Adaptation, Change, and Health, Incorporated (R.E.A.C.H. of Louisville, Inc.) Robert J. Illback, Executive Director.

In 2001, 3,873 families participated in the HANDS program. Single, separated or divorced parents headed sixty-five percent of these families. Sixty-four percent of families had inadequate or no income source while thirty-two percent were unemployed. Forty-two percent had an education less than 12 years and twenty percent had unstable housing. In FY02, a total of 103 Kentucky Counties were served, with plans to expand to all 120 by the beginning of FY03. In 2002, total individuals served increased again to 6,643 families. Sixty-nine percent of these families were headed by single, separated or divorced parents, 73.5% had inadequate or no income source (a substantial increase over 2001) and 33% were unemployed.

According to the KIDS NOW Early Childhood Initiative Summary dated March 2004, in FY 2003, 8,789 families participated in HANDS. All 120 counties were participating and 5,248 assessments were conducted. 35,670 professional home visits and 69,622 paraprofessional home visits were conducted.

Staffing support for the HANDS program has also improved with all positions now filled. The program again has a full-time Training Coordinator (based in Frankfort) and a full-time Quality Assurance staff member who coordinates a technical assistance team. Data input and reporting is monitored by a full-time staff person and the ACH/MCH Branch Epidemiologist, Tracey Jewell, assists in data analysis.

c. Plan for the Coming Year

Plan for the Coming Year

Now that the HANDS Home Visitation Program is up and running in all Kentucky counties, more emphasis will be placed on Quality Assurance and Data Analysis for the program. Upcoming plans include:

Statewide Quality Assurance Efforts - (monthly, quarterly, yearly):

Work directly with site and TA for quality improvement on the following:

- Development and implement site self-assessment tool (ensuring achievement of critical elements)
- Development and analysis of program drop-out/retention rates (quarterly)
- Development and analysis of employee turnover/retention (biannual)
- Development and analysis of outcome data (monthly)
- Analysis of site parent satisfaction survey (yearly)
- Analysis of HANDS software reports (quarterly)
- Referral sources, home visits (cancelled/ attempts), high refusal rate for parent survey, high refusal rate for home visitation
- Analysis of State Program Evaluation (yearly)
- Develop statewide program plan for improvement with Program Administrator

Issues for analysis in FY05 include assurance that training needs are met for HANDS staff and that adequate staffing levels are maintained.

State Performance Measure 5: State Performance Measure #6: Percent of children with inappropriate weight for height.

a. Last Year's Accomplishments

Changing this public health outcome is one of Kentucky's highest priorities. Unfortunately, at present, totals of children with inappropriate weight for height are increasing. Since 1999, the percent of children under this category has increased from 19.7% to 21.4%.

Much is being done in an attempt to counter the trend of increased obesity among our youth.

First, a network of 140 public health nutritionists are serving 108 out of Kentucky's 120 counties and have a total of 10,300 patients during 2003. They provide Medical Nutrition Therapy to approximately 8500 unduplicated patients at or below 185% of poverty and 1800 unduplicated patients above 185% of poverty.

All WIC participants are encouraged at certification to be physically active and to choose low fat and reduced fat foods. Some community activities include the Five a Day Campaign, Choose 1% or Less (Milk) Campaign, Folic Acid Supplementation, Weight Management Classes, Chronic Disease Nutrition and school-based nutrition and physical activity classes.

Bright Futures in Practice: Physical Activity trainings were provided during May of 2003 to 75 Healthy Start in Day Care Consultants and was funded by the CDC Cardiovascular Grant.

The Type 2 Diabetes Taskforce, led by Lieutenant Governor Steve Henry, M.D. drafted legislation in 2003 for the Kentucky General Assembly in an attempt to directly impact Kentucky's problem of obesity in children. Changes to occur at the local level included credentialing for school cafeteria staff, required physical activity in school and the creation of a legislative task force to address the obesity epidemic. While this legislation was not successful, it generated significant debate and editorial page support in leading Kentucky papers. Many of

the ideas brought forth from this taskforce will be used by a Grassroots subcommittee, which will begin to implement these changes at the local level. Agencies disseminating this information include local health departments, schools, Cooperative Extension Services and other agencies involved with youth.

b. Current Activities

Growing Healthy Kids II was sponsored by the Kentucky Department for Public Health, Cooperative Extension Service and Kentucky Department of Education in November 2003. This workshop built upon Growing Healthy Kids I and provided information about how to improve school breakfast and lunch choices, how to develop a contract for vending machines with healthy choices, how to provide physical activity in the schools and many other practical workshops for local staff. An additional 300 people attended these workshops for a total of 700 trained in the last two years. From these efforts we have seen 40 local coalitions develop to address policy change and activities to create healthy kids.

In an attempt to unify programmatic efforts throughout the state around this significant health problem, Division of Adult and Child Health Director Steve Davis, M.D. allocated 1.5 million in federal Title V funding specifically to address this measure during the FY04 local health department budget process. Additionally, nearly all of the federal Preventive Health Block Grant (\$ 1,700,000) was directed to increased physical activity at the local level.

In both nutrition and physical activity, specific scientifically-based activities were researched and recommended by staff members from both program specialties. Local health departments were given resource materials about these activities and selected those most appropriate for their county. Any deviation from these activities must be cleared through a designated staff person.

Discussion of Kentucky's CDC Grant - State Nutrition & Physical Activity Programs to Prevent Obesity and Other Chronic Diseases is included within Section IV, E. - Other Program Activities.

c. Plan for the Coming Year

For FY 2004-2005, the \$1.5 million set aside from the MCH Block Grant is for community and clinical nutrition services. Nutritionists, nurses, dietitians and health educators can provide these community services. The clinical services to provide Medical Nutrition Therapy (MNT) must only be provided by Registered Dietitians or Certified Nutritionists from the health department or referrals to local dietitians.

Community efforts for 2004-2005 include continued focus on increasing the incidence and duration of breastfeeding, Choose 1% or Less, 5 A Day and Weight Loss programs. During May and June 2004, training is being provided to 40 local health agencies to implement a 5 A Day Program centered around the 5 A Day Challenge. The activities that will be generated from this training will occur in FY 2005. Worksite wellness is another important issue that will receive attention during the next fiscal year at the State and Local level. Worksite packets are being developed to focus on the importance of nutrition, physical activity and breastfeeding friendly facilities. In an effort to coordinate nutrition services with the CDC Obesity Grant, we will continue to focus the State and local efforts on statewide campaigns in order to create positive change.

Discussion of Kentucky's CDC Grant - State Nutrition & Physical Activity Programs to Prevent Obesity and Other Chronic Diseases is included within Section IV, E. - Other Program Activities.

State Performance Measure 6: *State Performance Measure #7: Percent of counties who review child deaths with a local multidisciplinary investigation team.*

a. Last Year's Accomplishments

General Information: Child Fatality Review

The number of child fatalities in the Commonwealth continues at an unacceptable level. Collective resources and collaboration of state agencies, combined with education, environment and product changes, plus passage of primary enforcement legislation must be utilized to reduce this number.

In 1996, House Bill 94 was passed by the Kentucky General Assembly to provide a state child fatality review system and a multidisciplinary approach to the review of coroner reports of child fatalities. This review includes all unexpected or unexplained fatalities such as those due to obvious injuries, unexpected fatalities with questionable circumstances, and/or non-apparent injuries. The law mandates that coroners must contact the local Department of Community Based Services (DCBS), local law enforcement, and the local health department with information relevant to each child death. Coroners must submit reports to the Department for Public Health. DPH produces an annual report based on the information.

Programs that can affect this measure for primary and preventive services for women and infants include the Grief Counseling Program, Injury Prevention, that includes prevention program focuses such as the Child Safety Seat Program, prevention of Child Abuse and Neglect, Healthy Lifestyle Education, and Infant Mortality Review. Other preventive and primary services for children include Child Fatality Review and HANDS. Staff are working collaboratively with partners to increase training opportunities for child fatality review. Seed monies to local health departments to take the lead on developing child fatality review teams assisted in this improvement.

b. Current Activities

The percent of counties who participate in the review of child deaths with local multidisciplinary investigation teams continues to increase, from 47.3% in 1997 to 52.5% in 2002. In 2003, a dramatic increase was seen from 52.5% to 75%.

What was the catalyst for this increase? A minimum amount of funding toward assisting local child fatality review teams was required in the FY04 and FY05 budget years for local health departments. Because of this priority treatment, program planners anticipate near to 90% participating counties by the end of the FY05 year. Close to 100% participation is expected in future years.

Please see discussion within the next section.

c. Plan for the Coming Year

/2005/ In the FY04 budget year, every health department in Kentucky received the sum of \$ 850.00 (except \$1,250 each for the two largest counties) from state general funds, and were required to either boost the level of their existing CFR team or to begin one in counties where they did not exist. A total of \$102,800 was designated for this effort.

The goal of this initiative is to increase the percentage of counties with CHR teams from the current 52.5% (2002) to approximately 90% by June 30, 2005. Required participants in a local child fatality review team include the county coroner, law enforcement, local health department and community-based services representatives. Additional

participants may include EMS, other medical personnel such as a pediatrician, a county legal representative, a child abuse/domestic violence specialist and a citizen advocate. Meetings should be minimally twice a year with additional meetings as needed.

Ms. Burklow is monitoring the work of a committee developed by the National Child Fatality Review Center (Okemos, MI) to develop a national report tool and data system for Child Death Review Programs.

The committee's responsibility will include a review of case and annual reports currently in use by local and state programs. The assigned task will be to review what is currently in use to create the best hybrid possible, one that can then be easily adapted by any program. From June 2003 until December 2004, the committee's task will be to develop a standardized case report tool and set of definitions/instructions. As this is occurring, software programmers will be developing the web-based data system for all programs nationally.//2005//

State Performance Measure 7: State Performance Measure #12: Percentage of Medicaid enrolled members ages 0 through 21 continuously enrolled during the reporting year with at least one dental visit during the reporting period.

a. Last Year's Accomplishments

In 1999, the utilization of dental services by Medicaid eligible children reached a critically low level in Kentucky. KCHIP enrollment in Kentucky has been excellent, with over 77,000 children enrolled since beginning its Phase 1 campaign in June of 1998. But many of those children who have services available to them are not using these services. This problem is related to many factors including lack of Medicaid dental providers as well as a lack of knowledge among parents about the role of preventive care and how to access this benefit. Transportation has been identified as another barrier to care for this population.

Because Dr. James Cecil, D.M.D., M.P.H., Administrator of the Oral Health Program for the Division of Adult and Child Health provides consultation services to the Department for Medicaid Services (one day each week), the problem of lack of use of available services can be examined and improved by the development of new policies. With the completion of the Children's Dental Survey (Summer 2001), additional data are available to provide baseline information on the oral health status of our youngest Kentuckians.

In 1999, 14.2 % of continuously enrolled Medicaid children received services described under this measure. In 2000, this increased to 17.5%.

In both 2001 and 2002, this measure continued to increase; in 2001 to 34.6% and in 2002, to 40.1%.

b. Current Activities

In 2003, this measure experience another increase; from 40.1 percent in 2002 to 42.4 percent in 2003. What are the reasons for this increase?

1) The Department for Medicaid Services has developed resources to communicate with dentists about the importance of providing early care to children. The numbers of children seen by providers have increased by nearly 30% because of this effort.

2) Dentists who currently treat children enrolled in Medicaid have increased the number of clients that are seen.

3) The Kentucky Dental Association also has been very proactive in promoting this program to their membership

4) Strong partnerships have been developed between the state Oral Health Program, local health departments and dentists, to promote dental care for this population.

5) The HANDS Home Visitation Program, now operational in all 120 counties and serving over 7,000 Kentucky families, has emphasized the importance of early attention to oral health.

6) Finally, the addition of a health education staff member at the state level has increased communication and knowledge between all partners in the area of children oral health; as well as the importance of oral health in the maternal population.

All of these reasons have contributed to the success that now benefits Kentucky's children in the area of oral health.

Kentucky's Oral Health Strategic Planning process, discussed earlier within the narrative, also included Medicaid partners. The primary reasons for lack of access includes looming shortages of dentists for all clients as well as a maldistribution of providers in many rural areas, the continued shortage of providers willing to take Medicaid clients and low reimbursement rates for these providers. Reasons residing with Medicaid families include a lack of knowledge about oral health as well as a culture that does not place great importance on healthy teeth and gums. Transportation and distance to providers is also a substantial barrier.

//2005/ A report by Lacy McNary of Kentucky Youth Advocates is attached to this section. "Open Wide or Lock Jaw? Children's Dental Health Access in Kentucky" highlights the problem of Kentucky's provider shortages, particularly for Medicaid clients. Kentucky Youth Advocates (2003) //2005//

These issues will continue to be critical if increases of this measure are to be realized in future years.

c. Plan for the Coming Year

//2005/ Plans for the future for this program include continued partnership opportunities between the Department for Public Health, the Department for Medicaid Services at the state and community levels. While the primary issue for this measure involves increased numbers of dental homes for children enrolled in Medicaid, much is being done to serve these children until a regular dental home can be established.

The Kids Smile Program will continue to provide fluoride varnish applications to children by local health department nurses and sealant projects are currently underway in many local health departments. The Oral Health Program collaborates with the HANDS Home Visitation Program to get out important oral health messages to families served by HANDS. Through programs such as HANDS, the Oral Health Office not only hopes to provide direct services for children but also to educate families about the importance of oral health care; creating an expectation of these services as a part of the culture of the Medicaid population.

Through MCHB's Oral Health Collaborative Systems Grant, work will continue on the Oral Health Surveillance System to measure the needs of Kentucky children and on a new ManPower Study to be conducted by the University of Louisville. This will provide detailed information on providers needed throughout the state; including those taking Medicaid clients and those seeing only private patients.

Finally, as a part of our Oral Health Strategic Planning Process, Kentucky is reviewing its needs in the area of workforce. The need for increased partnerships and cross-training opportunities have been discussed (such as the fluoride varnish program now in local health departments and the inclusion of oral health training for residents through the Pikeville School of Osteopathic Medicine) as well as discussions about the role of a mid-level practitioner for service provision in dental health professional shortage areas. //2005//

State Performance Measure 8: *State Performance Measure #13: The proportion of young people who have smoked cigarettes within the past 30 days.*

a. Last Year's Accomplishments

The Youth Risk Behavior Survey (YRBS) is Kentucky's data source for this performance measure. Completed every other year, the 2003 YRBS shows a decline in youth smoking (9th - 12th grades); from 47 % in 1997 to 41.5 % in 1999. In 2003, this measure reached a new low with 32.7% of young people reporting smoking in the past 30 days.

The Kentucky Department for Public Health, in cooperation with the University of Kentucky College of Nursing, surveyed 1,282 middle school students at 37 schools and 1,313 high school students at 40 schools in Kentucky, using the Youth Tobacco Survey developed by the Centers for Disease Control and Prevention. Twenty-two percent of Kentucky middle school and 37 percent of high school students reported they had smoked cigarettes on one or more of the past 30 days compared to only 9 percent of middle school students and 29 percent of high school students in the United States. Please see the attachment with this section for more details about the survey results.

- Kentucky's Tobacco Use Prevention and Cessation Program is supported by funding from the Tobacco Master Settlement Agreement (MSA) and by a grant from the Centers for Disease Control and Prevention (CDC). Kentucky has had the CDC grant since 1993. The MSA funding was added at the request of Governor Patton to the Kentucky Legislature in their year 2000 session. As a result of that request they allocated \$5.4 million to the program for the 2004-2005 biennium. The majority of the funding goes to local health departments to support comprehensive community base programs addressing the following four goals established by the CDC:

1. Preventing the initiation of tobacco use among young people;
2. Promoting quitting among young people and adults;
3. Eliminating nonsmokers' exposure to environmental tobacco smoke (ETS);
4. Identifying and eliminating the disparities related to tobacco use and its effects among different population groups

Each local health department receives funding to address the goals above and the objectives related to tobacco in Healthy Kentuckians 2010. Local health departments have a coordinator who is responsible for forming a partnership and preparing an annual plan that indicates how these community partners will work with others to address the four CDC goals and local needs.

b. Current Activities

Currently 100% of local health departments coordinate teen smoking prevention activities, including teen smoking cessation activities and are working to assist adults (particularly pregnant women) with smoking cessation efforts. Some of the programs being used through

the public health system in Kentucky are LifeSkills, The Cooper/Clayton Method to Stop Smoking, Make Yours a Fresh Start Family, TEG/TAP, NOT, and TATU.

c. Plan for the Coming Year

In the next fiscal year (FY04/05, the Tobacco Prevention and Cessation Program's focus will be on reducing the percentage of pregnant women who smoke through a partnership with Medicaid, a mass media campaign, a campaign to increase provider interventions by encouraging OB/GYN's to participate in the Providers Practice Prevention: Treating Tobacco Use and Dependence CE video self-study program, and offering technical assistance to local health department clinic staff.

Clean indoor air policies will be addressed in public places and in workplaces through workshops, mass media campaigns, emphasizing policy and environmental changes to reduce exposure to secondhand smoke and adult prevalence.

FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) State Performance Measure #1: Percent of women between the ages of 18 and 44 reporting through the KBRFS to take folic acid regularly.				
1. Continued support of Folic Acid Supplementation Program at the LHD level	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Continued coordination of Kentucky's Folic Acid Partnership	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Incidence and Prevalence rates for Neural Tube Defects through the Kentucky Birth Surveillance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Collaboration with the March of Dimes Birth Defects Foundation and Kentucky Spina Bifida Association	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Genetic Clinics throughout the state via contact with University of Kentucky and Louisville.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) State Performance Measure #2: Percent of counties with comprehensive child safety education and injury prevention programs in place.				
1. Safe Kids Coalitions locally and statewide with programming appropriate for each community.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

2. Child Fatality Review to continually monitor deaths due to injuries and other causes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Collaboration with KIPRC - University of Kentucky Injury Prevention Research Center.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. On-going training for local health department staff and other health professionals in this area.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Healthy Start in Childcare program to work with preschools, assuring safety in the preschool setting	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) State Performance Measure #3: Rate of substantiated incidence of child abuse, neglect or dependency.				
1. Continuation of HANDS Voluntary Home Visitation Program.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Child Fatality Review Data System for on-going surveillance of child deaths	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Healthy Start in Childcare program to work with preschools, assuring safety in the preschool setting	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. On-going monitoring of HANDS data and HANDS evaluation process	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Full implementation of the Mental Health in Child Care Initiative.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) State Performance Measure #5: Families receiving support services/parenting assistance through HANDS (Health Access Nurturing Development Services) home visiting support program.				
1. Continuation of HANDS Voluntary Home Visiting Program for all families in Kentucky.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Development of Quality Assurance Efforts to include site self-assessment, drop-out/retention rate monitoring, parent satisfaction survey and analysis of outcome data.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Enhancement of HANDS database and reporting capabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) State Performance Measure #6: Percent of children with inappropriate weight for height.				
1. Growing Healthy Kids II Conference - Fall 2003	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Unified program efforts throughout Kentucky in the area of nutrition and physical activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Targeting of a portion of the Title V Block Grant funding and all of the Primary Health Block Grant	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Science-based interventions at the local level, monitored by the nutrition staff	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Efforts to increase the prevalence and duration of breastfeeding.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Training for local health department nutrition staff to include 5-A-Day program and worksite wellness.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7. Coordination with other CDC grants, to include Cardiovascular, Obesity Prevention and School-Based Coordination.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) State Performance Measure #7: Percent of counties who review child deaths with a local multidisciplinary investigation team.				
1. Expansion of child fatality review teams in each county.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Participation on the National Child Fatality Review Center to develop national reporting tool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Annual publication of the child fatality review report	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. On-going data analysis of child deaths and causes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Improved Child Fatality Review database with reporting capabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

STATE PERFORMANCE MEASURE	DHC	ES	PBS	IB
7) State Performance Measure #12: Percentage of Medicaid enrolled members ages 0 through 21 continuously enrolled during the reporting year with at least one dental visit during the reporting period.				
1. Collaboration with the DMS to increase the number of children utilizing services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Work with dentists to increase the number of Medicaid Clients seen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Partner with Kentucky Dental Association	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Partnerships between the state Oral health Program, local health department and local dentists	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Partnership with HANDS Voluntary Home Visiting Program in the area of oral health	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Health Education staff in the Oral Health Office at the Department for Public Health	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7. Development of a Kentucky Oral Health Surveillance System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Varnishes and Sealents for Kentucky Children (varnishes applied by trained LHD nurses).	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Contracts with the University of Kentucky and the University of Louisville in support of oral health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) State Performance Measure #13: The proportion of young people who have smoked cigarettes within the past 30 days.				
1. Take the Smoke-Free Home Pledge for parents	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Media Campaign with the Smoke-Free Home Pledge	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Continued programming activity at local health departments.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Spit-tobacco cessation project coordinated by the Oral Health for local health department clients	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Smoking cessation coordinators in each local health dept.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Reduction of smoking by women who are pregnant through a partnership with Medicaid, a mass media campaign and technical assistance to private and public providers.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7. Clean indoor air policies in Public Places and in workplaces, to reduce exposure to secondhand smoke and adult prevalence.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E. OTHER PROGRAM ACTIVITIES

Division of Adult and Child Health

/2005/

-State Nutrition & Physical Activity Programs to Prevent Obesity and Other Chronic Diseases is in its first year of capacity building.

With the ever increasing problem of obesity in the area of maternal and child health, the Division was pleased to receive this grant from the Centers for Disease Control and Prevention. Providing \$ 413,000 during the current year (and \$ 450,000 in FY05), this planning grant will provide funding for state and community partners to build this collaborative program with the expectation of implementation funding (\$ 750,000)in the near future.

One of the goals of the first year is to hire three full time positions: a program director, a physical activity coordinator and a nutrition coordinator. The second goal for the first year is to write a comprehensive state plan that will address the six areas of the grant: increase physical activity, increase fruit and vegetable consumption, increase breastfeeding, increase parental involvement, decrease computer and television screen time, and other dietary changes.

These areas of improvement will be accomplished through partnerships between many groups including schools, business and industry, public health and health care, families and communities and those focusing on the environment. Regional public forums will be held in nine communities throughout Kentucky; Ashland, Lexington, Louisville, Covington, Bowling Green, Paducah, Owensboro, Somerset and Hazard. A diverse group of individuals will be invited to discuss current activities (in their communities and statewide), their ideas for the future and how the Department for Public Health can support their local work. Participants will include schools, business, healthcare, political leaders, non-profits and consumers. The state plan will be completed by December 2004.

Other projects addressing obesity are occurring throughout the state; particularly in Kentucky Schools. Project staff expect to have a state plan for obesity prevention completed by the end of CY04. More information is available by contacting Wendy Carlin, Program Director for the grant at 502-564-3827, extension 3748.

-Kentucky Childhood Mental Health Program

The Early Childhood Mental Health Program is a program funded through the KIDS NOW. One million dollars annually for the next biennium has been allocated to support a mental health program for children from birth to five enrolled in early care and education settings. The overall goal of the program is to support the social and emotional growth by emphasizing the importance of nurturing relationships in multiple settings. Fourteen Early Childhood Mental Health (ECMH) Specialists have been employed through community mental health centers. Services provided by the Specialists to children and their families include; assessments, therapeutic services, training and resources for public and private providers. Additionally, the Specialists provide and sponsor training and consultation to child care providers and fellow clinicians to assure high quality care and to increase the number of qualified professionals to serve these children. This program is a cooperative effort between the DPH, DMH/MRS, KDE and the Cabinet for Health and Family Services.

According to the KIDS NOW Early Childhood Initiative Summary dated March 2004, to date in 2004, 1,586 children and their families have received services. Eight regional trainings have been presented to specialists and other mental health professionals. //2005//

-Healthy Start in Childcare

Implemented as part of the KIDS NOW Initiative, Healthy Start in Child Care provides training and education to childcare providers and parents in health, safety, nutrition, and the benefits of early intervention. Emphasis is also placed on the prevention of communicable diseases in group settings and the social/emotional well-being of children. Assessments of playgrounds are provided and recommendations are made to prevent childhood injuries. Eight-eight Healthy Start consultants

provide services in all 120 counties. There are approximately 103,000 children in child care in 2,000 licensed centers and 900 family care homes.

F. TECHNICAL ASSISTANCE

The Commission for Children with Special Health Care Needs and the Division of Adult and Child Health will discuss TA needs individually within this section.

Division of Adult and Child Health:

Request will be made during FY04 from the Maternal and Child Health Branch for technical assistance to support the development of a needs assessment and assistance with maternal and child health record linkage.

Commission for Children with Special Health Care Needs:

Request will be made during FY04 for assistance to support state staff and one parent representative traveling to AMCHP and for state staff traveling to MCHB mandatory meetings. The Commission will also request funding to support a consultation from staff of the Healthy and Ready to Work National Center for the leadership team that is designing the Building Linkages to Transition (BLT) project.

//2005/ The Commission requests technical assistance during FY 05 from the National Center for Cultural Competency to provide training and assistance during the implementation of the Center's cultural competency self-assessment questionnaire. Following completion of the survey, the state and district offices will develop a plan that identifies 2-3 strategies for improving cultural and linguistic competency. //2005//

V. BUDGET NARRATIVE

A. EXPENDITURES

Budget projections for this section are completed before the state fiscal year actually closes. Budgets for various activities should be considered "point-in-time" estimates however, staff completing this portion of the Title V provide as accurate information as is possible at that time.

Actual expenditures may also be different than budget because of carryover and the variance of grant years. The state fiscal year begins on July 1st and ends June 30th. The federal grant year (Title V) begins October 1st and ends September 30th. Many department grants have yet other timeframes.

Generally speaking, budgeted and actual expended dollars have been relatively consistent within a given year. Any notes to explain variances have been attached to the financial form which they address.

For this reason, questions regarding specific financial activities should be relayed to the Division for Resource Management; the Division within the Department for Public Health that is responsible for financial reporting.

B. BUDGET

Both the Division of Adult and Child Health and the Commission for Children with Special Health Care Needs will discuss FY05 budget within the section.

Division of Adult and Child Health, Dept. for Public Health

The vast majority of Title V Block Grant funding allocated by the Division of Adult and Child Health is given directly to local health departments to support community programs that work toward attaining MCH performance and outcome measures.

In addition to our MCH Title Five funding, revenue from several major sources including KIDS NOW Early Childhood Initiative, KCHIP and Bioterrorism supports local health departments. Local health departments receive the majority of Title V MCH Block Grant funds and funding has been at continuation levels.

Based upon the current estimated block grant allocations to Kentucky in FY05, (total of \$ 12,144,971) 34.9% or \$ 4,238,594 will be contracted through a memorandum of agreement with the Commission for Children with Special Health Care Needs and the remainder of \$ 7,906,377 will remain with the Division of Adult and Child Health Improvement.

The majority of this funding (94%) will be re-allocated through a block grant process to local health departments. Local health departments have the ability to select particular cost centers in which to use this funding. Additionally, they may use it for clinical (personal health) or community (population-based) services.

Clinical services include well-child, maternity and prenatal care, family planning, oral health and nutrition services. Approximately 90% of Title V funding will be used to cover local health department clinical services in FY05.

Community Services implemented by local health departments include prenatal classes, oral health classes, physical activity campaigns in schools, teen pregnancy prevention programs, injury prevention activities and smoking cessation campaigns; just to name a few. Approximately 10% of Title V funding will be used to cover community services in FY05.

Special emphasis for the FY04 budget period was placed upon physical activity and nutrition services for youth. The combined use of all of the Preventive Services Block Grant (1.7 million) and a portion of the Title V MCH Block grant (1.5 million) was allocated solely to underwrite activities addressing the issue of inappropriate weight for height in Kentucky in children. As this performance measure is a primary health concern Kentucky's population, combined use of these funds supports the intent of the block grant process; funding flexibility to address unique needs of states and communities.

Additionally, in FY05, funding to support prenatal care has been designated for each county and health district. A total of \$ 1,338,353 has been earmarked for prenatal care services; particularly for the uninsured and disparate populations. Required allocations for these services range from a high in Fayette County (Lexington) of \$ 216,000 to \$ 2,000 in many small Kentucky counties. Program planners estimated that the costs of an uninsured birth are approximately \$ 2,000 each. Hence, this sum was used to calculate allocations for Kentucky counties based upon historic needs.

Below is an estimated listing of how Kentucky's local health departments anticipate using Title V funding during FY05. This is a projection based on a 92% response rate of local health department budgets in as of June 15, 2004.

(CC 712)Dental Clinical Services \$ 4,573 (<1%)
(CC 800)Pediatric Well-Child \$ 2,374,453 (31.8%)
(CC 802)Family Planning \$ 1,067,024 (14.3%)
(CC 803)Maternity \$ 1,338,353 (17.9%)
(CC 805)Nutrition \$ 1,652,363 (22%)
(CC 852)Resource Persons \$ 1,524 (<1%)
(CC 818)Community Activities \$ 854,998 (11.5%)
(CC 857)Physical Activity \$ 165,389 (2%)

Total\$ 7,458,677

Local health department allocations are based on a formula that takes into account population and need on a county-by-county basis. Funds are provided for clinical and community health and while certain programs are required (such as family planning, prenatal, child preventative, adult personal health and medical nutrition therapy), allocations for individuals programs may vary depending upon community need as determined by a needs assessment process. Throughout this process, MCH Title V funds must be used to meet MCH performance measures and applicable 2010 health goals. The Title V Administrator works with the budget review team who read each local health department plan and verify the proper use of MCH funding as well as the effectiveness of planned activities.

The Commission for Children with Special Health Care Needs receives 34.9% of the Title V Allocation which, in FY05, will amount to \$ 4,238,594.

Additionally, capacity building costs for ACH underwritten with Title V Funding include portions of two program contracts (Maternal Mortality Review and Public Health Training) with the University of Louisville. Funding has also been allocated in FY05 to support the Mental Health/Mental Retardation Suicide Prevention team (\$ 30,000).

Finally, some infrastructure costs for the Department for Public Health are underwritten by Kentucky's Title V Block Grant. This included a portion of the cost of Kentucky's local health department billing and services reporting system, Patient Service Record System (PSRS). //2005//

Commission for Children with Special Health Care Needs

//2005/ The Commission anticipates the FY05 budget to include state and agency funds in

excess of the 1989 maintenance of effort level. State and agency funding is expected to remain above the 1989 maintenance of effort level of \$8,170,428 for the foreseeable future.

In addition to MCH Title V Block grant dollars, the Commission's primary source of funding are State dollars (mix of state general funds and Tobacco Settlement funds) and Agency funds. The agency revenues are receipts from third party billings for direct patient care and care coordination. The Commissions' budget for FY05 is projected as follows: State General funds \$6,205,000, Tobacco Settlement Funds \$555,000, and Agency Funds \$4,890,100. Other Federal sources of funding in the FY05 budget include CDC grant/University of North Carolina (\$66,000); MCHB/Wake Forest University (\$40,000); Sound Start (EHDI) Grant \$126,000. //2005//

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.