

STATE TITLE V BLOCK GRANT NARRATIVE

STATE: **KS**

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

To obtain a copy of the Assurances and Certifications, contact:

Linda Kenney, Director
Bureau for Children, Youth and Families
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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

A notice of public hearing was placed through the Kansas Rural Health Information System. (KRHIS is the new electronic public health information system with postings to all local health departments, hospitals, primary care clinics and other health care providers.)

A second notice was posted in the official Kansas newspaper, the Kansas Register, on February 12, 2004.

The public hearing was held before the House Appropriations Committee of the Kansas Legislature on Thursday February 19, 2004 in the Statehouse. An overview of the requirements of the MCH Services Block Grant was provided including the five-year statewide needs assessment and use of the funds to address priority needs identified in the needs assessment.

No comments were received through these processes.

II. NEEDS ASSESSMENT

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

III. STATE OVERVIEW

A. OVERVIEW

/2005/Located in the central plains region of the United States, Kansas encompasses 82,277 square miles (about 3% of the area of the U.S.). It is bordered on the north by Nebraska, on the south by Oklahoma, on the east and west by Missouri and Colorado respectively. Hills, ridges and wooded river valleys in eastern and central Kansas give way to the flat, dry, treeless High Plains of the western part of the State.

Geography, climate and economic resources influence Kansas' population distribution. The four most populous counties, Johnson, Sedgwick, Shawnee and Wyandotte, are located in the eastern and central parts of the state. The least populous counties are located in the western part of the state. In 2002 the population density of Kansas was 33.2 persons per square mile, slightly higher than the population density for the U.S. County population density ranged from 1,047 persons per square mile in Wyandotte County (eastern Kansas - Kansas City) to less than 6.0 persons per square mile in one far western county.

Economy: While the national economy rebounded significantly in 2004, the Kansas economy was slow to rebound. The unemployment rate in Kansas remains below the national rate. A slight decrease in the unemployment rate is expected from 5.0 percent in 2003 to 4.9 percent in 2004. Overall, the Kansas economy is expected to experience very modest growth in 2004.

While employment growth was experienced in farm employment, natural resources, finance, construction and education/health services, there have been reductions in jobs in other areas of the economy. Reductions in workforce in the aircraft industry were particularly hard on Wichita residents in south-central Kansas. In Kansas as elsewhere, telecommunications and other companies have continued to cut their workforces.

Population: According to the 2000 census, Kansas ranked 32nd among the states, with a population of 2,688,418 (about 1% of the U.S. population). This represented an 8.5 percent increase over the 1990 census. In 2000 the population of the state was 86.1 percent white, 5.7 percent black, 1.7 percent Asian, 0.9 percent Native American, and those of mixed heritage or not reporting race 5.5 percent. Native Hawaiians and other Pacific Islanders numbered 1,313. Seven percent (7%) of the population reported Hispanic ethnicity. Immigrants or foreign-born residents accounted for only 2.5 percent of Kansas' total population.

In 2000 the trend towards urbanization of the population continued with 71 percent of the state's people living in urban areas. While the Hispanics population live largely in rural areas, the majority of black Kansans reside in the Wichita, Topeka, and Kansas City metropolitan areas.

Age: In 2002, Kansas had 39,338 resident live births. The Kansas birth rate of 14.4 per 1,000 was only slightly below the national rate of 14.5. Counties in southwest Kansas (Finney and Seward) had the highest county birth rates and 5-year county birth rates due primarily to Hispanic births. There were 754,993 children age 18 and under or 26.5 percent of the population.

Kansas had 573,710 women of reproductive age 15-44 or 21.3 percent of the population. The pregnancy rate for females ages 0-19 decreased 13.5 percent from 33.3 pregnancies per 1,000 in 1991 to 28.8 in 2001. Teen pregnancy rates for females ages 10-17 decreased 17.4 percent during this same time frame in line with the national trend. Of the births to teenage women in 2001, 83.9 percent were to whites and 12.7 percent were to African Americans.

Disparities: Over the past decade, Kansas has seen an increase in the number of minorities living the State and increasing diversity. Between 1990 and 2000, the Hispanic population increased by 101 percent from 93,670 to 188,252, the Asian and Pacific Islander population

increased by 13.5 percent from 21,965 to 24,936. The African American population increased by 7.8 percent from 143,076 to 154,198). The increase for the white population over the same period was only 3.7 percent, from 2,231,986 to 2,313,944.

Languages: According to the 2000 Census, approximately 8.7 percent of the Kansas population 5 years and over spoke a language other than English at home. Of these 3.9 percent spoke English less than "very well." Between 1990 and 2000 there was a 66% increase in the population speaking a language other than English in the home. The Kansas percent increase was larger than the average increase for the Midwest (66% versus 58%) but considerably smaller than the increase for the South (87%).

Poverty: Compared to the U.S. population, a lower percentage of Kansans live in households with incomes below the federal poverty level (10.1% versus 11.7%). A lower percentage of children under age 18 live in households with incomes below the federal poverty level (13.6% versus 15.8%). Twenty percent (20.1%) of children living in poverty are Hispanic. Overall, the percent of Kansas families living at or below the federal poverty level is 6.7%. Poverty is more common in Kansas families headed by single females and those with children under the age of five in the household, regardless of race or ethnicity. Most Kansas children under age 18 living in poverty live in three population centers: Sedgwick Co. (Wichita), Wyandotte Co. (Kansas City, KS) and Shawnee Co (Topeka).

Education: Educational attainment for Kansans is favorable compared to the U.S. About 86.0% of Kansans age 25 and older are high school graduates compared to about 80.4% for the U.S. The percent of those age 25 and older who are college graduates is slightly higher for Kansas than for the U.S. (25.8% vs 24.4%). //2005//

Health Status: In 2002, a total of 282 infant deaths occurred in Kansas. The overall infant death rate was 7.2. This represents a slight increase from 2000 (6.7 per 1,000) and a decrease from the rate of 19.4 in 1971. The White infant death rate was 6.5 deaths per 1,000 live births in 2001, a decrease of 64.7% from the rate of 18.4 in 1971. The black infant death rate was 15.3, a decrease from the rate of 32.8 in 1971. Of all infant deaths in 2002, 48.2% were attributed to conditions originating in the perinatal period, 22.3% were attributed to congenital anomalies, 16.3% to sudden infant death syndrome and 13.2% to all other causes. During the five-year period, 1998-2002, the infant death rate for Kansas was 7.1. Elk county, a rural county in SE Kansas, had the highest infant death rate of 20.0 during this time period. Of those counties reporting infant deaths, Coffey county, south of Topeka, had the lowest rate at 2.0. The MCH program works in concert with the Perinatal Association of Kansas in reviewing these and other data to shift resources as needed to address community needs.

In 2002, a total of 46 infant deaths to otherwise normal, healthy infants were attributed to Sudden Infant Death Syndrome (SIDS), 39 of which occurred after the 28th day of life and before the 365th day of life. As elsewhere in the nation, there has been a significant drop in SIDS since the initiation of the Back to Sleep campaign in 1997. Kansas MCH funds the SIDS Network of Kansas to provide outreach and support to families.

In 2001, 19,878 infants (51.2% of live births) were seen in Kansas Women, Infants, and Children (WIC) program during their first year of life. According to the Pediatric Nutrition Surveillance System (PedNSS) data for 2002 for Kansas, the breast-feeding initiation rate was 63.2% and 21.2% at six months. In the Ross Laboratories Mothers' Survey for 2001, Kansas breast-feeding rates were 73.8% at hospital discharge and 28.7% at six months. The national rates were 69.5% and 32.5% respectively. Kansas' initiation rates are above the national average; however, the six month breast-feeding rates are below the national average and breast-feeding rates at six months have declined from 33.7% in 2000. The Title V program and the WIC program continue to support local breast-feeding initiatives.

In Kansas, there were 346 completed suicides in the general population in 2002. During this same period, suicide was the second leading cause of death among adolescents ages 15 to 24. In the 10 to

24 age-group there were 77 completed suicides in Kansas, 9.4/100,000, which compares to 7.3/100,000 nationally. Discharge of firearms was the method of choice in 54% of suicides, hanging/strangulation in an additional 31%. Males comprised 88% of completed suicides. In 1999 to 2000, hospital discharge data includes 685 self harm hospitalizations. Drugs was the method of choice for 88% of the hospitalizations. Females comprised 71% of hospitalizations. MCH collaborates with the Bureau of Health Promotion in its health education campaign to address youth suicide.

Data from the 1997-98 retrospective survey of kindergarten students indicated that Kansas had achieved the Healthy People (HP) 2010 objective for Measles-Mumps-Rubella vaccine (91% coverage) and Polio (94% coverage) for two-year-olds. The coverage for Diphtheria-Tetanus-Pertussis vaccine was 81%, which represents an increase from the 1994-95 level of 73%. An increase was also realized for the Hepatitis B vaccine coverage, which was 87% compared to 67% in 1995-96. National Immunization Survey data for Kansas for the past several years has shown a downward trend. This is the focal point for the Governor's Blue Ribbon Immunization panel which initiates assessment and other activities in 2004. MCH serves on the panel. The Immunization Program provides incentives to local health departments who meet immunization goals through the MCH Block Grant funding.

Trend data on obesity in Kansas have mirrored data for the U.S. According to Kansas Behavioral Risk Factor Surveillance System (BRFSS) data, the estimated prevalence of obesity (body mass index [BMI] \geq 30) among adults age 18 years and older increased from 13.1% in 1992 to 21.6% in 2001, an increase of almost 65%. The estimated prevalence of overweight/obesity (BMI \geq 25) among Kansas adults was 57% in 2001 BRFSS. While considerable disparities in obesity exist among population subgroups, it is important to note that the prevalence of obesity is high among almost all populations in Kansas.

Data for Kansas children show a similar trend. The PedNSS data show the increasing prevalence of obesity (\geq 95th percentile of weight for height) among children enrolled in WIC between 1992 and 1999. During these years, the prevalence of obesity increased from 5.3% to 8.4%. The most recent data (first quarter 2000) indicate that the prevalence of overweight was highest among children of Hispanic origin, followed by blacks, and then whites (11.6, 9.2, 7.6, respectively). Reducing the prevalence of overweight children (aged 36 to 59 months) through nutrition and physical activity is a performance measure for the State's MCH Block Grant and also for WIC's Action Plan.

Data on physical activity for children is not available but data for adults from the 2001 Kansas BRFSS indicate that more than one in four (26.7%) adults do not participate in any leisure-time physical activity. More than half (55.8%) of adults do not participate in the recommended level of physical activity (moderate activities \geq 5 days per week for \geq 30 minutes or vigorous activities \geq 3 days per week for \geq 20 minutes).

Health Coverage and Uninsured: According to the 2001 Kansas Health Insurance Study, over two thirds of Kansas children (age 18 and under) are covered by private insurance. Fifteen percent are covered by public insurance and approximately 8% have no health insurance. For women of reproductive age (15-44), 82.6% are covered by private insurance, 4.3% by public insurance, and 13.2% uninsured. The percentage of average annual growth of Medicaid enrollees is 5.6% in Kansas compared to 9.8% for the U.S. Fifty-two percent (52%) of Kansas Medicaid enrollees are age 18 or younger. Kansas maintains the eligibility level for the Medicaid program at the federally required minimum. See Form 18 for eligibility levels for Medicaid and SCHIP.

Among Kansas' Medicaid enrollees, 55.3% are enrolled in managed care compared to 58.3% for the U.S. The percentage of Medicaid spending on children under age 18 (15%) in Kansas is the same as for the U.S. However, long term care (fee-for-service) Medicaid spending is higher (53%) compared to the U.S. (38%). The number of births financed by Medicaid in Kansas has risen from 7,718 (23% of Kansas live births) in 1999 to over one third in 2002. Joint application was allowed for children's Medicaid and the SCHIP-funded separate programs in 2002. Kansas is one of 18 states in the U.S. with 12-month continuous eligibility for Medicaid eligible children. For federal fiscal year 2003, the

SCHIP federal matching rate is 72%.* ***//2005/ As was the case for many States, there have been increases in cost-sharing requirements for the Kansas SCHIP program. This is due to state budget shortfalls. Still, no decrease in benefits has occurred at this time. //2005//*** An Interagency Agreement between the State Medicaid Agency (SRS) and the State Health Agency (KDHE) defines the roles and relationships of the two programs in assuring the health of mothers and children.

In 2003, there was no Medicaid waiver to expand family planning services for 60 days postpartum to 2-5 years as has been done in other States. Currently, a 24-hour waiting period between receiving information and abortion is enforced. A parental consent / notification requirement for minors' abortion is enforced. The number of reported legal abortions per 1,000 women of reproductive age (ages 15 to 44) is higher than for the U.S. (22 vs. 17, respectively). In 2000, the percentage of women between the ages of 18 and 64 who reported having a Pap smear within the last three years was 86%. Kansas does not have comprehensive laws requiring coverage of all FDA-approved prescription contraceptives by all health insurance policies written in the State that cover other prescription drugs and devices. There is no mandated coverage for infertility diagnosis and treatment. However, there is mandated direct access to OB/GYN limited to one visit a year from an in-network OB/GYN. OB/GYNs are not mandated as primary care providers.

Kansas laws mandate benefits for breast, cervical, and prostate cancer screening, but not colorectal. Kansas laws also require insurers to provide coverage for diabetic supplies, equipment, and/or out-patient management training. Insurance coverage of newborn hearing screening is not mandated. The Title V agency acts in an advisory capacity to the state insurance agency and to the legislature in insurance matters relating to pregnant women and children.

State Health Expenditures: In Kansas, total state health care expenditures per capita for state fiscal year of 2001 was slightly lower (\$3,275) than U.S. (\$3,590). Total includes both state-funded operating and capital spending. For state fiscal year 1999, state health care expenditures per capita was lower (\$696) than the U.S. (\$872). During SFY 2000-2002, tobacco settlement funds, cumulative total to date are \$103,903,000 for Kansas and \$20,828,646,000 for U.S. For that time period, \$1,000,000 was allocated for tobacco use prevention: \$46,115,000 for health services, \$2,500,000 for health research, \$5,403,000 for education, and \$28,585,000 for children and youth (nonhealth). During SFY2002, the annual appropriation of state allocation of tobacco settlement funds was \$500,000 for tobacco use prevention, \$19,350,000 for health services, \$1,250,000 for health research, \$15,500,000 for children and youth (nonhealth). Total tobacco settlement funds to the State Health Agency (KDHE) is \$1,250,000 in state fiscal year 2002 and 2003. ***//2005/ \$2 million in SFY 2005. Of this amount, \$500,000 is for youth tobacco prevention, \$1,000,000 is for children's developmental services through Part C of Individuals with Disabilities Education Act (IDEA), \$250,000 is for home visiting through health departments, and \$250,000 is for prenatal smoking cessation.//2005//***

Health Manpower: In 2000, there were ten federally qualified health centers and 156 rural health clinics in Kansas. The rate of nonfederal physicians per 100,000 civilian population for Kansas (227) was lower compared to U.S. (268). Nonfederal physicians are employed in the private sector of the U.S. physician population. They represent 98% of total physicians. Rate of registered nurses per 10,000 population in Kansas (84) was slightly higher compared to the U.S. (79). Registered nurses include advance practice nurses such as nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists. Title V supports manpower development activities for rural health and other practitioners through its support of the Office of Local and Rural Health at KDHE.

Cumulative number of AIDS cases in children under 13 reported through December 2001 was 12. There were no new pediatric AIDS cases reported in 2001. Estimated number of children living with AIDS at the end of 2001 was two. In Kansas, there is no specific law or language on testing for mothers and newborns, but Kansas follows the CDC guidelines and voluntary HIV testing is in place to implement the CDC's 1995 recommendations on HIV counseling and testing of pregnant women

and infants.

The goals for health care delivery in Kansas are: to engage communities in prevention and improvement of health, to expand health care insurance coverage for all of the citizens who are uninsured or underinsured, and to make health services available through a medical home to people in even the more remote areas of the State while maintaining services of high quality. Kansas strives for a seamless system, coordinated locally, but with the potential of applying the most sophisticated and highly technical skills. Since 1995, the health care delivery environment has been altered through capitation programs, the privatization of certain services, and a managed care environment. Historically, local county or multi county health departments (99 county health departments in 105 counties) have been providers of direct care services to low-income and underserved populations. The shift to managed care by the State's Medicaid Program and SCHIP has resulted in a lesser role for the local health departments in direct care services. It is in the context of this backdrop that the Title V program functions.

State Health Agency Current Priorities or Initiatives/Title V Role:

The Kansas Department of Health and Environment (KDHE) is the State Health Agency and the applicant for the Title V funds. While there have been a number of priorities during the past two years, none has been so labor intensive and far reaching in the broader public health system as bioterrorism.

Bioterrorism: During the past year, KDHE and other statewide partners have developed formal plans to protect the public in the event of public health emergencies, including bioterrorism. In addition to the statewide plan, all 105 counties have developed local plans for preparedness and response to bioterrorism and other public health emergencies. KDHE staff in all areas of the agency have participated in this effort with the Office of Local and Rural Health and the Bureau of Epidemiology and Disease Prevention taking the lead. Direct technical assistance has been provided to all organizations and counties in the development of bioterrorism plans and initial draft plans have been reviewed and updated. As local and state plans are reviewed and updated in the coming year and beyond, additional content will be recommended, including specific interventions for special populations, such as children in the school setting and persons of limited English proficiency.

In order to coordinate these preparedness activities with school personnel, bioterrorism preparedness content will be incorporated into the Kansas School Nurse Conference. The session focused on identifying epidemiologic clues that may indicate that a bioterrorism attack has occurred in the community and the potential impact. The role of the school nurse in bioterrorism preparedness and response was addressed. This information was tied to efforts within KDHE to promote involvement by school nurses in disease surveillance activities, in conjunction with local health departments and regional medical investigators from KDHE. As the coordinator of school nursing standards and education within the Agency, Title V has participated in this effort.

In order to safeguard persons of limited English proficiency in a bioterrorism event, public information materials were translated into languages spoken in Kansas, particularly Spanish. In addition, medical interpreter training is widely available to health professionals and other public service workers involved in bioterrorism planning. The Title V program assists in these and other efforts relating to the maternal and child population.

Oral Health: A second broad initiative of the Department during the past year was sponsorship of legislation to establish an Office of Oral Health within KDHE. The legislation failed as did the request for an appropriation for oral health activities. Another piece of legislation passed which expanded the practice of dental hygienists in public health settings. Widely supported by the dental and public health communities, this legislation promises to challenge the public health system to step forward and address the oral health needs of children. ***/2005/ An appropriation for an Office of Oral Health was approved in the 2004 legislative session. Delta Dental of Kansas created a new nonprofit, charitable organization. Goals of the foundation are to provide grants to fund projects that will***

increase access to dental care for underserved populations, build the capacity to provide dental care, increase public awareness of oral health, and work to promote the prevention of oral disease. //2005//

The Title V program employs the only dental health professional in the department, a dental hygienist. This individual, the Oral Health Consultant, serves as the KDHE contact with federal (ASTDD) and state organizations (e.g., United Methodist Health Foundation) focusing on oral health issues. The consultant handles a broad range of assessment, policy development and assurance activities ranging from an open mouth survey, to the Oral Health Coalition, and education for public health nurses, child care providers and others regarding oral health issues. See www.kdhe.state.ks.us/ohi

HIPAA: All programs in the State Health Agency participated in a self-assessment process with legal and other reviews of interagency communications and transmission of information due to implementation this year of the Health Insurance Portability and Accountability Act (HIPAA). The CSHCN program was subject to particular scrutiny due to its data sharing and billing requirements, as was the Family Planning Program for colposcopy reimbursements. At the conclusion of the review, the Agency legal advisors determined that neither program was to be considered a covered entity under HIPAA. Still, the need to address confidentiality was identified within the Title V area. The confidentiality policy for the Infectious Disease programs was modified to suit the requirements of all programs in the Title V area. These confidentiality guidelines have been implemented with education of all staff. Title V continues to work with the State Agency legal staff as HIPAA issues arise.

Budget shortfalls: The most prominent issue for the State Health Agency this year was lack of State funds to meet budgetary requirements. The 2003 Legislature followed in the footsteps of the 2002 Legislature in passing no new taxes to make up for the revenue shortfalls to the State. The Graves administration was forced to make drastic reductions in State funds to state agencies in August 2002 and again in November of 2002. The new administration that took office in January of 2003 faces the same challenges and is conducting a top to bottom review of State government looking for efficiencies through targeted program reductions and state agency reorganizations to eliminate duplication of services. **//2005/ Budget shortfalls continue to be a primary concern for the administration, but the 2004 legislature approved no new taxes during the session. //2005//**

//2005/ The Kansas Hospital Association (KHA) developed provider assessment legislation which passed quickly through the 2004 Kansas legislature. Hospitals and HMOs (except critical access hospitals and state institutions) and the Medicaid HMO, First Guard. Eighty percent (80%) of the hospital assessment revenues are to be used to increase Medicaid rates for hospitals and 20% of these revenues are to be used to increase rates for physicians (with the possibility that some dental rates could be raised). The assessment is not effective until the plan to obtain additional federal matching funds is approved by CMS. A Health Care Access Improvement Panel is created to oversee the disbursement of the revenues. This panel is made up of three hospital representatives appointed by KHA, two physician representatives appointed by Kansas Medical Society (KMS), one SRS representative appointed by the Governor, one First Guard representative, and one representative of the Kansas Association of Medically Underserved (KAMU). This will result in an assessment of \$12.4 million and including federal funds \$32 million total. //2005//

Fee-Based Systems: **//2005/ There has been a gradual shift in financing of essential public health functions from State dollars to fee-based systems. Licensing, credentialing, and most recently Vital Statistics have all been shifted to fee-based systems. In particular, the shift of Vital to fee-based has been costly for MCH. Whereas formerly the operations were supported by state general funds, now the operations are supported by the fees that are generated through the sale of data. MCH, Immunizations, and other federally funded programs are now assessed fees for access to Vital data at each point of contact. //2005//**

Note:

B. AGENCY CAPACITY

AGENCY CAPACITY

During the past year, the capacity of the agency to provide leadership to maternal and child health in Kansas has been challenged on a number of fronts. Among the challenges faced by the KDHE were budget issues. There were revenue shortfalls to the State and state general funds (SGF) were reduced to all State agencies. In August of 2002 a reduction called the August allotment resulted in a loss of SGF to Bureau for Children, Youth and Families (BCYF) programs and three months later the November allotment resulted in a further reduction. These reductions affected Pregnancy Maintenance Initiative, residential maternity homes, salaries, operating, and Part C of IDEA. In addition, there was a loss of federal dollars. Some state agencies, in response to SGF reductions, discontinued long-term partnerships involving the interagency transfer of federal dollars. The impact on BCYF programs was a loss of TANF to BCYF teen pregnancy prevention projects. Loss of other federal dollars was substantial. In some cases, loss of the state general funds resulted in loss of matching funds from sources such as Medicaid. This was the case for teen pregnancy prevention salaries and operating.

In state fiscal year 2003, vacant positions in the BCYF were held open. At one point, one in five positions were vacant and many were held open for several months. There was a reduction in state funds to school health clinics, BCYF salaries and operating. In early 2003, the incoming Governor submitted a budget to the legislature restoring funding for local teen pregnancy prevention projects. The 2003 legislature approved this restoration along with restoration of SGF funds for pregnancy maintenance projects and Part C. As well, Part C received an increase in tobacco settlement funds. Tracking the constant budgetary changes has been a major challenge for the BCYF staff. **//2005/ Budget issues have continued to challenge the agency's capacity to assure essential public health services. Federal, state and local funds are all unstable and there is considerable cost shifting to maintain basic infrastructure and core public health functions. //2005//**

Other State Agencies and local agencies also reported reductions. At the same time, caseload increases were reported for many programs including WIC and Medicaid. As of July, 2003, Medicaid and State Childrens Health Insurance Plan (SCHIP - called HealthWave in Kansas) had not reduced services for mothers and children. **//2005/ Due to caseload increases and sharply rising costs of food items in the WIC food package (milk and eggs), this year staff started planning a strategy for implementation of waiting lists. An application to the USDA for federal contingency funds was approved, however, resulting in an increase of \$2.1 million to the program which should eliminate the need for client waiting lists. //2005//**

Bioterrorism preparedness was a second challenge to agency capacity during the past year. The directive from HRSA and from the State Health Officer was to prioritize bioterrorism activities and MCH/CSHCN staff answered this call. Public health workers at the State and local levels became immersed in this activity, which at times took precedence over maternal and child health activities. **//2005/ The MCH Director was invited to participate on the Governor's Bioterrorism Coordinating Council in 2004. The invitation preceded the news of a \$1,085,000 reduction in federal bioterrorism funds to Kansas. //2005//**

A third challenging area was the heightened interest in Early Childhood (EC) and School Readiness issues. Since the release of the IOM report, Neurons to Neighborhoods, there has been considerable interest in "investing early" which translates in Kansas to a focus on services for the 0-5 population. Several BCYF staff participate in various early childhood, early care and education, and related groups. The Kansas State Department of Education has initiated an update of its EC standards. The Department of Social and Rehabilitation Services programs (Child Care Development Block Grant, Early Head Start Collaboration Project and others) have developed strategies relating to improved

child care through training and reimbursement initiatives. Chief among these strategies is funding of Smart Start projects (seven funded to date) which rely on community coalitions to determine the funding priorities. Of the seven projects in Kansas all except one focus on training and adequate salaries for child care providers. ***/2005/ The Governor's budget proposal to the 2004 Kansas legislature contained an increase in Tobacco Settlement funding for Smart Start projects from the SFY 04 level of \$3.2 M to a full \$10 M. Despite an expected shortfall in expected Tobacco Settlement receipts both chambers approved approximately \$8.45 M for the coming year. Meanwhile, Kansas MCH applied for and received funding for State Early Childhood Comprehensive Systems planning. The coordinator hired on this grant works out of the Children's Cabinet offices. //2005//***

In an effort to make State government more efficient while at the same time effective in meeting the needs of consumers, the Governor has initiated Budget Efficiency Savings Team (BEST) team reviews. Groups of interested Kansans have been assembled to review the operations of State agencies and to make recommendations. These teams have made efficiency recommendations for consolidation of State government functions, reorganization, and elimination of functions. The process is ongoing in an effort to trim State government budgets. ***/2005/ MCH director participated in a BEST review of the inter-agency coordination relating to contracts/grants. The final action on this review is pending. //2005//***

This year, concern about rising Medicaid costs for low birth weight infants prompted one legislator to request an audit of KDHE programs that address low birth weight. The legislative audit team of five individuals conducted a study over a period of several months. This was a labor intensive activity for the MCH staff, so a contractor was hired to assist the auditors with the review. At the time of the review, it was noted by the auditors that 10 of 50 Bureau staff positions were vacant. These positions, which had been held open pending the outcome of the legislative session, have since been filled. Since one out of every five BCYF staff is new, orientation and training will be a priority in 2003-2004. ***/2005/ All positions but one have been filled. Orientation and training are complete for new staff in the BCYF. //2005//***

Governor Kathleen Sebelius who took office in January has appointed a new agency head for the Department of Health and Environment. Roderick L. Bremby took office in January of 2003. He promises to lead the agency in a positive direction relating to maternal and child health, chronic disease, disparities issues and others. He has a background in community health and has strong administrative experience. Priority areas he has adopted for KDHE to address are heart disease, cancer, immunizations, and tobacco prevention and cessation. Our State Health Officer resigned in April to accept a job in Ohio. Dr. Michael Moser had been with the agency for almost four years. His tenure was notable for a strong support of evidence-based decision making and building epidemiology capacity. Richard Morrissey, Director of the Office of Local and Rural Health, is serving as Interim Director. ***/2005/ The search for a Director of Health continues this year. Also, the legislature approved funding to be matched by foundation funds for an office of Oral Health in KDHE. Staffing for the office will include the MCH registered dental hygienist who has made some very satisfactory progress in obtaining grant funding, undertaking assessment and systems development activities. Therefore, a search for a State Dental Director is also underway. //2005//***

The Department has undergone various legal and programmatic reviews and self-reviews relating to HIPAA compliance during the past year. A subsequent determination was made that MCH/CSHCN programs were covered by the public health provisions of HIPAA. Nevertheless, as a result of the reviews, steps were taken within the BCYF to strengthen confidentiality through a formal written policy, new and existing staff orientation, and follow up. HIPAA compliance issues continue to consume substantial resources at the State and local agency levels. ***/2005/ HIPAA issues have taken a second seat to the Agency-wide assessment of information systems compliance with OMB 15 requirements relating to race/ethnicity. BCYF participants coordinated responses from the Division. There is a need for many programs to update the manner in which they***

collect data on race/ethnicity but funds to do so are lacking in several instances. //2005//

The March of Dimes and others advocated strongly during the 2003 legislative session for expansion of newborn screening tests through tandem mass spectrometry (MS/MS) technology. Lack of funding for this new technology was a major barrier to passage of legislation. The Agency and the State of Kansas continue to review the situation and try to develop State Laboratory capacity to expand testing. ***//2005/ During the 2004 session, the March of Dimes and other supporters successfully sponsored a bill creating a birth defects surveillance system in KDHE. BCYF will apply for federal dollars in late 2004 to support the system. //2005//***

Performance and accountability requirements for all programs require that we have adequate information systems. During the past year, the BCYF engaged in three major automation projects. Part C of IDEA implemented new case management software systems in each of its 37 local networks. This project is ongoing. The \$5.5 million WIC data project is nearing the rollout stage after many months of testing. Kansas is adapting the system utilized in Washington State. The completion of the project is expected within the next year. The MCH/Family Planning (FP) Data System was rewritten from Genexis to Progress programming language to conform to Kansas Public Health Information System (KPHIS) software installed in most local health departments. The BCYF is attempting to tie in with the local health department data system which has been many years in development in Kansas. ***//2005/ Nutrition and WIC services completed its rollout of the new system in May, 2004. The final cost of the project was \$5.8 million. The staff are recuperating from months of travel while providing on-site training and orientation to local agency staff in use of the new system. //2005//***

The BCYF works closely with the Children's Cabinet which has been given the responsibility by law for oversight of the use of Tobacco Settlement funds for children's programs. Three State Health Department programs receive these funds: Healthy Start Home Visitor, Part C of IDEA, and Teen Tobacco Prevention program. Two of these programs are located in the BCYF. The statutes governing Children's Cabinet functions require use of the funds for programs that utilize best practices and there are strict accountability measures and reporting requirements for the recipients of these funds. In addition to its role in accountability for the funds, the Children's Cabinet has assumed responsibility for a number of early childhood/early care and education initiatives. One of these is the foundation-funded Rhode Island School Readiness Project. A team from Kansas participates and the health representative is from BCYF. ***//2005/ In 2004, BCYF continued to participate in the National School Readiness Initiative, the Kansas Zero to Three Technical Assistance Project, and the development of Quality Performance Guidelines through the Kansas Department of Education. //2005//***

Despite all these challenges, MCH and CSHCN have developed systems of care for pregnant women and infants, children and adolescents, and children with special needs through strong ties with stakeholders and partners both within and outside the agency. For example, CSHCN works closely with Medicaid to serve families of children with special health care needs.

The Kansas Title V program has never completed a formal Capacity Assessment for State Title V (CAST-V assessment) ***//2005/ although capacity assessment is included as part of the Five-Year MCH State Needs Assessment. //2005//*** Nevertheless, Kansas uses the ten essential public health services (see www.kdhe.state.ks.us/bcyf) to guide decision-making in all aspects of program operation. Examples of the ways in which the ten essential services have guided program decisions during the past year:

1) Assessment and monitoring of maternal and child health status to identify and address problems. MCH shifted resources to a second epidemiologist position. ***//2005/ Orientation and training have been completed for the two epidemiologists. //2005//***

2) Diagnosis and investigation of health problems and health hazards affecting women, children and youth. MCH retained outside contractor, Envisage consulting, to engage in a continuous State needs

assessment process with both quantitative and qualitative analyses that also interfaces with the BCYF strategic planning. ***/2005/ MCH epidemiologists completed a review of Kansas gastroschisis clusters with KU Medical Center and probable participation in the CDC multi-state study. //2005//***

3) Information and education to the public and families about maternal and child health issues. MCH engaged in a partnership with March of Dimes on a public education campaign to promote folic acid usage. ***/2005/ Nutrition and WIC services have expanded breastfeeding promotion through all local health departments. //2005//***

4) Mobilizing community partnerships with policy makers, health care providers, families, the general public, and others to identify and solve maternal and child health problems. In partnership with the United Methodist Health Ministries, MCH established an Oral Health Coalition broadly representative of Kansans. ***/2005/ MCH helped to sponsor the Great Plains Regional Perinatal Organization conference in partnership with Perinatal Association of Kansas. //2005//***

5) Providing leadership for priority setting, planning, and policy development to support community efforts to assure the health of women, children, youth, and their families. CSHCN has provided leadership in the area of telemedicine in Kansas by piloting this technology in Special Child Clinics. ***/2005/ MCH partnered with March of Dimes and others in passage of a new State statute creating a birth defects information system. //2005//***

6) Promotion and enforcement of legal requirements that protect the health and safety of women, children, and youth, and ensuring public accountability for their well-being. Title V supports the development of health and safety standards in child care settings through Healthy Child Care Kansas and the transitioning grant. ***/2005/ BCYF coordinated the review of certification standards for maternity care and birthing centers. //2005//***

7) Linking women, children and youth to health and other community and family services and assure quality systems of care. MCH/CSHCN support a statewide system of providers of primary and preventive care and medical specialty services. While there are gap filling services available to the uninsured and underinsured, the focus is on linking families with Medicaid, SCHIP (HealthWave) and other sources of care. ***/2005/ In partnership with Medicaid/SCHIP, provided Regional workshops to train public health nurses and other local health department staff to help potentially eligible participants complete the application form. //2005//***

8) Assuring the capacity and competency of the public health and personal health work force to effectively address maternal and child health needs. The Title V role in training of school nurses as first responders during bioterrorism events is described in a later section. ***/2005/ In partnership with a number of programs including Head Start and Early Head Start, obtained grant for quality, standardized home visitor training across all early childhood programs. //2005//***

9) Evaluation of the effectiveness, accessibility and quality of personal health and population-based maternal and child health services. Program evaluation is mostly outsourced on an as needed basis rather than as a continuous quality improvement process, as for example when the Healthy Start Home Visiting services were evaluated in 2002 by the Kansas Health Institute (KHI), although through the rehire process we are developing internal capacity. ***/2005/ MCH coordinated a review of lead screening for all Early Head Start children following a federal finding of incomplete testing. Medicaid staff were included in the review of results and appropriate action was taken. //2005//***

10) Support for research and demonstrations to gain new insights and innovative solutions to maternal and child health related problems. Internal capacity to conduct research is very limited for Title V. Large projects are outsourced. However, small projects are undertaken such as cluster analyses and survey research to determine information systems capacity of local MCH agencies. ***/2005/ A research study is underway with the Mid-America Poison Control Center (Kansas City) on accidental poisonings while in grandparent care. MCH provided partial***

C. ORGANIZATIONAL STRUCTURE

ORGANIZATIONAL STRUCTURE

The Secretary of the KDHE is appointed by the Governor and serves on the Governor's Cabinet reporting directly to the Governor. Reporting to the KDHE Secretary are four division heads: Health, Environment, Laboratory, and Vital Statistics. The Director of Health serves as the State Health Officer and the direct line supervisor of Bureau Directors in the Division of Health.

The Division of Health has six Bureaus: Bureau of Health Facilities (hospital and nursing home regulation, and credentialing); Bureau of Consumer Health (lead program and restaurant/grocery store and food inspections); Bureau of Child Care Licensing (standards, inspections); Office of Local and Rural Health (manpower, primary care, migrant health, hospital bioterrorism); Bureau of Health Promotion (chronic disease); Bureau of Epidemiology and Disease Prevention (infectious disease, bioterrorism); Bureau for Children, Youth and Families (maternal and child health). **//2005/ In the past year, there have been several reorganizations in the Division reducing the number of Bureaus from six to four. First, the Bureau of Health Promotion was renamed the Office of Health Promotion and became merged with the Directors Office. The Bureau of Child Care Licensing was merged with the Bureau of Health Facilities (renamed the Bureau of Child Care Licensing and Health Facilities) after the BHFlost its nursing home operations (transferred to the Kansas Department of Aging). The Bureau of Consumer Health lost about a third of its operations (food manufacturing inspections, etc) which were transferred to the Department of Agriculture. Budget and other issues may necessitate further reorganization in the Agency. //2005//**

The Bureau for Children, Youth and Families has four sections: Nutrition and WIC Services; Children's Developmental Services, Children and Families Services and Children with Special Health Care Needs. Please refer to the functional organization chart in the attachment file. Official and dated organizational charts that include all program elements of the Title V program, clearly depicted, are on file in the BCYF office and in the Human Resources Management office of the KDHE. These will be available at the time of the MCH Block Grant review. Also, for information about staffing and programs, please refer to the BCYF website ? www.kdhe.state.ks.us/bcyf.

Two cross-cutting initiatives in the Bureau are oral health and epidemiology. 1) A registered dental hygienist was hired to serve as Oral Health Consultant (OHC) to all programs in the BCYF. Since there is no office of oral health in the KDHE, this individual is relied upon for many departmental duties relating to oral health including link to Association of State and Territorial Dental Directors (ASTDD), consultation and technical assistance to state and local entities, assessment (oral health survey), policy development (coalition-building), and assurance (fluoride varnish training). The OHC serves as consultant to all Bureau programs including MCH/CSHCN and WIC. **//2005/ Please see Agency Capacity for an update on the establishment of an Office of Oral Health within the Agency. //2005//** 2) The Bureau has two epidemiologist positions with one vacant at the time of this writing. These two assist all BCYF programs. They also interface with epidemiological work done in other Bureaus within KDHE, work with other State agencies, and outside the agency. The lead epidemiologist serves as the State Systems Development Initiative project director, coordinates all data analysis for MCH/CSHCN needs assessment with Envisage Consulting, supports assessments and evaluations of MCH/CSHCN programs, conducts original MCH research, addresses epidemiologic needs of the Bureau. Each of the Sections is attempting to build data capacity through staff training and education and rewrite of job descriptions to require data skills for newly hired employees. **//2005/ Both epidemiologist positions have been filled. Orientation has been completed. The epidemiologists have been sent to a number of national workshops and training in MCH epidemiology. There have been many opportunities for networking with colleagues in other states. //2005//**

The Children & Families Section includes the following responsibilities: 1) Systems Development activities for perinatal systems of care including coordination with Perinatal Association of Kansas (PAK); 3) Systems Development for child, school and adolescent health; 3) Maternal and Child Health grants to assist local communities to improve health outcomes for pregnant women and infants and for children and adolescents; 4) Teen Pregnancy Prevention grants to assist communities with school/community health education; 5) Disparity grants in two communities addressing adolescent health needs; 6) State Abstinence Education Program to assist communities to help adolescents abstain from sexual activity until marriage; 7) Women's Health Care and Family Planning - Systems of care and grants to communities to support the health of women in their reproductive years.

CSHCN assumes the following responsibilities: 1) Systems development activities - promotes the functional skills of young persons in Kansas who have a disability or chronic disease by providing or supporting a system of specialty care for children and families including specialized services and service coordination, quality assurance, and community field offices; 2) Make a Difference Information Network (MADIN) - Assists children and adults including those with disabilities, their families and service providers to access information and obtain appropriate resources. MADIN serves as the MCH toll-free line.

The Children's Developmental Services Section includes the following services: 1) Infant-Toddler Services (Part C of IDEA) - Promotes the early identification of developmental delays and disorders through child find, services coordination (case management), resource referral and development, and direct service provision for eligible infants and toddlers and their families; 2) Newborn Metabolic Screening - Assures early identification and intervention for infants with phenylketonuria (PKU), galactosemia, hypothyroidism and sickle cell; 3) Newborn Hearing Screening - Assures early identification of significant hearing loss in newborn infants.

Federal law requires that Part C (KDHE) and Part B of IDEA (State Education Agency) maintain an advisory committee. The Kansas Coordinating Council on Early Childhood Developmental Services serves in this advisory capacity and the staffers for this council have their offices in the BCYF. Members are parents of children with special needs, legislators, early intervention service providers, state agencies, and community members.

The Nutrition and WIC Services Section includes the following programs: 1) Nutrition Services - Improves the health and nutritional well being of Kansans through access to quality nutrition intervention services including educational materials, consultation services, program coordination and referrals; 2) the Special Supplemental Nutrition Program for WIC - Provides nutrition education, breast-feeding promotion and support, substance abuse education, nutritious supplemental foods, and integration with and referral to other health and social services; 3) Commodity Supplemental Food Program (CSFP) - Improves the nutritional status of eligible women, infants, children, and the elderly over age 60 through supplemental foods and nutrition education.

The State health agency is "responsible for the administration (or supervision of the administration) of programs carried out with allotments under Title V" [Section 509(b)]. Within KDHE, BCYF is responsible for MCH Services Block Grant funds. When funds are allocated for maternal and child health activities outside the BCYF, the Bureau maintains legal contracts or memoranda of agreement to clarify the nature of the work that is done in support of the MCH state priorities.

D. OTHER MCH CAPACITY

OTHER (MCH) CAPACITY

The BCYF has 54 full-time equivalent (FTEs) positions: 6 FTEs including 2 epidemiologists and one registered dental hygienist are located centrally in administration, 11 FTEs in CSHCN Section, 11.5

FTEs in Children & Families Section, 11.5 FTEs in Children's Developmental Services, and 14 FTEs in WIC. None of these positions are out-stationed in local or regional offices. All non-clerical staff position descriptions have been re-written to require planning, evaluation and data analysis capabilities. The qualifications, in terms of a brief biography, of senior level management employees in lead positions are as follows.

Since 2000, Linda Kenney has served as Director of the Bureau for Children, Youth and Families and Kansas Title V Director. From 1989-2000 she served as Director of the Children and Families Section in the Bureau, primarily responsible for services to pregnant women and infants, children and adolescents, and women's health. She has held positions as director of a state breast and cervical cancer screening program, director of a state mental hospital-community transition project, case management supervisor for a community disability organization, and director of a local family planning clinic. She has served on the Board of the Kansas Public Health Association (KPHA), and on a number of state and federal advisory groups relating to maternal and child health. She holds an MPH degree in Health Services Administration from the University of Pittsburgh, Pennsylvania and a bachelor's degree from Indiana University. In addition to the four Section Directors, five other staff report to her (2 epidemiologists, 1 dental hygienist, 1 fiscal, 1 clerical).

Jamey Kieffer is the State CSHCN Director. She has a Bachelor of Science degree in Nursing from Wichita State University. Since 1997 she has served as Director of CSHCN. Prior to 1997, she worked as a CSHCN nurse consultant (1989-1997), pediatric staff nurse at Stormont-Vail Regional Medical Center in Topeka, case manager for a Visiting Nurse Service in Fort Wayne, Indiana, and home visitor for high risk infants and families with the Wichita health department. Jamey is involved with the Kansas Commission on Disability Concerns, the Kansas Chapter of American Academy of Pediatrics Subcommittee for Children with Special Health Care Needs, Assistive Technology for Kansas Advisory Board, Kansas Asthma Coalition, Head Start Collaboration, and Governor's Commission on Autism. Nine staff -- 10 FTEs -- report to her (2 nurse case managers, 1 social worker (toll-free line), 1 fiscal, and 5 clerical). The CSHCN program has a contract with the Developmental Disabilities Center at University of Kansas Medical Center (KUMC) and another contract with the University of Kansas School of Medicine in Wichita (UKMC-W). The staff in these two regional CSHCN offices are not included in the FTE count for the BCYF.

Ileen Meyer is a professional registered nurse experienced in serving the pediatric and young adult population throughout her 35 year career in public health. Along with her nursing background she holds a Master of Science degree in Counseling Education from Emporia State University. She has extensive experience working with adolescent health and education issues. She joined KDHE as the Director of Children & Families Section in 2000. She is involved with the Kansas Chapter of the American Academy of Pediatrics and its specialty subcommittees, Kansas Perinatal Council, Kansas Suicide Prevention Steering Committee, Early Childhood Stakeholders Advisory Committee, Head Start Collaborative Stakeholders, Kansas Safe Kids Coalition, Kansas Action for Children, Kansas Fatherhood Coalition, and Kansas Works Interagency Coordinating Council. Meyer manages a staff of 10.5 FTEs (4 nurses, 4 program planning and evaluation, 1 data entry and 1.5 clerical).

Carolyn Nelson has served as the Director of Children's Developmental Services since 2001. From 1999 to 2001, she coordinated services for the Infant-Toddler (Part C) Program at KDHE. Prior to 1999, she worked as Director of Children's Developmental Services at Arrowhead West, Inc. in Southwest Kansas and as a speech-language pathologist in Arkansas. Carolyn holds a degree in Speech-Language Communication and English from Henderson State University in Arkansas. She represents KDHE on the Kansas Division of Early Childhood Board and the Kansas Coordinating Council on Early Childhood Developmental Services. She is also involved in the Head Start Collaboration Council and Advisory Board, Early Childhood Stakeholders, the National Part C Coordinators' Association, School Readiness Task Force, Child Care and Early Education Advisory Committee, and the National Council for Exceptional Children. Nelson manages a staff of 10.5 (1 nurse for newborn screening, 1 audiologist for newborn hearing screening, 1 early childhood, 1 fiscal, 4 program planning and evaluation, 2.5 clerical).

David Thomason is the Director of Nutrition and WIC services. He has served in that capacity since 1998. From 1989 to 1998, he managed fiscal services and reimbursement in the Kansas Medicaid Program. David holds a Master's degree in Public Administration from the University of Kansas and a Bachelor of Science degree in Human Service Agency Management from Missouri Valley College. The WIC program is currently involved in implementing an automated WIC system for Kansas. The new WIC system will allow local agency staff to spend more time on mission oriented educational activities and less time on administrative duties. Thomason manages a staff of 13 FTEs (4 nutritionists, 1 information systems, 4 program analysts, 4 clerical).

The Bureau employs a parent of a child with special needs as a Benefits Coordinator in the Children's Developmental Services Section. The job responsibilities of this parent include identification of services and programs for families. He works closely with a variety of advocacy groups and support systems. Also, he is a liaison with Families Together Inc., serves as a board member for the Assistive Technology for Kansans project, and attends various meetings and conferences.

//2005/ There have been no changes to the leadership within the BCYF during the past year. BCYF staff have been appointed to a number of Governor's Initiatives: State Hunger Team, Blue Ribbon Task Force on Immunization, Bioterrorism Coordinating Council, State Developmental Disabilities Council. Both Carolyn Nelson and David Thomason have completed the Kansas Public Health Certificate Program. //2005//

E. STATE AGENCY COORDINATION

STATE AGENCY COORDINATION

Within the State Health Agency --

MCH and CSHCN work with a number of program areas on public health issues.

Office of Local and Rural Health: Primary Care Cooperative Agreement; District Nursing Consultants; Community Health Assessment Coordination; Farmworker Health; Refugee Health; Trauma Registry; Bioterrorism Hospital Preparedness. Bureau of Child Care Licensing: standards for health and safety in out of home care; inspections of residential facilities; inspections for state schools for deaf and blind; inspections of birthing centers. Bureau of Consumer Health: Childhood Lead Poisoning and Prevention. Bureau of Health Promotion: Breast & Cervical Cancer Screening Program; Office of Injury/Disability Program; Youth Tobacco Prevention Program; Diabetes Control Program; Kansas LEAN Program; Arthritis Program; 5 A Day; Kansas LEAN 21. Bureau of Epidemiology and Disease Prevention: HIV/STDs Program; Immunization Program.

Division of Health and Environmental Laboratories: Inorganic Chemistry (Lead Screening); Neonatal Metabolic Screening. Center for Health and Environmental Statistics, Vital Statistics: Perinatal Outcome Data, Adequacy of Prenatal Care Utilization Index (APNCU); hospital discharge data, and data linkages with Medicaid.

Other State Agencies --

Education and Social Services are the two State Human Services Agencies with whom MCH/CSHCN frequently has contact. MCH works with the State Department of Education on health related issues for preschool and school-age children including guidance for school nurses and administrators (see the BCYF website --- http://www.kdhe.state.ks.us/bcyf/c-f/school_resources_docs.html). There are ongoing efforts to expand the school nurse role to include preventive and primary health care at school for children and youth who are at risk including underinsured and the uninsured school population. Delegation of nursing tasks to unlicensed school personnel is an ongoing issue. Title V staff assist the State Education agency and Kansas Board of Nursing with this issue. Title V staff serves on the Statewide Education Advisory Council and attends the special education administration

staff meetings. This collaboration has served to strengthen the health services components for special health care needs students in local school districts.

The federal legislation on inclusion has necessitated the reeducation of school nurses and training for allied school personnel in the provision of care to medically complex children. "Guidelines for Serving Students with Special Needs Part II: Specialized Nursing Procedures," helps local education agencies provide services to CSHCN students. This was a collaborative project between Title V and the State Department of Education. Standards for CSHCN are also underway for early childhood education programs and child care providers. Other areas of significant collaborative efforts include: Part B of IDEA, School Readiness, and School Nutrition.

Schools, health departments, and primary care providers are encouraged to use "School Nursing and Integrated Child Health Services: A Planning and Resource Guide" in tandem with Bright Futures as the standard for provision of public health services to children. Multiple professional development opportunities are provided utilizing the statewide Area Health Education Centers (AHECs) and local area education service centers as training sites. It is anticipated that a day long video conferencing format will become the norm with facilitators available at times and sites convenient for any school district.

The Social Service Agency (SRS) programs with which MCH/CSHCN has most frequent contact are Medicaid and SCHIP (HealthWave). MCH/CSHCN assists with outreach and enrollment efforts, reviews data relating to utilization patterns, assists with provider recruitment, promotes standards of care, assures provider training, among others. Local MCH agency dollars expended on Maternal and Child Health services are utilized as match for federal Medicaid dollars to provide prenatal case management, nutrition and social work service for high risk women as well as newborn postpartum home visits. These and other collaborative arrangements are formalized in a KDHE/SRS Interagency Agreement (updated in 2002 to include HIPAA and data sharing). MCH/CSHCN staff meet monthly with Medicaid and HealthWave staff to discuss mutual concerns and to plan for identified service needs. ***//2005/ Medicaid includes information about the WIC program in its notices to clients reminding them of immunizations due. Currently Medicaid and Family Planning are working on a waiver to extend eligibility after birth from 6 weeks to 2-5 years. //2005/***

MCH/Infant-Toddler Services staff, in collaboration with Medicaid staff, have developed a Medicaid reimbursement fee for a service system of early intervention services (such as occupational therapy, physical therapy and speech-language therapy) through a specially designed Infant-Toddler early intervention Medicaid providership. Training was provided to teach the Infant-Toddler Networks how to use their providership numbers to bill for these services. In February, 1999, the Infant-Toddler Services Medicaid providership was enhanced to include targeted case management (service coordination) as a reimbursable service for eligible infants and toddlers. Preliminary steps were implemented to add developmental intervention services as a Medicaid reimbursable service which was added in February, 2002.

For the high-cost services for special needs children, the interagency agreement directs mutual referrals, cross program education, fiscal responsibilities and case management services for children participating in both Medicaid and CSHCN programs. Title V implemented linkages with the Medicaid and Blue Cross/Blue Shield Automated Information System (AIS) so that CSHCN has direct access to Medicaid information on children eligible for both Title V and Title XIX. CSHCN staff have the ability to prior approve and receive immediate approval or denial through AIS.

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

evaluations. CSHCN staff have begun initial contact with Social Security Administration (SSA) to have a B agreement in place that would allow increased access to SSA data.

Through the Farmworker Health with Medicaid coordination (described in the interagency agreement), children and families of migrant and seasonal farm workers receive primary, preventive, acute and chronic care services at seventy-five clinic sites. Title V staff coordinate with Farmworker Health staff in the Office of Local and Rural Health to identify methods to maximize use of individual program funds to assure access to prenatal care and specialty care/follow up for farmworkers and their families.

Title V works with Employment Preparation Services in SRS on issues such as teen pregnancy prevention and public health assistance for indigents. Title V has worked with Alcohol and Drug Abuse Services on a number of substance abuse issues including prevention programs for youth, identification and intervention for pregnant women, and treatment facility standards for pregnant substance abusers. Title V has worked with Mental Health on a state plan for adolescent health, youth suicide and other issues. MCH serves on the State Developmental Disabilities Council located in SRS. KDHE's Child Care Licensing works with Foster Care regarding quality of child placements. CSHCN works with Rehabilitation Services (Vocational Rehabilitation), Disabilities Determination and Referral Services.

Other State agencies with whom MCH/CSHCN collaborates include the following: Kansas Department of Insurance on issues of public and private insurance coverage for the maternal and child population. MCH works with the Kansas Department of Transportation (KDOT) and the Kansas Board of Emergency Medical Services through the Injury Prevention program on data and policy issues. MCH/CSHCN have participated with the Kansas Advisory Committee on Hispanic Affairs and the Kansas African American Affairs Commission on cultural and linguistic competence issues. The Kansas Advisory Committee on Hispanic Affairs provides assistance with finding translators. MCH has assisted the Kansas Department of Corrections on health standards for youth facilities, finding providers of prenatal care for pregnant inmates.

Other Agencies and Organizations --

University and other collaborations are as follows: University of Kansas; Bureau of Child Research/Center for Independent Living; Life Span Institute; University Affiliated Programs, Kansas University Center for Developmental Disabilities, Lawrence and Parsons; Developmental Disability Center/LEND Program; School of Medicine; School of Social Welfare; Preventive Medicine; Mid-America Poison Control Center at KUMC; Area Health Education Center; Wichita State University; Kansas State University; Cooperative Extension Kansas Nutrition Network; University of Kansas School of Medicine - Wichita, MPH Program.

MCH works with professional groups, private non-profit organizations and others such as the following: March of Dimes; American Academy of Pediatrics - Kansas Chapter; Kansas Children's Service League; Children's Coalition; Kansas Adolescent Health Alliance; Dietetic Association of Kansas; Kansas Action for Children; Families Together, Inc; Kansas Hospital Association; Assistive Technology Project of Kansas; Kansas Medical Society; Kansas Lung Association; SAFE Kids Coalition; Kansas Immunization Action Coalition; Kansas Health Foundation (KHF); Sunflower Foundation; Kansas Health Institute; Kansas Public Health Association; Perinatal Association of Kansas; SIDS Network of Kansas; Mexican American Ministries; Campaign to End Childhood Hunger; United Way; Kansas Head Start Association; Kansas Nutrition Council; Kansas Dental Association; Kansas Association of Dental Hygienists; United Methodist Health Ministries; Fetal Alcohol Syndrome pilot project; National School Readiness Indicators Workgroup; Kansas Head Start Collaboration Project.

There is an interdependent relationship between the State and local public health agencies. Kansas' 99 local health departments (LHDs) serve all 105 counties. The local health

departments are organized under city and/or county government. They are mostly reliant on county mill levy funding, although some modest per capita 'State formula funds' are provided to each county. Contracts and grants from the State health agency provide a third significant source of funding. The staffer for the Kansas Association of Local Health Departments assures coordination with KDHE and LHD representatives serve on all KDHE workgroups and committees with potential impact on LHDs.

MCH Block Grant dollars support regional public health nurse activities such as: regional public health meetings which serve as a forum for updates; technical assistance to local health departments regarding administrative issues, including billing, grant writing, budget, human resources, information systems, policy/procedures, HIPAA; technical assistance to local health departments regarding public health practice issues, including public health performance standards and competencies, as well as the MCH Pyramid of Core Public Health Services; collaboration with Heartland Center for Public Health Preparedness and University of Kansas School of Medicine, Department of Preventive Medicine and Public Health, for training sessions on cultural competency and diversity, risk communication, informatics, and public health law, through Kansas Public Health Grand Rounds series; distribution of resource publications and information necessary to support practice, including Connections Newsletter, Kansas Rural Health Information Service (KRHIS), OLRH website, Public Health Nursing and Administrative Resources Manual, and Domestic Violence Manual. Public health nurses maintain ongoing partnerships to support education/training for public health with state and regional training partners, including: Heartland Center for Public Health Preparedness, St. Louis University School of Public Health, University of Kansas School of Medicine, KU Public Management Center, Professional Associations, and Kansas Association of Local Health Departments (KALHD). Ongoing training activities include the Kansas Public Health Certificate Program (underway), and the Kansas Public Health Leadership Institute (implementation date: Fall 2003).

Other Kansas MCHB Grants --

KDHE staff are involved in numerous ways with Grants that are awarded by MCHB to the State of Kansas. The BCYF is a partner agency in the on-going collaborative efforts between the Kansas Title V agency and the Kansas City Healthy Start (KCHS) and with the Healthy Start Initiative awarded to the Wichita-Sedgwick County Health Department. The Kansas University Affiliated Program which was awarded to the University of Kansas Medical Center works closely with the CSHCN program staff and contract staff actually share office space with the program. BCYF staff currently serve on the advisory board for the Traumatic Brain Injury Implementation grant and have served in the past with the Healthy Childcare Kansas grant. Staff within the bureau directly administer community project funding for MCHB Section 510 of the Title V Abstinence Education Grant, Community Integrated Service Systems (CISS) ? Early Childhood planning grant and the Universal Newborn Hearing Screening. We have written letters of support and look forward to working with the Health Systems Development in Child Care, Emergency Medical Services for Children(EMSC) Partnership and Bioterrorism grants.

F. HEALTH SYSTEMS CAPACITY INDICATORS

Forms 17-19 provide critical information on annual data linkages, data registries and surveys. These are indicative of Kansas capacity to assess the health needs of mothers and children. Data for 1998 through 2002 are provided as follows:

Health Systems Capacity Measure #1 - The rate of children hospitalized for asthma (ICD-9 codes: 493.0-493.9) per 10,000 children less than five years of age: **/2005/ There is a clear trend towards increasing rates and numbers of children hospitalized with asthma from a rate of 27.1 in 1999, 27.7 in 2000, 32.5 in 2001, to a high of 35.8 in 2002. There are probably several reasons for the increase such as improved awareness and diagnosis, environmental and home construction**

among others, but Kansas activities to address childhood asthma are focused on partnerships plus development of basic infrastructure and capacity.

Within the KDHE, the Bureau of Consumer Health (BCH) serves as the lead regarding asthma issues. BCH has had a number of staffing and organizational changes during the past year and BCYF staff along with the Kansas Asthma Coalition (KAC) have stepped forward in this area.

The American Lung Association of Kansas (ALA/K) is a primary sponsor of the State Coalition activities. ALA/K received an "Asthma Friendly Initiatives" grant from CDC that targets the largest urban school district in the state, Wichita Public Schools, USD #259. From this initiative the newly formed Wichita Asthma Task Force assists Wichita Public Schools in updating all Indoor Air Quality (IAQ) and asthma management policies, collection and analysis of asthma data from the 12 elementary schools participating in the grant. This project utilizes the Asthma Incident Reporter (AIR) database, and implements an IAQ policy using the Environmental Protection Agency's (EPA) approved "Tools for Schools" program. The BCYF Child & School Health Consultant provides consultation on best practice, education, and support to school staff developing asthma management care plans, IAQ standards, and policy with regard to children with asthma within the school setting.

In the 2004 session, the Kansas Legislature passed SB 304 that allows students in grades 6-12 to self-carry and administer asthma medications and Epi-Pens for anaphylaxis, with a prescription from their primary physician and written permission from the parents. SB 304 carried a sunset provision. Unless the sunset is removed in the 2005 session it will expire June 30, 2005. A Legislative Interim Committee will study the issue. The Kansas School Nurse Organization (KSNO) opposed this bill due to absence of a provision for school nurse assessment and individual health plan prior to self-administration of asthma medications.

The BCYF Child & School Consultant received a scholarship to attend the National Association of School Nurse (NASN) "Managing Asthma Triggers/Indoor Air Quality" train the trainer conference in Washington, DC in October of 2003. She has provided education to 265 nurses through July, 2004. She has also provided asthma trigger education to 135 Kansas Healthy Start Home Visitors, and 50 Early Head Start administrators to assist with identification of asthma triggers within the home setting. Sixty-five Kansas Business Association Officials (school administration officials) also received training on management of asthma in the school setting. She provided public health staff trainings through six regional sites, the Pediatric Asthma Symposium, 1st Annual Public Health Nurse Conference, one Telenet training, two Kansas Association of State Business Official gatherings, and the Kansas School Nurse Conference.

The ALA/Ks. has provided 9 trainings to 213 nurses, physicians, and respiratory therapists through the Asthma Educator Certification Workshop, since 2002. The National Asthma Educator Certification Board (NAECB) provides the curriculum and national certification for asthma education and ALA/Ks. is working with third party payers in Kansas to create billing codes for reimbursement of asthma education by these certified professionals.

Patient awareness of the disease, physician and health care provider knowledge for diagnosis at an early age and current management and treatment of asthma will all have a positive impact on the incidence, and outcomes of asthma. As the percentage of children under 5 years of age hospitalized for asthma has continued to steadily increase over the past four years, accompanied with the fact there is minimal staff allocation towards asthma within KDHE, the BCYF staff anticipates that asthma will be one of the priorities for the 2005-2010 MCH Needs Assessment process targeting strategies to reduce this increasing rate. //2005//

Health Systems Capacity Measure #2 - Percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen: The percent of infants with at least one screen during the year ranges from a low of 73.9% in 1998 to a high of 82.0% in 2000. No

clear trend is evident.

Health Systems Capacity Measure #3 - Percent SCHIP enrollees whose age is less than one year during the reporting year who received at least one periodic screen: For 1999 through 2001, the data are relatively level from 40-41% but 2002 data showed a large increase to 57.9%.

//2005/According to Medicaid data staff, there are no notable differences in data reporting that would account for the significant increase in SCHIP enrolled infants that got at least one service during calendar year 2002. Instead, Medicaid data staff say the increase is probably linked to the increase to the number of months of eligibility each child under age one had during the reporting years. By way of explanation - Very few children are covered from the month of birth under the SCHIP program (only those whose mothers were also covered by HealthWave 21 at the time of birth). Usually children reported in the under age one category are receiving services for a variable amount of time from the date of eligibility until their first birthday (i.e., a full twelve months continuous eligibility is rare for these children). If a child had 10 months of eligibility in the program before turning age one, the child would be much more likely to also have a well child encounter submitted by the provider. If the child only had 3 months of eligibility before the first birthday, the likelihood decreases that there will also be a well child check submitted. So, Medicaid data people attribute the increase in this reporting statistic to the potential increase in the months of eligibility (due to maturity of the program, better public information, etc.) the child had during the subject time period and while their age was less than one.

MCH staff add that Kansas appears to be shortening the time from birth to enrollment (numerator) and also increasing the numbers of enrolled infants (denominator) through various outreach efforts, including those of MCH and the public health system. Plus more families may be signing their infants up and doing so earlier due to economic circumstances. //2005//

Health Systems Capacity Measure #4 - Percent of women (15-44) 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: The rates are relatively level over the past few years and range from a low of 80.3% in 1999 to a high of 81.6% in 2000.

Health Systems Capacity Measure #7 - Percent of EPSDT eligible children ages 6 through 9 years who have received any dental services during the year: Although the actual number of children served has grown from 9,806 in 1998 to 13,526 in 2002, the rates for the time period 1998 through 2002 range from a low of 33.5% in 2001 to a high of 37.5% in 2002.

Health Systems Capacity Measure #8 - Percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the state CSHCN Program: The rates have remained relatively level from 1998 to 2003 ranging from a low of 31.7% in 1998 to a high of 38.9% in 2002. This indicator bears watching to see if the 2002 rate can be sustained in subsequent years.

Health Systems Capacity Measure #5 - Comparing 2000 data for Medicaid, non-Medicaid, and all MCH populations in the State, the Medicaid population is relatively high risk. Percent low birth weight is 9.7% for the Medicaid population compared to 5.3% for non-Medicaid and 6.9% for all live births. Infant deaths per 1,000 live births was 8.3/1,000 live births for Medicaid, 5.2/1,000 live births for non-Medicaid and 6.7/1,000 live births for all.

The percent of infants born to pregnant women receiving prenatal care beginning in the first trimester was low for Medicaid mothers at 76.4%. For non-Medicaid mothers, 92.8% had prenatal care in the first trimester and for all women with live births 86.9% of the women had prenatal care in the first trimester.

Percent of pregnant women participating in the Medicaid program with adequate prenatal care

(observed to expected prenatal visits is greater than or equal to 80% - Kotelchuck Index) was 72.5%, non-Medicaid participants was 86.7% and for all women with live births is was 81.6%.

Health Systems Capacity Measure #6 - The percent of federal poverty level (FPL) for Medicaid eligibility in Kansas: The Kansas Medicaid program FPL eligibility is set at the federally required minimum. Infants (0-1) are eligible at 150% FPL, children age 1-5 are eligible at 133% FPL, children 6-18 at 100% FPL, and pregnant women at 150% FPL.

Health Systems Capacity Measure #6 - SCHIP (HealthWave) eligibility is set at the minimum level of 200% for infants 0-1, 200% for children age 1-5, 200% for children 6-18, and 200% for pregnant women age 18 and under.

Health Systems Capacity - Form 19 - State MCH data capacity is indicated by our ability to obtain timely analyses of data for programmatic and policy issues. The MCH program is able to obtain data from annual linkage of infant birth and infant death certificates. MCH has the ability to do annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files, but this is not done on a consistent basis. MCH does not have the ability to access: annual linkage of birth certificates and WIC eligibility files; annual linkage of birth certificates and newborn screening files; hospital discharge survey for at least 90% of in-State discharges; annual birth defects surveillance system; survey of recent mothers at least every two years. The MCH program has direct access to data files for: infant birth certificates and infant death certificates, Medicaid Eligibility/Paid Claims Files, WIC, and newborn screening files. MCH does not have direct access to data files for: hospital discharge data (available indirectly), birth defects surveillance system, Pregnancy Risk Assessment Monitoring System. (PRAMS is not done in Kansas due to statutory restrictions on follow back on birth certificates.)

MCH data capacity for assessing adolescent tobacco use is limited. Kansas Department of Education has the Centers for Disease Control and Prevention (CDC) grant for the Youth Risk Behavior Survey (YRBS). Due to poor participation by some schools the sample size is never large enough for valid statewide estimates for youth in grades 9-12. Another survey instrument used in Kansas is the Youth Tobacco Survey for which the sample size is adequate. The MCH program does not have direct access to either database for analysis.

Health Systems Capacity Indicator #9C - The ability of Kansas to determine the percent of children who are obese or overweight is fairly good. YRBS data are limited by inadequate sample size as noted above, plus MCH has no direct access to the data. WIC program data and PedNSS data are readily available and of good quality.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

BACKGROUND AND OVERVIEW

In Kansas as elsewhere, higher standards of accountability prevail due to scarcity of resources from State, Federal and Other funding sources. Funding sources require regular in-depth review of performance measures and outcome measures, evidence of linkage of these data to funding decisions to see if there are improved outcomes for target populations. As examples of BCYF accountability, the Legislature conducts annual and special reviews such as the Legislative Post Audit, and the Childrens Cabinet requires annual review of performance and outcomes.

Since 1999 BCYF has included performance plans and performance information in its federal MCH budget submission. BCYF submits annual reports to Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB) on the actual performance achieved compared to that proposed in the performance plan. This Section of the Kansas MCH Services Block Grant Application describes how the State-Local partnership will implement the federally-required performance reporting requirements.

The MCH Block Grant Performance Measurement System is an approach utilized by Kansas that begins with the state/local needs assessment and identification of priorities. It culminates in improved outcomes for the maternal and child population. After Kansas establishes its priority needs for the five-year statewide needs assessment, programs are designed, assigned resources, and implemented to specifically address these priorities. Specific program activities are described and categorized by the four service levels found in the MCH Pyramid: direct health care services, enabling services, population-based activities, and infrastructure building activities. Since there is flexibility available to Kansas in implementing programs to address priority needs, the program activities or the role that MCH plays in the implementation of each performance measure may be different from that of other states. Kansas can track its individual progress on 7-10 unique State performance measures and if Kansas feels competitive, it can track its progress in comparison with that of other states on eighteen national performance measures.

Accountability in BCYF programs is determined in three ways: (1) by measuring the progress towards successful achievement of each individual performance measure; (2) by budgeting and expending dollars in each of the four recognized MCH services: direct health care, enabling services, population-based activities, and infrastructure-building activities; and (3) by having a positive impact on the outcome measures.

While improvement in outcome measures is the long-term goal, more immediate success may be realized by positive impact on the performance measures which are shorter term, intermediate, and precursors for the outcome measures. This is particularly important since there may be other significant factors outside BCYF control affecting the outcomes.

B. STATE PRIORITIES

STATE PRIORITIES

In order to determine state MCH priorities for the five year period 2000-2005, a formal MCH state needs assessment was conducted in 1999-2000. The needs assessment conformed with federal requirements to determine the need for services for each of the three MCH population groups:

- pregnant women and infants;
- children and adolescents, and
- children with special health care needs.

To eliminate duplication of effort and to ensure an efficient use of resources, MCH partnered with two

other HRSA programs within KDHE who had similar federal five year state needs assessment requirements. The two other programs were the Primary Care Program and the HIV/AIDS Program. A Steering Committee with representation from each of the three programs provided oversight to the project. A contractor, Envisage Consulting, served as facilitator for project meetings and coordinated collection of data for review by program staff and the members of the Steering Committee. This state needs assessment project was called the Joint State Needs Assessment, or otherwise it was known as the JSNA.

Some data was common to all three programs (MCH, Primary Care, HIV/AIDS) such as demographic data, manpower data, etc. Other data was very specific to a program such as HIV/AIDS program client satisfaction data available through survey, interviews and focus groups. The data specific to MCH was sorted first by MCH population group, then by perceived importance (weighted), then into indices. The indices plus the component data for the indices, plus staff reviews and analyses were used to produce a draft document. This document was reviewed by Steering Committee members and public input was solicited. The final report was submitted to the MCHB in July of 2000 as part of the FY 2001 MCH Block Grant Application.

Products of the JSNA are available on the KDHE website (www.kdhe.state.ks.us/jsna). The 10 MCH state priorities are prominent on the BCYF website (www.kdhe.state.ks.us/bcyf). State-level and county-level data can be accessed and downloaded by clicking on a county from the map of Kansas.

Since the submission of the state needs assessment, the BCYF has had three bureau strategic planning sessions with reviews of the ten priority needs as a focal point including facilitation by Envisage Consulting. Retraining of state staff to the 10 priorities has helped to focus limited staff time and resources. The BCYF has also utilized the data to shift resources towards priority needs, as for example, hiring of oral health staff. County health departments and other local agencies are required by contract to utilize the county-level data to determine their own priority needs and to direct the use of their MCH grant funds toward those local priority needs.

MCH contracted with Envisage Consulting for a second project halfway through the 2000-2005 state needs assessment period. The second project called the mid-course review consisted of an update and review of data which generally confirmed the findings of the JSNA relating to MCH state priorities. However, the mid-course review also pointed to the need to rearrange and reword the ten priorities to (1) better communicate the meaning of the priorities to our constituents (e.g., the term Behavioral Health was confusing to many constituents) and (2) reflect our current focus within a priority area (e.g., current oral health focus is better described as improving oral health and access to oral health services rather than develop improved oral health capacity within community and state public health systems). A side-by-side comparison of the original and revised priorities (proposed) is shown on Table 1 in the attachment.

The priorities were also arranged into a diagram to show that four were cross-cutting across all MCH/CSHCN programs and activities. Five were discrete issue or problem areas. This diagram is used to help us better communicate priorities to our constituents. See Figure 1 in the attachment.

Kansas has continued to treat needs assessment as an ongoing activity rather than a one-time event. Kansas is wrapping up an 18-month mid-course review effort with an emphasis on qualitative studies and is currently making plans for the next five-year needs assessment activities to begin immediately after the mid-course review is completed. Here is a summary of mid-course review activities used to determine whether or not the priority needs are still relevant:

1. Updated key quantitative indicators and indices
2. Structured phone interviews of all local health department administrators, supervisors and/or MCH coordinators
3. Three community focus groups
4. Focus group of physicians serving children with special health care needs
5. Email survey of parents of children with special health care needs (in progress)

6. Interviews with families attending CSHCN clinics (in progress)

Many participants expressed appreciation for the opportunity to share their opinions and expertise. The qualitative efforts of the mid-course review promoted partnerships and collaboration between Title V staff and community members, local health department staff, local MCH program staff, parents of CSHCN, Families Together advisory group, and physicians.

Furthermore, Kansas has continued interagency and intra-agency collaboration and partnership-building through the Joint State Needs Assessment (JSNA), a combined needs assessment effort between three HRSA programs (Maternal and Child Health, Primary Care, and HIV/AIDS). While the mid-course review focused on MCH priorities, relationships have been maintained and/or strengthened, as appropriate, with Primary Care, HIV/AIDS, and other partners through ongoing JSNA efforts.

A JSNA steering committee meeting was held in January with a broad representation of participants. Preliminary mid-course review results were presented. Relevance of priority needs and possible new linkages to better address priorities were discussed. Participants included representatives of Medicaid and SCHIP programs, Department of Education, nutrition and physical activity programs, injury prevention programs, Kansas Health Institute (health policy and research organization), Kansas Association of Local Health Departments, data and healthcare information, state Primary Care program, Kansas Association of the Medically Underserved, WIC, child development services, rural health, MCH programs, HIV/STD programs, Healthy Kansans 2000.

Kansas analysis of need by MCH population group through quantitative and qualitative methods pointed to the States 7 to 10 priority needs and any changes in the State capacity to meet those needs since the last BG application. Both the quantitative and qualitative analyses of the mid-course review continued to point to the states priority needs. There were few substantial changes in the quantitative indicators. Most significant, with the release of the 2000 Census data, was the shift in the Kansas population towards greater racial/ethnic diversity, as was the case nationwide. The changing demographics, health outcome and qualitative data continued to point towards disparities as an important priority. The data also continued to support disparities across the rural-urban continuum.

Other priorities supported by quantitative data include access, preventable injuries, violence, obesity, oral health, and mental health and substance abuse. All priority areas, particularly obesity, oral health, and mental health, could benefit from improved indicators and greater analysis resources and expertise.

As explained above, changes have been proposed in the wording and arrangement of some of the priorities. These will be finalized with the completion of the mid-course review.

Priorities with significant support from the qualitative data included oral health, access, coordinated systems of care, nutrition/physical activity, disparities, and access for CSHCN.

Table 2 in the attachment summarizes and justifies each of the revised priority needs.

The State priorities of Access, Disparities, Data Capacity, and Coordinated Systems of Care relate to almost all National and State performance measures. Oral Health, Mental Health & Substance Abuse, Obesity, Violence, and Preventable Injuries are each linked to at least one national performance measure. The Kansas Title V Program has capacity and resource capability to address each of the State priorities through activities conducted at the State and Local levels.

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

Please refer to Form 6 for the data related to this NPM.

Direct Health Care Services:

CSHCN contracts provide statewide coverage for consultations on metabolic conditions. CSHCN purchases PKU formula and food products for individuals.

Enabling Services:

After an infant is 24 hours old, hospital personnel collect a blood spot specimen and it is sent to the KDHE State Laboratory for processing. The Neonatal Screening staff at the State Laboratory notifies the MCH newborn screening nurse of abnormal screening results. The NBS nurse serves as a case manager. She notifies the primary care physician of the findings by phone and mail. The PCP is informed of consultation and referrals available through the CSHCN program. The parents are also notified of the need to follow up with the PCP regarding abnormal screening results. The NBS nurse continues to provide case management services to assure that the infant has appropriate testing, diagnosis, referral and treatment services as appropriate.

Infrastructure Building Services:

In partnership with the State Laboratory staff, MCH/CSHCN provided information to policy makers relating to tandem mass spectrometry technology and the feasibility of utilizing this technology in Kansas. Unfortunately, funding is not available for expansion at this time. The newborn screening brochure for parents is made available in both English and Spanish and posted on the NBS webpage

b. Current Activities

Enabling Services:

Same as last year.

Infrastructure Building Services:

The staff at the Neonatal Screening unit at the State Laboratory was reduced by a half-time position. The person formerly in this position matched the lab data against the birth certificate data to assure that every infant born in Kansas is screened and counted only once even though the infant's name might have changed. This change may affect the reliability of 2003 NBS data.

SB 418 was passed in the 2004 legislative session. It established statutory authority for a birth defects information system but no funding was appropriated. After funding is identified and a system is established, NBS will collaborate with the birth defects information system to more efficiently manage clinical and other resources.

c. Plan for the Coming Year

Enabling Services:

Same as last year.

Infrastructure Building Services:

Update the NBS procedure manual to reflect the current procedures and post on the web page. Initiate quality assurance (QA) activities relating to the NBS program. Engage in regular meetings with the hematology and endocrinology consultants to facilitate QA, problem solving and exchange of current information. Utilize consultants' expertise to update the NBS policy manual. Review progress towards HP 2010 objectives.

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

Please refer to Form 11 for data related to this NPM.

This measure was new with the 2003 submission. The data was extrapolated from the National Survey of State and Local Area Integrated Telephone Survey (SLAITS). The Kansas objective is that 75% or three out of every four families served will report satisfaction with services and partnering in decision making. Fifty-nine percent (59%) of families reported partnering and satisfaction in the SLAITS survey. The survey will be repeated in 2005 when we will be able to measure any gains.

Direct Health Care Services:

When children are seen in CSHCN multidisciplinary clinics, families are involved in the evaluation in order to voice concerns and work with the team when recommendations are made. SHS staff members are included in the multidisciplinary clinics and assist families with various appointments prior to and after the clinic visits in order to assure efficient use of families' time.

Enabling Services:

CSHCN staff work with families in the development of health care plans that are used to outline care coordination. Families help to identify the providers used for services. When families use a provider that is not a contracted provider, staff work to get a new provider identified or work with the provider to become a contracted provider for the CSHCN program. Providers can include: hospitals, labs, primary care physicians, specialists and interpreters. Families are notified of resources and services available in their local communities.

Population-Based Services:

Families involved with the early intervention program are involved in the development of the Individual Family Service Plan. Families are also involved in the development of Individual Education Plans from age 3-21. When families report difficulty in obtaining services from school districts, families are referred to the Kansas Parent Training and Information Center, Families Together Inc.

Infrastructure Building Services:

An advisory group of parents was developed and has met throughout the year, both in person and by conference call.

b. Current Activities

The CSHCN program continues to partner with families as above.

Enabling Services:

A Spanish translation was added to our toll free number for families who speak Spanish. We have interpreter services in place to assist when the families call. Sign language interpreters have been provided in the multidisciplinary clinics when requested.

Population-Based Services:

Staff has been involved with Health Fairs and conference exhibits to educate parents and agencies about CSHCN services.

Infrastructure Building Services:

Families Together staff continue to convene the advisory group for the CSHCN program. The advisory group will continue to assist in review of policies for the program. The advisory meetings are held on Saturdays with travel and lunch provided. Families that accessed CSHCN multidisciplinary clinics participated in focus groups to provide input to the Mid-Course Review for the Kansas State MCH Needs Assessment.

c. Plan for the Coming Year

The CSHCN program will continue to partner with families maximizing the use of the Families Together contract.

Infrastructure Building Services:

CSHCN will continue to recruit and train new advisory group members to assist in infrastructure building activities such as reviews of CSHCN policies and procedures and review of Standards of Care. Families will be involved in the 5-year Needs Assessment in which they will serve on the panel of experts for the CSHCN program. Families will also be involved in the Strategic Planning process that will be performed with the CSHCN program through a Champions for Progress grant. A family member is also attending the Champions for Progress Multi State Meeting as a representative of Kansas.

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

Please refer to Form 11 for data related to this NPM.

This measure is new for the 2003 submission. The data is extrapolated from a National Survey of State and Local Area Integrated Telephone Survey (SLAITS). Even though the SLAITS survey showed only 58.9% of families receive care within a medical home, the Kansas objective is that 90% of it's CSHCN will receive care within a medical home. The survey will be repeated in 2005 when we will be able to measure our gains. Our current data system is unreliable in terms of producing this data. New data systems have been explored that will be able to produce the data. The CSHCN program educates families that children enrolled in the program are best provided care within a medical home.

Direct Health Care Services:

The CSHCN program authorizes care for children eligible for treatment services when the child is seen by the primary care provider related to an eligible condition. A copy of the plan of care is shared with the child's primary care physician (PCP).

Enabling Services:

The CSHCN program provides assistance for transportation if the child lives more than 50 miles from an authorized provider. Program staff work with the families who are eligible for Medicaid/SCHIP services to educate them in the process to obtain transportation reimbursement. CSHCN staff have also continued to work with families during the transition to a new Medicaid fiscal agent and assisted them with new contact numbers. CSHCN also entered into a formal agreement with an interpretation/translation service in order to help central/field office staff converse with families who do not speak English. Interpretation services are also provided for families when they attend out patient medical appointments. This is authorized by care coordination staff. For those children who are assigned a PCP with Medicaid/SCHIP, CSHCN staff obtain a referral from the physician who is the PCP that serves as a referral for the length of the plan of care for authorized services. Medical reports are also shared with the child's PCP when they are received by SHS staff from medical specialist.

Infrastructure Building Services:

The CSHCN program uses providers that are board certified. For local care the providers will hold a license with the Kansas Board of Healing Arts. Pediatricians are required to be board certified in Pediatrics. Staff continue to be involved in the Oral Health Coalition and will work with the coalition on concerns of dental access for all children and those with special health care needs. The rural communities of Kansas also have severe access issues. Many children in the state who are covered by Medicaid/SCHIP have additional access issues, as they are unable to find providers who accept Medicaid/SCHIP coverage.

b. Current Activities

The program continues to support medical homes for children with special health care needs as above.

Enabling Services:

The CSHCN program has noticed an increase in those residents who speak Low German. Staff has worked with the Farm Worker Health Program to share some funding responsibilities. Brochures and applications have not been translated to Low German since the majority of the population is unable to read Low German.

Infrastructure Building Services:

The state Infant-Toddler program has investigated the use of the "Caring for Infants and Toddlers with Disabilities: New Roles for Physicians" (CFIT). CSHCN program staff have discussed partial funding of the project as it was not funded by a private grant. The Kansas AAP chapter subcommittee on CSHCN have shown interest in the CFIT program in order to increase physician referral to early intervention and communication between the networks and the physicians.

c. Plan for the Coming Year

Infrastructure Building Services:

CSHCN staff will continue to investigate the use of the CFIT program in Kansas and possibly a "Medical Home Project" for the State of Kansas through the American Academy of Pediatrics. It is the hope of staff that participation in the CFIT and "Medical Home Project" will help to educate primary care physicians and increase the number of physicians that will work with CSHCN and those transitioning to adulthood. Program staff will provide information about the CSHCN program to outside community resources.

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

Please refer to Form 11 for data related to this NPM.

The Kansas objective is that 85% of CSHCN will have adequate health insurance coverage. "Adequate" private and/or public insurance would provide access to health services including preventive care, primary care and tertiary care. SLAITS data show that only 64% of Kansas CSHCN have adequate health insurance coverage. Many Kansas families have policies that cover only well visits or catastrophic care. The survey will be repeated in 2005 when we will be able to measure our gains.

Direct Health Care Services:

During multidisciplinary clinics, the insurance/Medicaid coverage status is assessed. Families that are uninsured and are potentially eligible are given information about Medicaid/SCHIP and the CSHCN program. They are encouraged to apply and/or assisted with the application process. The CSHCN program continues to be the sole source of coverage for numerous undocumented citizens. We continue to use the SHS program application to help determine if the applicant is a U.S. citizen and/or here with legal documentation. Many families were starting the Medicaid application process but not able to complete it due to lack of documentation. By adding questions to our application, we can screen families for Medicaid eligibility.

Enabling Services:

Families that apply for the CSHCN program are required to apply for the State Medicaid/SCHIP programs. Applications are sent to each applicant. The applications are labeled with our program name and instructions for the Clearinghouse staff to compute a spenddown if the family is not eligible for SCHIP and over Medicaid income guidelines. A staff person has been designated at the Clearinghouse to work with the CSHCN program referrals. CSHCN staff contact the Clearinghouse to resolve problems if these are reported by families.

Infrastructure Building Services:

CSHCN staff ensure that billing has been completed with Medicaid/Insurance prior to CSHCN payment. CSHCN uses contracted providers that will take the CSHCN rate of payment as payment in full.

b. Current Activities

The CSHCN program continues with the activities listed above.

Enabling Services:

Case managers work with local agencies and other State agencies to help families find other assistance for services not covered by the CSHCN program.

c. Plan for the Coming Year

Enabling Services:

CSHCN will continue a close working relationship with Clearinghouse staff.

Infrastructure Building Services:

CSHCN staff will work with the Kansas Advocacy and Protective Services to assist families in getting medically necessary items covered by Medicaid when the applicant is EPSDT eligible.

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

Please refer to Form 11 for data related to this NPM.

This is a new measure for 2003. In Kansas, we would expect 75% of families to report community-based service systems. About 71% of families report favorably on this measure. Due to the rural nature of the state it is difficult to exceed this expectation and the SLAITS data indicate only 71% report community-based service systems. The survey will be repeated in 2005 when we will be able to measure our gains.

Direct Health Care Services:

The CSHCN program supports services in the local community by encouraging outreach by our Specialists. Outreach clinics include pediatric cardiology, orthopedic, pediatric neurology, pediatric rheumatology, urology, endocrinology, otolaryngology, audiology and developmental pediatrics. An agreement is in place with the Kansas State Department of Education that helps to fund Special Child Clinics. The clinics are held throughout the state, with a multidisciplinary team that is organized based on each community's needs.

Enabling Services:

Interpretation services are also provided for families for whom English is a second language. This is authorized by care coordination staff.

Population-Based Services:

The Kansas early intervention program is a frequent referral source for the CSHCN program. As the program provides services to children in a natural environment (child care center, home etc) the services are easy for the families to use.

b. Current Activities

The program continues with the activities listed above.

Direct Health Care Services:

Special Child Clinics have assisted local communities in the diagnosis and treatment of many conditions such as autism. The waiting period to attend the Tertiary Centers for an autism diagnosis can be 6-9 months. The number of Special Child Clinics for this year has increased in number and locations.

c. Plan for the Coming Year

The program will continue to work with local partners such as Part C infant toddler, education and physicians to ensure that services are available to special needs children.

Direct Health Care Services:

CSHCN stakeholders including family members will be involved in a strategic planning meeting. The focus will be to look at creative ways to strengthen community based services and the impact of moving from direct services to infrastructure and systems building activities.

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

Please refer to Form 11 for data related to this NPM.

In Kansas, our objective is that 40% of adolescents with special health care needs will receive services necessary to make the transition to all aspects of adult life. SLAITS data indicate that only about 6% of CSHCN youth receive necessary services. It is felt that the vocational/education transition is more comprehensive than transition to adult medical services. The survey will be repeated in 2005 when we will be able to measure our gains.

Direct Health Care Services:

CSHCN staff have used the timeline that was developed by the CHOICES project to assist families in early transition issues from the toddler stage through adolescence.

Infrastructure Building Services:

CSHCN staff were members of the planning committee for an annual transition conference. Presentations have been done in the past related to "Transition in the Lifespan." Participants of the conference were broadly representative of the variety of disciplines that serve the youths who are transitioning including: transition counselors, vocational rehabilitation staff, parents, early intervention staff, special education staff and nursing staff.

b. Current Activities

The CSHCN program continues with the above activities.

Infrastructure Building Services:

Staff continue to participate in planning for the "KansTran" conference. The main focus is education/vocational rehabilitation but CSHCN promotes a health care/medical component for each conference. CSHCN staff continue to participate in the Kansas Commission on Disability Concerns (KCDC) in order to promote "Each student with a disability will receive adequate transition services to achieve independence and, if desired, post secondary education and employment."

c. Plan for the Coming Year

Infrastructure Building Services:

Staff will continue to participate on the planning committee for the "KansTran" conference. The plan is to add a panel of staff and patients from the multidisciplinary clinics for adolescents and young adults. It is hoped that transition issues will be addressed if a "Medical Home Project" is received by Kansas.

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

The Kansas immunization coverage rates are reported on Form II.

DTP4, Polio3, and MMR1 combination are reported. These are estimated vaccination coverage rates from the U.S. National Immunization Survey (NIS). In Kansas, vaccination for Haemophilus Influenza type B and Hepatitis B were not required for school entry for the survey years reported here, but recommended and may be under reported. The NIS rates for Kansas for this age group exhibited a sharp decrease, from 76.7% in 2001 to 74.0% in 2002 which was lower than the U.S. rate of 78.5%. An analysis by staff in the Bureau of Epidemiology and Disease Prevention and the Kansas Health Institute indicates that the data are likely due to late/no 4th DTP. For the past four years, a trend towards decreasing rates in Kansas and rates lower than the national average has been apparent.

Population-Based Services:

School entry requirements were re-instituted as vaccine supplies became adequate. The Kansas Immunization Program (KIP) continued to make funding available to county health departments through grants to enhance the provision of immunization services and raise immunization rates in the underserved population. A Medicaid Outreach Project collaboration between KDHE and SRS was initiated targeting ten counties with low immunization rates. An outreach coordinator was hired and an incentive and reward program was in place by July, 2003. According to the NIS conducted by CDC, Quarter 3 - 2002 through Quarter 2 - 2003, Kansas was at 64.6% for the 4:3:1:3:3 vaccination series. Due to concerns about low rates, the Governor established a Blue Ribbon Task Force to make recommendations for increasing these rates. In October, 2003, vaccine guidelines were put into place to assure that the publicly provided vaccine is administered to the target population.

Infrastructure Building Services:

A Health and Environment Research Analyst for registry development was hired. It is anticipated that registry pilot sites will be initiated by the fourth quarter of 2004. A sixth immunization nurse consultant position was created in order to devote more KIP staff time to private provider recruitment and education in order to improve access to immunizations in the child's medical home.

b. Current Activities

Current Activities:

As of April 15, 2004, Hepatitis B and Varicella have been added to the school entry immunization requirements for the 2004-2005 school year.

Population-Based Services:

The KIP continues to provide guidance and resources for the immunization of children. Children are being recalled for immunizations deferred due to vaccine shortages. Limited state funding has necessitated the restriction of PCV7 (Pevnar) vaccine from the KIP to only those children who are VFC eligible. KIP staff time is focused on improving access to immunizations in the child's medical home. Delegation agreements between Local Health Departments (LHD) and Rural Health Clinics (RHC)/Federally Qualified Health Centers (FQHC) were signed allowing LHDs to vaccinate the underinsured children with VFC vaccine.

Infrastructure Building Services:

A VFC/AFIX coordinator was hired in January, 2004 to develop a VFC performance improvement plan to enable the Immunization Program to design/re-design its processes and systematically monitor, analyze and improve its performance resulting in improved customer outcomes. Under the leadership of this coordinator, quality control procedures for activities related to vaccine storage and handling, wastage, inventory, shipping and order discrepancies are being developed. The coordinator is developing processes with Medicaid and their intermediary to address payment issues which arise from VFC providers. MCH staff completed 97 of 105 MCH funded agency monitoring/site visits providing opportunity to monitor quality assurance of service provision, including immunizations, to children in Kansas. MCH participates in the deliberations of the Governor's Blue Ribbon Task Force on Immunizations and assists with recommendations of the Governor's Blue Ribbon Task Force.

c. Plan for the Coming Year

Population-Based Services:

The provision of guidance and resources for the immunization of children will continue. The KIP will continue with the Medicaid Outreach Project even though funding is not anticipated for next year. Increasing costs of vaccine purchase will require monitoring of resources and their usage to assure that public vaccine supplies meet the needs of the intended population. If resources permit, expansion of the use of PCV7 (Pevnar) vaccine to the underserved populations will be accomplished.

Infrastructure Building Services:

The KIP will implement a new statewide immunization registry that will access multiple sources of electronic immunization data and result in a useful source of immunization data for healthcare providers. MCH staff will support through all program resources in the BCYF an increase in immunization rates. Final recommendations of the Governor's Blue Ribbon Task

Force on Immunizations will be assessed and program plans for each Section will be developed and implemented.

Preliminary recommendations of the Governor's Blue Ribbon Task Force are as follows:

1. Do a study on immunization financing in Kansas to determine what modifications in the system might optimize access to vaccine for Kansas children.
2. Develop a confidential, web-based Immunization Registry that meets Functional Standards for Immunization Registry Certification through CDC - Accelerate the timetable for completion. The registry should be marketed to private providers and be private provider-friendly.
3. Do a systematic assessment of the barriers that prevent private-sector medical providers from offering childhood immunizations.
4. Collaborate with physician professional organizations to consider recommendations of 4th DTaP at 12 mos vs current 15 mos. Work with KAAP but also osteopaths and the Kansas Medical Society.
5. Continue the two Medicaid Immunization Outreach Projects. Medicaid funds are still available for these projects.
6. Expand the Sedgwick County WIC Immunization Project to densely populated counties with low immunization rates through a redistribution of funds.

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

a. Last Year's Accomplishments

In 2003, Kansas data showed a teen birth rate of 21.2 per 1,000 teenagers aged 15 through 17 years. The teen birth rate decreased in the last year continuing the steady decline since 1998. This continued decline is due to a variety of factors that may include the introduction of Abstinence Education, the delay of the first sexual contact, and the use of more effective methods of contraception by sexually active teens. However, the Hispanic teen birth rate for 2002 was 64.2 per 1,000 teenagers which was above the national rate of 50.7.

Direct Health Care Services:

Through the Comprehensive School Health Initiative, one local project provides accessible adolescent-focused sexuality and contraceptive education and services. The other programs provide sexuality education as needed. Adolescents are referred to the teen pregnancy prevention program through the Comprehensive School Health Initiative projects.

Population-Based Services:

School and community based education is provided through the Teen Pregnancy Reduction Projects and Peer Education Projects. Education assists youth ages 10 through 17 in recognizing the value of postponing sexual intercourse.

The two Disparity projects address teen pregnancy rates for racial and ethnic groups in Sedgwick County (teen pregnancy for urban black youth) and in SW Kansas (teen pregnancy for rural Hispanic youth). These projects work with the community to improve and strengthen families and youth by providing educational information, support group services, mentoring, family preservation and support, and leisure time activities for youth. The projects also sponsor and co-facilitate community asset building workshops for adults and youth and collaborate with the family planning program initiative, "Male Involvement Information and Education." One community has adopted the curriculum, "It Takes Two: Shared Responsibility Pregnancy Prevention for Youth."

Infrastructure Building Services:

Kansas continued its participation in the Abstinence-Only Education Program under Section 510 of Title V of the Social Security Act. In 2003, Kansas hired an Abstinence Education Consultant for administration and evaluation of the projects. Continuation funding was made available to existing projects and new projects were funded following a competitive application process. Requirements for participation included the administration of the Youth Risk Behavior Surveillance Survey (YRBSS) to adolescents in order to obtain consistent current statewide data on adolescent risk-taking behavior, monitor impact of programs, and use in policy and program development.

b. Current Activities

Direct Health Care Services:

The Comprehensive School Health Center Initiative funds one project that delivers sexuality and contraceptive education and services within a school-linked framework as appropriate. The other projects provide classroom-based and individual sexuality education and refer youth to other community agencies for contraceptive services as appropriate.

Enabling Services:

The teen pregnancy program's case management projects provide case management services to Medicaid teens under age 21 who are currently pregnant or parenting one child. The goals of the program are to reduce the incidence of repeat pregnancies and to reduce welfare dependency. In order to achieve these goals, case managers work with clients on eight life domains: family planning and health, finances, education/training, employment, parenting, key relationships, daily living and empowerment. These projects assist adolescents to access community resources and services. They enable teen mothers to complete life goals and to become self-sufficient.

Population-Based Services:

Teen pregnancy reduction and peer education programs provide educational programs to encourage youth to delay initiation of sexual activity to decrease teen pregnancy rates. All projects including the disparity projects will be continued in these targeted geographic areas.

The Comprehensive School Health Initiative funds three projects which deliver school-based medical services and health education including human sexuality.

Infrastructure Building Services:

Kansas continued its participation in Section 510 Abstinence Education for the FFY 03-07. A requirement in the program is that the projects encourage school districts in their areas to administer the YRBSS so consistent data can be obtained regarding adolescent behavior and measure change over time.

Regional Workshops on Human Sexuality and HIV/AIDS/STDs Education and Abstinence-Only Education were developed through collaboration with the Adolescent Health Consultant, Abstinence Education Consultant, HIV-STD Consultant, and the Health and Physical Education Program Consultant in the Kansas State Department of Education. The purpose of these workshops was to ensure that all teachers of human sexuality and HIV/AIDS/STD education have current medically accurate information and sensitivity about of these topics including

Abstinence-Only Education.

c. Plan for the Coming Year

Direct Health Care Services:

Continue the Comprehensive School Health Initiative for direct health care services.

Enabling Services:

The teen pregnancy prevention program's case management projects will continue to provide comprehensive services to Medicaid teens under age 21 who are currently pregnant or parenting one child.

Population-Based Services:

Continue the teen pregnancy prevention projects and explore possible modification of teen pregnancy reduction and peer education projects to include the developmental asset building model. The Comprehensive School Health Initiative will continue school based sexuality education. Continue Abstinence-Only Education projects and begin the collection of YRBSS data to measure outcomes in behaviors and attitudes. Explore avenues of providing teen pregnancy prevention education to target the Hispanic population.

Infrastructure Building Services:

Revise the teen pregnancy prevention and peer education models to include the adolescent developmental asset building framework by incorporating the concepts at the state and local levels from the "Improving the Health of Adolescents & Young Adults: A Guide for States and Communities."

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

Data for NPM #9 are found on Form 11.

LAST YEAR

Direct Health Care Services:

The CSHCN program covered some dental services for children with special health care needs on a limited basis.

Population-Based Services:

The Oral Health Consultant provided oral health promotional activities at the State Fair and in other public settings. Strong linkages were established with: dental schools (UMKC) and dental hygiene schools (WSU and other), foundations (United Methodist Health Ministries and Delta Dental) that support sealant and other dental projects such as the Kansas Mission of Mercy (KMOM), and ten safety-net dental clinics in the State.

Infrastructure Building Services:

Guidance and training were provided to dental professionals, nurses, teachers and child care providers. Guidance is posted on the KDHE Oral Health Initiative website at www.kdhe.state.ks.us/ohi.

Medicaid reimbursement was obtained for fluoride varnish applications in public health settings. Fluoride varnish application training was provided to non-dental public health personnel (public health nurses in local health departments, graduate nurses, Healthy Start home visitors, and Head Start specialists).

b. Current Activities

Direct Health Care Services:

Continuation of last year's activities.

Population-Based Services:

Last year's activities were continued into the current year. New activities included the following: serving in an advisory capacity to the Oral Health Kansas (OHK) coalition, maintaining state linkage with the Association of State and Territorial Dental Directors (ASTDD). Consultation and coordination activities include: Kansas Access to Baby and Child Dentistry (ABCD) pilot projects, the Head Start Collaboration project, March of Dimes Prematurity Campaign, United Way Success by Six Oral Health Initiative, KMOM volunteer dentistry projects, and University dental departments.

Infrastructure Building Services:

Last year's activities were continued into the current year. The Oral Health Initiative website became the most visited KDHE website generating nearly 100,000 hits per month.

The first ever statewide open-mouth survey of Kansas 3rd grade children was conducted during the 2003-2004 school year. Preliminary data showed that 33% of third grade children had received dental sealants on at least one permanent molar. Fifty-nine percent (59%) had treated caries, 28% had untreated caries, 2.5% had the need for urgent care beyond preventive and restorative care. Based on provider reports we expected more unfavorable results. Although we are pleased at these findings, we continue to view oral health as a priority in the State due to infrastructure and other deficits.

MCH participated in the Oral Health Summit on September 12, 2003 which was held for the purpose of planning a statewide annual strategy to improve the oral health of all Kansans.

The Kansas legislature appropriated funds to establish an Office of Oral Health with a State Dental Director. (Kansas has not had a dental director since 1993.) A bill requiring Kansas localities with over 10,000 service connections to fluoridate their drinking water was favorably reviewed in the legislature. Although the bill did not pass, the manner in which the bill was received reflects a positive change in public opinion relating to fluoridated drinking water.

c. Plan for the Coming Year

PLAN FOR THE COMING YEAR:

Direct Health Care Services:

Continuation of last year's activities.

Population-Based Services:

Infrastructure Building Services: The results of the first Kansas open mouth survey will be analyzed, written up, published and disseminated. The Oral Health Consultant will be integrated into the Office of Oral Health. There will be continued participation in Oral Health Summits which are expected to generate further interest in oral health policy development. Next scheduled summit is September 22, 2004.

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

Data for NPM #10 are found on Form 11.

Direct Health Care Services:

Some local health departments provided car seats for children living in low-income families at a no cost or at least at very minimal rental rates.

Enabling Services:

MCH Block Grant funds also provided mini-grants to 16 local communities to implement child injury prevention activities, many of these targeting motor vehicle injury. Child Passenger Safety Check events are provided across the state. Currently 377 volunteer Child Passenger Safety Seat (CPS) technicians and 28 volunteer CPS technician instructors have been nationally certified in Kansas and there is a trained technician in 101 of 105 counties. Kansas also now boasts 41 permanent fitting station locations where care givers can go to receive occupant safety education and child safety seat checks.

Population-Based Services:

Kansas SAFE Kids staff worked extensively to promote proper use of child passenger restraint (training of technicians, sponsoring car seats/booster seat round-ups and check stations, etc.). Kansas Healthy Start Home Visitors distributed information about the importance of the use of car seats/booster seats and proper installation to families.

Infrastructure Building Services:

The Office of Health Promotion provided leadership for the agency in injury prevention, including motor vehicle safety through the Kansas SAFE Kids network which consists of 61 statewide and regional organizations and businesses, 4 local Coalitions, and 19 local Chapters throughout the state. Kansas SAFE Kids worked in partnership with the Kansas Highway Patrol, Kansas Department of Transportation, and the Kansas Emergency Medical Services to coordinate efforts in Child Passenger Safety efforts.

The Kansas Emergency Medical Services (KEMS) has been the lead agency in charge of EMS-C initiatives. The primary focus has been to equip ambulances with child sized medical equipment and standardize trauma triage protocol of pre-hospital care for ambulance services, and to access communication linkage for ambulances with receiving hospitals across Kansas.

Kansas does not have a children's injury surveillance registry. The Kansas Trauma System, located in the Office of Local and Rural Health, is an inclusive system requiring all trauma to be

reported to a central site registry to capture information on the most severe injuries. Only those admitted to a hospital for 48 hours or more, or are transferred to or from a hospital, are required to report this data to the trauma registry.

The State Child Death Review Board a multi-disciplinary, multi-agency board under the Kansas Attorney General's office examines the circumstances surrounding the deaths of all Kansas children (birth through age 17) and children who were not Kansas residents but who died in the state. The focus has been primarily prosecutorial for child abuse and neglect.

b. Current Activities

Direct Services:

About 4,727 CPS and booster seats are being distributed with 65 of these from local public health departments.

Enabling Services:

Currently 568 volunteer Child Passenger Safety Seat (CPS) technicians, a 191 member increase, and 28 volunteer CPS technician instructors have been nationally certified in Kansas and there is a trained technician in 86 of 105 counties (15 fewer than last year). These technicians work with local and state SAFE Kid Coalitions and other community organizations to promote occupant safety education. The Kansas Healthy Start Home Visitor program has 42 trained CPS technicians providing service to communities within their region. Thirty-five counties identified motor vehicle safety education or service provision as a top priority need, each identifying specific goals to address this need.

Population Based Services:

Kansas SAFE Kids Coalition facilitated bicycle safety programs in 50 communities which is an increase of 20 communities from last year. SAFE Kids distributed bicycle helmets to 3,771 youth.

The Kansas Department of Transportation (KDOT) in its leadership in the prevention of motor vehicle collisions, injuries, and deaths conducted a survey to measure safety belt/safety seat use among three targeted age groups: 0-4, 5-9, and 10-14. Collected over a two year period, the data produced observations from about 650 randomly selected sites. The data identified lower safety restraint/safety belt use per age group in specific counties providing information for targeted injury prevention efforts and education. As survey efforts continue, this will provide baseline data for motor vehicle injury prevention. The data indicates seat belt usage rates decrease as the child ages.

KDOT also conducts a Drunk Driving Prevention Survey for Middle/Junior High students which contains questions specific to seatbelt usage relating to reducing motor vehicle injury. A total of 3,629 responses were received in the latest survey and 41.8% of the respondents "always" wear their seatbelts. From this data, we know there is a need to educate the adolescent population in seat belt usage and injury prevention.

Infrastructure Building Services:

The Kansas SAFE Kids statewide coalition is now increased to 20 local Chapters and leads a well-coordinated effort to improve Kansas restraint laws for children.

The Kansas Trauma System is requesting a change in the current trauma system criteria to include collection of data on all injured children admitted to a hospital, regardless of length of

stay or transfer to a hospital which should depict a more accurate picture of the number of children injured in Kansas.

Continued linkage with the State Child Death Review Board (SCDRB) to describe the trends and patterns of child deaths in Kansas to develop prevention strategies.

c. Plan for the Coming Year

Continue activities currently underway.

Direct Health Care Services:

Over 5,000 CPS and booster seats will be distributed.

Enabling Services:

Injury prevention education including seat belt usage and bicycle safety information will be provided to school nurses and community public health nurses targeting the young adolescent population.

Collaboration with local public health departments and Healthy Start Home Visitor services to ensure all 105 Kansas counties have a trained CPS technician. The Healthy Start Home Visitors will provide information to families about the correct use of car seats, booster seats or seat belts, the danger of air bags, and safety in the street around cars. Information will also be available in Spanish.

The data from the Kansas Department of Transportation (KDOT) survey which identifies lower safety restraint/safety belt use per age group in specific counties will be shared with local health departments. They will be encouraged to use these ongoing survey efforts to measure outcomes resulting from their educational and intervention efforts.

Population-Based Services:

Expanded trauma reporting to include all injured children admitted to a hospital will allow collection of data to be matched with community injury prevention needs and will allow improved targeted prevention planning at the local level.

KDOT will conduct a Drunk Driving Prevention Survey for Middle/Junior High students which contains questions specific to seatbelt usage relating to reducing motor vehicle injury.

Infrastructure Building:

Reintroduce expansion of the child passenger restraint law to include the booster seats and mandatory seat belt usage through age 18. The Kansas SAFE Kids Coalition will again assume a leadership role in this initiative.

The Emergency Medical Services for Children (EMS-C) grant is now in the Office of Health Promotion. MCH participates on the newly formed Emergency Medical Services Coalition that will coordinate pediatric injury treatment and prevention educational programs across the state targeting community level child health providers and school nurses.

Plans are underway to support the Kansas trauma system's revision of criteria for trauma reporting to include all injured children admitted to a hospital. Kansas does not have a statewide trauma registry specific to children's injuries which would be helpful in evaluating needs, program planning and the impact of interventions.

The child death review team will be asked to provide analysis of deaths of children ages 1 through 14 that are involved in motor vehicle crashes. Information will be refined as statewide data changes and improved data linkages are formed.

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

a. Last Year's Accomplishments

From 1998 to 2001 Kansas breastfeeding rates have steadily improved. In 2002 the data showed a slight decrease to 72.2%.

Infrastructure Building Services:

WIC funding was provided to increase the number of International Board Certified Lactation Consultants (IBCLC) working in the local health departments. One additional IBCLC was added with two more scheduled to take the test in the summer of 2004.

Incorporated into the new WIC automation system are quarterly reports of infants turning 7 months old within the specific time frame. This allows both local and state staff to look at data quarterly and evaluate more efficiently if interventions are increasing breastfeeding initiation and duration rates.

Breastfeeding data will begin to be collected on the Kansas Live Birth Certificate starting in January of 2005. This will provide Kansas with more accurate initiation data.

Kansas MCH Program has not traditionally played a significant role in supporting breastfeeding promotion with community-based projects having a wide difference in the amount of breastfeeding education in their prenatal education efforts. During FFY04 State MCH staff have attended breastfeeding training (including Certified Breastfeeding Educator) thus increasing their focus and knowledge on breastfeeding issues.

Healthy Start Home Visitor (HSHV) staff have been encouraged to attend breastfeeding training including Certified Breastfeeding Educator classes in particular when there is a turnover in local staff. Furthermore, the HSHV staff have been charged with the responsibility of collaborating with local and/or regional breastfeeding educators including the WIC Breastfeeding Coordinators.

The BCYF/Nutrition & WIC Services Section staff updated the breastfeeding promotion and management self-instruction modules for local health department employees.

The Kansas WIC Program approved the purchase of electric breast pumps in addition to the manual breast pumps previously allowed. These electric breast pumps will be loaned to WIC clients based on procedures and guidelines developed.

b. Current Activities

Enabling Services:

State WIC staff continue to work with communities to develop training opportunities for staff regarding breastfeeding management and promotion.

Infrastructure Building Services:

The Kansas Women's Health Survey has been completed with 2,026 respondents. The data is currently being evaluated to include information on opinions regarding breastfeeding.

Kansas Child Care Resource and Referral Network continues to work with local breastfeeding coordinators to provide training opportunities. The breastfeeding curriculum for childcare providers continues to be used to encourage breastfeeding friendly childcare facilities.

The Kansas WIC Program has a long history of providing leadership in the promotion of breastfeeding. Ongoing activities include State-level and local promotion events during world breastfeeding week, training and technical support for WIC professional and clerical staff, and routine counseling for pregnant and postpartum women. A critical component is that each WIC agency has a designated Breastfeeding Coordinator who is charged with ongoing breastfeeding education and Best Start training of all new employees including non-WIC health department employees.

Every year Kansas participates in World Breastfeeding Week (WBW). The theme for WBW August 1-7, 2004 is Exclusive Breastfeeding: The Gold Standard: Safe, Sound and Sustainable. A packet will be mailed to local WIC agencies to use to support WBW. Local communities release breastfeeding information throughout the month of August through a wide venue of activities.

c. Plan for the Coming Year

Population-Based Services:

The Healthy Start Home Visitors will: educate prenatal clients on breastfeeding; provide breastfeeding support post-partum; and refer mothers to lactation consultants as indicated. We will continue to educate home visiting staff to improve their ability to assist mothers with breastfeeding support and education.

Infrastructure Building Services:

Healthy Start Home Visitors are in an ideal position to talk to new Moms right after delivery. With training they can help identify problems and know where to refer within the community. Dates for training of Healthy Start Home Visitors have been set for the Fall. This will increase breastfeeding support especially in rural communities.

The new WIC automation system survey feature will be used to ask pregnant and postpartum women questions regarding breastfeeding and perceived barriers.

The breastfeeding information collected through the Kansas Women's Health Survey, 2003-2004 will be evaluated.

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

a. Last Year's Accomplishments

Kansas has continued to screen at 90% or better since 2000. The percent of newborns screened before hospital discharge was 90% in 2002. There was a decrease in the number of newborns screened in 2002 due to infants in the NICU that had an extended birth admission

were reported as having screening post discharge. Hospitals have been advised of proper reporting for NICU infants to reflect when screening is completed prior to discharge.

Enabling Services:

A contract to enhance the Parent-to-Parent program was renewed. The focus of the contract was on information resources available to parents including publication of a family's story of early identification and resources. Another focus area was education of providers about the program and support available for families. An in-service was provided to the Parent-to-Parent program staff.

Population-Based Services:

The screening is implemented at the local level by hospitals, birthing centers, or other obstetrical/newborn services licensed facilities. Sound Beginnings administered the statewide system for newborn infant hearing screening, tracking, and follow-up.

Infrastructure Building Services:

Three additional hospitals have added the electronic birth certificate system enabling electronic submission of newborn hearing screening results before hospital discharge. Eighty-four percent (84%) of the birthing facilities are on the electronic birth certificate system that account for 98% of births reported electronically.

Birth registrar training for the newborn hearing screening section of the electronic birth certificate system was completed at three regional sites and for new birth registrars.

The Sound Beginnings Advisory Committee continues to have quarterly meetings.

A newborn hearing screening informational brochure that is provided to families at the hospital is available in English and Spanish.

Distortion Product Otoacoustic Emissions (DPOAE) and Pediatric Diagnostic Evoked Potentials training was provided in collaboration with the Kansas Speech-Language and Hearing Association (KSHA).

Training was provided by Mary Koch and Dr. Thomas Kryzer for Early Intervention direct services personnel with a focus on cochlear implants, listening and sign.

A workshop for pediatric diagnostic audiology has been completed for audiologists to increase access for families.

Support through mini grants has been provided to remaining eligible hospitals for enhancing implementation of universal newborn hearing screening in hospitals.

b. Current Activities

Enabling Services:

Continue collaboration with Families Together to enhance the Parent-to-Parent program services for families. The focus areas continue to be information resources available to parents and education of providers about the program and support available for families.

Population-Based Services:

The screening is implemented at the local level by hospitals; birthing centers or other obstetrical/newborn services licensed facilities. Sound Beginnings administers the statewide system for newborn infant hearing screening, tracking, and follow-up.

Infrastructure Building Services:

Continued submission of hearing screening results through the electronic birth certificate system.

A pilot has been initiated with large birthing hospital audiology departments to use the web-based data management system to report screening results that occur on an outpatient basis for those infants who do not pass the newborn hearing screening prior to discharge.

The planning committee has been meeting to consider the first conference in Kansas for families of newly identified infants and toddlers who are deaf or hard of hearing.

Sound Beginnings Newborn Hearing Screening Program Advisory Committee continues to have quarterly meetings. The Committee reviewed and provided feedback for the proposed regulations. They continue to bring to the group for consideration the issues of concern from their constituents.

Follow-up to newborn hearing screening refer, missed, transfer and NICU results with parents and physicians. Continued work with providers to submit all outpatient and diagnostic reports to Sound Beginnings.

The Kansas Department of Administration approved proposed regulations for the Newborn Infant Hearing Screening Act (K.S.A. 65-1,157a) including an economic impact statement. The Joint Committee on Administrative Rules and Regulations introduced Senate Bill 511 to amend the existing law to provide sufficient statutory authority for the Secretary to carry out a screening program as proposed in rules and regulations. Senate committee amendments were requested by KDHE to delete the word "significant" for detection of hearing loss and revised timeline of within five days of birth for hearing screening. The House Committee amendment was requested by the Kansas Medical Society and KDHE to remove the establishment of responsibilities for any primary medical care physicians or other person who performs a newborn infant hearing screening. An agreement was reached to keep this language in the rules and regulations but not in statute.

c. Plan for the Coming Year

Enabling Services:

Continued collaboration with the Families Together, Parent-to-Parent program and investigate a support group specifically for families of children who are deaf or hard of hearing.

Population-Based Services:

The screening is implemented at the local level by hospitals, birthing centers, or other obstetrical/newborn services licensed facilities. Sound Beginnings administers the statewide system for newborn infant hearing screening, tracking, and follow-up.

Infrastructure Building Services:

Continued submission of hearing screening results through the electronic birth certificate system.

Continued conferences or workshops for Audiologists, Early Intervention Service Providers and physicians provided through collaboration with professional organizations. Develop workshop for hospital screeners by an audiologist/nurse team including data reporting, data results and tips/techniques to screening. A Conference will be offered in September to families of newly identified children who are deaf and hard of hearing.

Continued technical assistance provided to hospital personnel, Audiologists, Early Interventionists, Primary Care Physicians and other stakeholders of newborn hearing screening and intervention services.

Sound Beginnings Newborn Hearing Screening Program Advisory Committee continues its quarterly meetings. The committee is establishing goals for the new Advisory year which begins July, 2004. Preliminary discussion of goals for consideration include: parent communication and family concerns; focus on education to all members involved in early intervention and including the focus of the family perspective; and information sharing of legislative issues or advocacy from the Kansas Commission of the Deaf and Hard of Hearing or other organizations that are related to early hearing detection and intervention.

Staff at selected large hospitals and large outpatient screening facilities will be trained on transmittal and data entry for the web-based data management system.

Collaborate with the Office of Vital Statistics for continual training of birth registrars as turnover occurs and in implementation of the new web-based birth certificate system inclusive of hearing screening results.

Senate Bill 511 amending K.S.A. 65-1,157a will become effective July 1, 2004 and the Rules and Regulations are anticipated to be adopted and effective in July, 2004.

Performance Measure 13: *Percent of children without health insurance.*

a. Last Year's Accomplishments

In 2002, 8.1% (U.S. Census) of Kansas children were without health insurance which is lower than the 2001 U.S. rate of 12%. This percentage has gone from a high of 12.1% in 1999 to a low of 7.6% in 2001. Eight percent (8.1%) of Kansas children were uninsured in 2002.

Enabling Services:

The Healthy Start Home Visitor (HSHV) educates clients on the availability of health insurance through referrals to Medicaid and the HealthWave program.

Population-Based Services:

Comprehensive School Health Services aided families in the completion of the eligibility forms for Medicaid/HealthWave programs.

Schools were encouraged to provide Medicaid/HealthWave enrollment information and applications at school enrollment and parent teacher conference events.

Infrastructure Building Services:

The KDHE/BCYF has an interagency agreement with SRS/Medicaid which outlines the role of Title V funded local agencies in identifying Medicaid eligible pregnant women and children and assisting them with enrollment procedures. Implementation of Health Insurance Portability and Accountability Act (HIPAA) regulations beginning April 14, 2003 temporarily interrupted flow of information needed for outreach to this population. Procedures and protocol have since been reintroduced which follow HIPAA compliance standards for information sharing with regard to pregnant women but there is not information sharing for outreach to children.

Kansas Covering Kids was the state of Kansas initiative to enroll children in the Medicaid/HealthWave program. Maximus was the contractor hired by the state to conduct outreach for HealthWave. The contractor helped create additional bilingual materials, videos, billboard campaigns, etc. Specific regions of the state were targeted and received additional efforts to encourage Medicaid/HealthWave enrollment.

MCH staff provided follow-up on Child Health Assessment at School Entry (CHASE) reimbursement billings by Local Health Departments to ensure that LHDs have assessed each child for potential eligibility for Medicaid/HealthWave and that they have provided enrollment assistance to the family.

b. Current Activities

Enabling Services:

Comprehensive School Health Services projects are required to aid families in the completion of the application for HealthWave/Medicaid programs.

Population-Based Services:

Support and promote outreach activities in local education agencies through school nurses, school social workers, and school psychologists to enroll Medicaid eligible women and children and to promote the use of health services. Educate families of children who receive either free or reduced school lunches about their eligibility for Medicaid/HealthWave insurance coverage.

Infrastructure Building Services:

Due to budget reductions in SFY 2003, SRS consolidated its administrative regions from 11 to six thus closing 26 local offices. This afforded an opportunity to establish over 300 "SRS Access Points" in communities across the state to pursue more efficient ways of doing business while at the same time improving services to Kansans. SRS simplified and created a universal enrollment process between Medicaid/HealthWave and also placed the application on-line making application more accessible to many.

The state MCH staff trains local health department staff: to assess client eligibility, to inform families about the benefits of Medicaid/HealthWave participation, to assist families to enroll (including on-line), and to engage in public education efforts.

Follow-up by MCH state health department staff on Child Health Assessment at School Entry (CHASE) reimbursement claims by Local Health Departments to ensure that children are assessed for Medicaid/ HealthWave eligibility and families are assisted with the enrollment process.

Provide technical assistance to school health staff so they understand the enrollment process

and specifics about the health insurance programs. Again, schools are encouraged to provide information about Medicaid/HealthWave to parents at parent teacher conferences and school enrollment.

Collaborate with SRS to enroll all children in the Medicaid/SCHIP child health insurance programs.

c. Plan for the Coming Year

Enabling Services:

Healthy Start Home Visitors will continue to assist families to enroll in Medicaid/HealthWave programs. Outreach efforts will be launched for hard-to-reach special populations to improve their access to quality health insurance. Local coordination and collaboration between agencies will be improved to eliminate duplication.

Population-Based Services:

Support and promote outreach activities in local education agencies through school nurses, school social workers, and school psychologists to enroll Medicaid eligible women and children and to encourage their use of health services available to them under each program. Educate families of children who receive either free or reduced school lunches of their eligibility for Medicaid/HealthWave.

Require Comprehensive School Health Initiative grantees to assist families to enroll and re-enroll their children in the Medicaid/SCHIP (HealthWave) programs.

Infrastructure Building Services:

Discontinue reimbursement to LHDs for Child Health Assessment at School Entry (CHASE). Local health department staff with MCH contracts in 104 local public health agencies will be requested to develop outcome-based plans to decrease the percent of children without health insurance within their regions.

Convene a task force of Social Rehabilitation Service, Kansas State Department of Education, and KDHE representatives to assess the integration and possible merger of the applications for the free and reduced school lunch program with the Medicaid/HealthWave program for school-aged children. Promotion of medical homes is one area of emphasis for all children in Kansas. Health insurance is a critical component for children to access a medical home.

Collaborate with the Child Care Licensing and Registration Program to explore and incorporate enrollment of eligible children in Medicaid/HealthWave into their daycare enrollment process. WIC programs are proceeding with plans to provide Medicaid/HealthWave outreach materials to their respective clients.

Local health department staff will receive further training to help families enroll their children in the Medicaid/HealthWave programs.

Provide technical assistance to school and local health department staff so they understand the Medicaid/HealthWave process; as well as, how to read and understand the coverage provided by private health insurance programs and enable them to counsel clients in the best utilization of the coverage plan in which they are enrolled.

Collaborate with the Department of Social and Rehabilitation Services to monitor progress

toward enrolling all children in a child health insurance program.

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

a. Last Year's Accomplishments

In FFY 2002, 94.2 % of potentially Medicaid eligible children received a service paid by the Medicaid program. This estimate is based on data supplied by the Medicaid program. FFY 2003 information is not available. The new Medicaid Management Information System (MMIS) was initiated in October of 2003 and the data conversion is still underway.

Enabling Services:

Kansas Healthy Start Home Visitors and Kansas school nurses were provided technical assistance on how to assist families with the Medicaid/SCHIP application process (either on-line or paper) method.

Population-Based Services:

Technical training for the local public health departments, Kansas Healthy Start Home Visitors, and school nurses has been expanded to address HIPAA regulations, the importance of EPSDT, and current Medicaid/SCHIP enrollment guidelines.

Infrastructure Building Services:

Support and promote community collaborative partnerships that identify gaps in service and how public and private resources can best be used.

b. Current Activities

Enabling Services:

Outreach to hard-to-reach populations has been enhanced by adding more language interpreters, access to sign language and an expanded telephone interpreter service. Applications are available in both English and Spanish.

Population-Based Services:

Priority populations are families of children who receive either free or reduced school lunches, those who utilize health department programs (WIC, Immunizations, M&I) and Children with Special Health Care Needs.

Infrastructure Building Services:

Grantees that are supported with MCH funds are instructed to assist families with the application process and the access to direct services or services via a referral. Documentation is reviewed during onsite visits and at the time of the grant renewal process to ensure compliance.

Ongoing training to new health department administrators and support staff on the Medicaid/SCHIP enrollment process. Monitoring during MCH onsite visits to local public health departments, yearly school enrollments and Special Health Service updates that eligible

children are enrolled in Medicaid/SCHIP (Healthwave) and remain enrolled if they so desire.

During the MMIS data update, the requirement for current EPSDT has been removed as a requirement for expanded services so that families can still access the services while the technical "glitches" are corrected. A nurse from Children with Special Health Care Needs and the Child Health and School Coordinator serve on the Kansas EPSDT (Kan-Be-Healthy) board. They continue to provide recommendations and support the importance of keeping this screening process current.

c. Plan for the Coming Year

Enabling Services:

Continue to build on programs started in FFY 03.

Population-Based Services:

Comprehensive School Health Clinics and local/rural health departments continue to provide direct services or make a referral to identified providers. Local health departments continue to assist families with enrollment and referral for services.

Infrastructure Building Services:

CSHCN was awarded an incentive award from Champions for Progress to convene a Statewide Stakeholder's meeting to assess the current needs and recommend solutions to address access and services for this population.

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

a. Last Year's Accomplishments

In 2003, very low birth weight infants made up 1.3% of all live births in Kansas. This percentage rate has remained stable over the last five years.

Direct Health Care Services:

In 2004, 89 Maternal Child Health (MCH) contracts were given to local health departments, hospitals, regional county health agencies and other child health care providers. Prenatal care/care coordination services were provided to 11,349 mothers and infants. Services were prioritized for at-risk populations at increased risk of low birth weight infants: adolescents, minority populations, low income families, substance users and those who have less than a high school education.

Enabling Services:

Healthy Start Home Visitors received education on folic acid and SIDS. In addition, the home visitors were given printed materials and online resources from which to obtain additional information, educational tools and/or free or low cost products to provide support and information to families served in the program. Adolescent pregnancy risk reduction efforts and abstinence education programs continue which have the potential to decrease the number of adolescent pregnancies and subsequent delivery of low and very low birth weight infants.

Infrastructure Building Services:

Perinatal outcome data (Perinatal Casualty Report) was provided to all in-patient obstetrical facilities to be used in evaluating appropriate management and referral of high-risk maternal/fetal cases to specialty and subspecialty perinatal care providers/centers.

KDHE/BCYF has a formal contract with the Perinatal Association of Kansas (PAK) to obtain consultation in perinatal matters. The Kansas Perinatal Council (KPC), a subcommittee of the Perinatal Association of Kansas (PAK), serves in the consulting role to KDHE/BCYF. The council consists of a multidisciplinary group of individuals with expertise in perinatal services and outcomes. There is good collaboration with the Farm Worker Health Program which provides coverage for prenatal care services for farm worker women living in remote rural areas.

On-going monitoring of resident and hospital occurrence data relating to the percent of very low birth weight live birth weights continues. KDHE/BCYF continues to support federal Healthy Start projects/initiatives. Collaboration continues with community action groups and faith-based organizations.

Also, a provider driven perinatal referral system is on-going which assures access to city/county/regional consultation between primary obstetrical care providers and speciality maternal-fetal medicine professionals. This continues to serve as a resource for assuring access to risk-appropriate medical care and interventions.

A system of data sharing was established between KDHE and SRS/Medicaid in order to provide local health departments information to assist them with case management and prenatal care coordination for high risk women.

b. Current Activities

Direct Health Care Services:

Ongoing education of providers of M&I prenatal care/care coordination about LBW risk factors and interventions.

Enabling Services:

Healthy Start Home Visitors will continue to reach out to pregnant women and their families by informing, supporting, and linking these families to essential health and social services. MCH staff at KDHE will collaborate with the Office of Local and Rural Health to provide the second annual Kansas Public Health Nurse Conference in Wichita to include education on prevention strategies aimed at decreasing the number of LBW infants. Visitors will receive education on accessing the Migrant Farm Workers Program, breastfeeding education and perinatal maternal nutrition, mental health of infants, children and adolescents and the safety and health concerns of infants, children and adolescents. MCH will continue to partner with the Migrant Farm Worker Health Program and other Primary Care Projects in gathering resources to assist high-risk women.

The Perinatal Association of Kansas will have a conference focusing on mental health issues which have been shown to significantly impact pregnancy outcomes.

The Perinatal Casualty Report, the Adequacy of Prenatal Care Utilization Index and selected Kansas and United States Perinatal Outcome Data reports continue to be distributed to all in-patient obstetrical facilities for their use in evaluating appropriate management and referral of

high-risk maternal/fetal cases to specialty and subspecialty perinatal care providers/centers.

Population Building Services:

The WIC-Medicaid-Vital Statistics Birth Records Matching Project will analyze the data it has collected in order to help better identify pregnant women most in need of nutritional counseling and prenatal medical care.

Infrastructure Building Services:

Begin use of the PPOR as a statewide process, then in metropolitan Kansas City and Wichita as endorsed by the KPC. Ongoing collaboration between KDHE/BCYF and KPC to determine the effectiveness of programs in reducing the numbers of very low and low birth weight infants through the evaluation of existing programs and systems.

Continue partnership with Medicaid in data sharing. KDHE will assess and subsequently outline the establishment of smoking cessation programs for pregnant women in local health departments.

c. Plan for the Coming Year

Direct Health Care Services:

Ongoing education of providers of M&I prenatal care/care coordination about LBW risk factors and interventions.

Enabling Services:

Healthy Start Home Visitors will continue to reach out to pregnant women and their families by informing, supporting, and linking these families to essential health and social services.

MCH staff at KDHE will collaborate with the Office of Local and Rural Health to provide the second annual Kansas Public Health Nurse Conference in Wichita to include education on prevention strategies aimed at decreasing the number of LBW infants.

The Perinatal Association of Kansas will have a conference focusing on mental health issues which have been shown to significantly impact pregnancy outcomes.

The Perinatal Casualty Report, the Adequacy of Prenatal Care Utilization Index and selected Kansas and United States Perinatal Outcome Data reports continue to be distributed to all in-patient obstetrical facilities for their use in evaluating appropriate management and referral of high-risk maternal/fetal cases to specialty and subspecialty perinatal care providers/centers.

Healthy Start Home Visitors will receive educational presentations in the areas of accessing the Migrant Farm Workers Program, breastfeeding education and perinatal maternal nutrition, mental health of infants, children and adolescents and the safety and health concerns of infants, children and adolescents.

Continue to partner with the Migrant Farm Worker Health Program and other Primary Care Projects in gathering resources to assist high-risk women.

Population-Based Services:

The WIC-Medicaid-Vital Statistics Birth Records Matching Project will analyze the data it has

collected in order to help better identify pregnant women most in need of nutritional counseling and prenatal medical care.

Ongoing promotion of folic acid consumption for women of reproductive age, provision of education to home visitors and other MCH providers on prematurity prevention issues in partnership with the March of Dimes.

Infrastructure Building Services:

Begin use of the PPOR process in Kansas City and Wichita as endorsed by the KPC.

Ongoing collaboration between KDHE/BCYF and KPC to determine the effectiveness of programs in reducing the numbers of very low and low birth weight infants through the evaluation of existing programs and systems.

Continue partnership with Medicaid in data sharing.

Adolescent pregnancy risk reduction efforts and abstinence education programs that have the potential to decrease the number of adolescent pregnancies and subsequent delivery of low and very low birth weight infants will continue.

KDHE will assess and subsequently outline the establishment of smoking cessation programs for pregnant women in local health departments.

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

a. Last Year's Accomplishments

Completed suicide is the second leading cause of death for Kansas adolescents ages 15 to 19 (1999-2002). For 2002, the rate of completed suicides was 8.7 per 100,000 (95% CI, 5.2-13.8) which decreased from 13.3/100,000 (95% CI, 8.8- 19.2) in 2001 - this difference wasn't significant. Presently, 2002 national data isn't available for this age-group. In 2000 and 2001, the national rates of completed suicide were higher than Kansas rates.

Direct Health Care Services:

Family therapist counseling is provided in the Comprehensive School Health projects by a local church minister. The goals of the program are to help identify needs of the students and families, provide support to students and families, define goals to enable student success in the classroom, monitor progress, and readily intervene as appropriate. Interventions utilized are individual sessions, small group sessions, teacher input and family involvement.

Enabling Services:

Referrals for mental health counseling are provided through the Comprehensive School Health projects.

The Statewide Suicide Prevention Steering Committee conducted a poster contest with entries from students in middle and high schools throughout Kansas. The theme centered on the warning signs of suicide. The posters were displayed during Suicide Prevention Week at the

State Capitol during the legislative session. A Governor's proclamation of Suicide Prevention Week was signed.

Population-Based Services:

A presentation on suicide prevention measures was provided during the Annual Summer Kansas School Nurse Conference. The Signs of Suicide Prevention Program is a high school based program that was presented by school nurses. The purpose of this program brings students in need of service to the school's attention by educating teens about the signs of suicide and outlining steps for dealing with this mental health emergency.

Other information relayed to school nurses during the Annual Summer School Nurse Conference included a session on Management of Depression and Bipolar Disorders: A Guide for School Nurses. This session included information on: how to identify signs and symptoms of depression and bipolar illness in children and adolescents, the treatment modalities available, interventions for students in crisis, suicide assessment and interventions, and how to evaluate appropriate referrals.

Infrastructure Building Services:

Progress was made toward the completion of a statewide suicide prevention plan by the Suicide Prevention Statewide Steering Committee through monthly meetings.

b. Current Activities

Direct Health Care Services:

Family therapist counseling is provided to students by a local church minister through one Comprehensive School Health project. Services are provided through funding from the grant. The staff on this project have been developing sustainability plans to maintain services on-site at the end of the funding cycle. The program has implemented the Behavior Assessment System for Children (BASC). A complete picture of a child can be obtained using the family of BASC tools. A comprehensive set of rating scales and forms including the Teacher Rating Scales (TRS), Parent Rating Scales (PRS), Self-Report of Personality (SRP), Student Observation System (SOS), and Structured Developmental History (SDH). Together, they help you understand the behaviors and emotions of children and adolescents. The BASC was developed from the concept that all children have strengths that should be recognized and used to help remediate behavioral and emotional problems. As such, the BASC incorporates a multidimensional perspective of the child including both positive (adaptive) and negative (maladaptive) aspects. This helps target interventions most likely to succeed in reducing a child's problematic behavior and negative emotions. Thirty-five students and families are utilizing this program in various degrees. Three students have completed the program.

Enabling Services:

Assure case management of students referred for mental health counseling through the Comprehensive School Health Initiative.

Population-Based Services:

A poster contest solicited entries from students in middle and high schools throughout Kansas. The posters were displayed at the State Capitol during the legislative session. The theme was communication between parents and teens.

Infrastructure Building Services:

Review and possible revision of the statewide suicide prevention plan through a strategic planning process. The Suicide Prevention Statewide Steering Committee must determine the feasibility of the current plan, how the plan can be implemented across the state, and what evaluation methods can be used.

c. Plan for the Coming Year

Direct Health Care Services:

Continue family therapist counseling through one of the Comprehensive School Health projects.

Enabling Services:

Continue referrals for mental health counseling through the Comprehensive School Health projects.

Population-Based Services:

The Kansas Suicide Prevention Steering Committee will adapt the poster contest to include entries of essays from students in middle and high schools throughout Kansas. The posters and essays will be displayed at various professional conferences. A Governor's proclamation during Suicide Prevention Week will be signed. Suicide Prevention Week is moved from May to September.

Begin discussions regarding depression screening with Comprehensive School Health projects staff.

Infrastructure Building Services:

Finalize the statewide suicide prevention plan through the Suicide Prevention Statewide Steering Committee and begin awareness education. An ad hoc committee will be formed to propose a plan and time table of activities for implementation.

Incorporate the adolescent developmental asset building framework and concepts at the state and local levels from the "Improving the Health of Adolescents & Young Adults: A Guide for States and Communities."

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

a. Last Year's Accomplishments

Infrastructure Building Services:

MCH staff at KDHE monitored residence and occurrence data relating to delivery site for very low birth weight infants.

BCYF/KDHE distributed the annual Kansas Perinatal Casualty Report to all in-patient obstetrical facilities for their use in evaluating appropriate transfer of high-risk maternal/fetal cases to specialty or subspecialty perinatal centers.

Identified established patterns from basic and specialty perinatal centers where the delivery of very low birth weight infants were anticipated and the availability of transfer criteria and obstetrical management protocols were in place.

Worked with specialty and subspecialty perinatal centers to identify the number of obstetrical cases where there were non-emergency and emergency obstetrical transfers.

The Perinatal Casualty Report and associated reports were distributed to all in-patient obstetrical facilities to provide a means of evaluating appropriate management and referral of high-risk maternal/fetal cases to specialty and subspecialty perinatal care providers/centers. MCH in partnership with local hospitals and other health care providers, through the Perinatal Association of Kansas, has remained involved in providing professional education.

Kansas has continued to have a working provider-driven perinatal referral system that facilitates access to inter-city/county/region consultation between primary obstetrical care providers and specialty maternal-fetal medicine professionals. This system includes five hospitals across the state that are self-designated subspecialty perinatal care centers providing out- and in-patient high risk obstetrical/fetal and neonatal services: Wesley Medical Center in Wichita; Via Christi and St. Francis in Wichita; Stormont Vail Health Care Center in Topeka; Overland Park Regional Medical Center in Overland Park; and the University of Kansas Bell Memorial Hospital in Kansas City. Obstetrical care providers in the public and private sectors continue to utilize a variety of methods to identify women at risk for preterm deliveries or other complications potentially leading to the delivery of low birth weight or very low birth weight infants.

The Perinatal Association of Kansas attempts to improve communication among providers of basic, specialty, and subspecialty perinatal care centers. Three of the subspecialty perinatal centers continue to provide formalized perinatal transport systems to maximize the potential for the delivery of referred high-risk obstetrical cases to their hospitals.

b. Current Activities

Infrastructure Building Services:

Continue work as in previous years.

Ongoing assessment of residence and occurrence data relating to delivery site for very low birth weight infants.

Annual distribution of Perinatal Casualty Report to all in-patient obstetrical facilities for their use in evaluating appropriate transfer of high-risk maternal/fetal cases to specialty or subspecialty perinatal care centers.

KDHE in collaboration with KPC has begun an examination of best practices, programs with the greatest potential to effectively reduce the number of low birth weight infants. As a part of this process, KPC members had training on the Perinatal Periods of Risk (PPOR) approach. PPOR will be used as a community tool to describe and encourage best practices among perinatal health care providers and to assure strategic linkage to existing programs (eg. Healthy Start). Furthermore, the KPC approved the use of the PPOR in Kansas City and Wichita in an attempt to reduce the number of LBW/VLBW infants within high-risk urban settings.

c. Plan for the Coming Year

Infrastructure Building Services:

Continue work as in previous years.

Work through the Perinatal Association of Kansas (PAK) in partnership with KPC to develop a process for identifying perinatal centers as providers of basic, specialty or subspecialty perinatal care in lieu of self-designation.

In partnership with the Kansas Hospital Association and PAK begin a process of assessing those who are self-designated as basic, specialty or subspecialty providers of perinatal care for any changes in level of services provided, availability of transfer criteria and the presence of protocols for obstetrical case management.

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

a. Last Year's Accomplishments

Since 1998, there has been a generally positive trend in this measure with a slight decrease to 86.0 in 2001. In 2002, this measure increased again slightly to 86.1%. This slight increase is also associated with an increase in the number of live births from 38,832 in 2001 to 39,338 in 2002.

Direct Health Care Services:

In 2003, 85 MCH grants were given to local county health departments and other local health care providers serving 104 out of 105 counties in order to address low birth weight incidence and to reduce barriers to early and appropriate prenatal care. A handful of local providers continue to provide medical prenatal services as the community situation warrants.

Enabling Services:

In 2003, the 15,395 encounters with pregnant women and 2,793 encounters with infants were

mostly for the purpose of providing care coordination utilizing multidisciplinary teams. M&I care coordination and HSHV outreach are aimed at increasing the number of pregnant women accessing early and comprehensive prenatal care services.

Dissemination of federally prepared print materials (e.g., Healthy Start Initiative, which publicizes a toll-free hotline and ultimately connects with the Kansas MADIN toll-free line.

In collaboration with Medicaid developed outreach and case management strategies to assure entry into and compliance with prenatal care for pregnant women receiving Medicaid.

Collaborated with the Migrant Farm Workers Program in assuring access to prenatal care services for this at risk population.

The toll-free Make a Difference Information Network (MADIN) line is available to provide pregnant women information on resources that will facilitate their access to and compliance with prenatal care.

Collaborated with March of Dimes, Juvenile Justice Authority, Pregnancy Maintenance Initiative projects and Comprehensive School Health Centers.

Population-Based Services:

Provided support to public media initiatives to address the importance of prenatal care and associated health issues.

Infrastructure Building:

The Adequacy of Prenatal Care Utilization Index was provided to all in-patient obstetrical facilities along with the Perinatal Casualty Report and selected statistics for the United States and Kansas. From this collection of data, the facilities could evaluate the use of their prenatal care services for pregnant women and to aid in identifying potential system, provider or consumer barriers to care.

Monitoring of live birth and death certificates for information pertaining to prenatal care entry and compliance trends across race and maternal age categories.

Provided technical assistance to MCH funded M&I clinics in the development and continuation of translation services and print materials (primarily Spanish and Vietnamese).

Continued the effort to identify women at risk for late entry and/or noncompliance with prenatal care in collaboration with WIC, M&I, HSHV, and Family Planning services.

b. Current Activities

Activities from previous year are continued.

Infrastructure Building Services:

A three hour "Survival Spanish for Health Care Providers" inservice was provided at the Perinatal Association of Kansas Annual Conference.

In collaboration with PAK, March of Dimes, KPC and Kansas Action for Children every

endeavor has been made to share and publish data, promote initiatives and distribute print and multimedia resources related to the importance of early and comprehensive prenatal care.

c. Plan for the Coming Year

Activities from previous year are continued.

Enabling Services:

Continue collaboration with partners listed under current activities section to continue the effort of promoting early and comprehensive prenatal care.

Infrastructure Building:

In collaboration with the partners listed under current activities section and the entire array of local obstetrical and perinatal care providers to continue maximizing resources to provide conferences, initiatives and support of programs designed to promote and assure access to early and comprehensive prenatal care.

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. Nursing case management of infants with abnormal screens.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Contracts providing statewide coverage for consultations on metabolic conditions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Purchase of PKU formula and food products for individuals.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Arranging transportation, as needed, to access follow up services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Data collection and reporting on NBS followup and congenital malformations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Information to policymakers on MS/MS technology.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. QA activities with hematology and endocrinology consultants.	<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
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. Review health care plan with parents.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Families are involved in decisions at multidisciplinary and specialty clinic appointments.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. A toll-free line is available for families to call to discuss services and concerns.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Families are given a choice of providers.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. A family advisory group assists the CSHCN program in policy decisions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. CSHCN staff assist families with identifying resources in their communities.	<input type="checkbox"/>	<input checked="" 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
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. Referrals are obtained for Medicaid/SCHIP clients who have an assigned medical home.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Reports from the medical specialists are provided to the local primary care physician.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Educate providers about CSHCN services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. CSHCN staff identify a care provider when the family has no medical home.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. CSHCN program provides interpreter services to assist families who are attending out patient medical appointments.	<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"/>

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. Require families applying for CSHCN program to make Medicaid/SCHIP				

application.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. CSHCN program is payor of last resort. Insurance/Medicaid denial prior to processing CSHCN payment.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. CSHCN program has an identified staff person to work with the Kansas Clearinghouse (XIX and SCHIP).	<input type="checkbox"/>	<input checked="" 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
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. CSHCN contracts support outreach clinics.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. CSHCN (ages 0-2) are referred to Part C early intervention networks in their communities.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. CSHCN (ages 3-21) are referred to local school districts for Part B services.	<input type="checkbox"/>	<input checked="" 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
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. Vocational Rehabilitation is used as a referral source for clients when necessary.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Cystic fibrosis and cerebral palsy clinics assist older adolescents in transitioning to adult services.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Transition issues are reviewed with families during clinics beginning in early childhood.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Transition issues are addressed in the CSHCN plan of care.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Attempts are made to locate services after children are no longer				

eligible for the CSHCN program.	<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"/>

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. Collaborate with schools & public health agencies to provide education on age-appropriate immunizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Maintain accurate records on the Kansas Certificate of Immunizations through nurse and LHD education.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Provide inservice training annually through regional workshops and the statewide school nurse conference	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provide technical assistance and consultation on questions and problems regarding immunizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue interagency collaboration to maintain high levels of immunization for all children and youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Initiate Medicaid outreach project for counties with low rates.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Participate in Governors Blue Ribbon Task Force.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Start Immunization Registry.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. QA of vaccine service provision.	<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"/>

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. Address reproductive health issues through Comprehensive School Health Centers.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Maintain Teen Pregnancy Prevention, Peer Education, & Case Management Projects.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Continue Teen pregnancy Prevention Projects which address disparities in teen pregnancy for black and Hispanic youth.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Maintain and assure Abstinence Only Education through local projects.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Encourage participation in YRBSS through Abstinence Only Education projects.	<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
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. Direct services for CSHCN as indicated.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Provide fluoride varnish training to public health nurses.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Public health education to promote oral health through the KDHE Oral Health Initiative.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Coordinate with other agencies and associations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Participate in the Oral Health Kansas coalition.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Provider education and guidance by presentation and website.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Participate in policy development activities.	<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
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. Participation in the Kansas SAFE Kids Coalition.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Collaboration with the Kansas Dept of Transportation data collection to target injury prevention efforts to match community needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Participation on the Emergency Medical Services for Children Coalition to assist in coordination of pediatric injury treatment and prevention educational programs targeting community level child health providers and school nurses.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Support of Kansas' trauma system's revision of criteria for reporting all children injured and admitted to a hospital.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Child Death Review Board analysis of deaths of children ages 1-14 that are involved in motor vehicle crashes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Legislation supporting expansion of child passenger restraint law.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Train Healthy Start Home Visitors as child passenger seat technicians in select counties with distribution of car seats at no-cost or low-cost.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Monitor local health departments' evaluation of local injury data assessment, and provide education and services to reduce the motor vehicle unintentional injury rate.	<input type="checkbox"/>	<input type="checkbox"/>	<input 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"/>

	Pyramid Level of Service			
	DHC	ES	PBS	IB

NATIONAL PERFORMANCE MEASURE	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. Support community breastfeeding coalitions by encouraging LHDs to play an active role.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Communicate breastfeeding information with a variety of state and community agencies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue collaboration with the Kansas AAP Breastfeeding Coordinator.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue the support of the Lactation Room in the Curtis State Office Building.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Disseminate breastfeeding newsletter for LHDs to send to community contacts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Require LHDs participating in the WIC Program to continue their breastfeeding community action plans.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Provide self-instruction modules on breastfeeding promotion and breastfeeding management for LHDs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Increase breastfeeding knowledge of LHD staff for both MCH and WIC programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input 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
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. Continue education on data submission through the electronic birth certificate (EBC) reporting system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue quarterly meetings of the Sound Beginnings Advisory Committee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue the education training to professionals on audiologic assessment and early intervention.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Collaborate with the Families Together organization for parental input and parent to parent.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Statewide workshop for hospital screening personnel to be implemented.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Continued use and training of web-based data management system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Continue dissemination of Newborn Hearing Screening brochures for families to hospitals, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Collaborate with OVS on implementation of web-based birth certificate reporting system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Rules and Regulations for Sound Beginnings program.	<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"/>
NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
13) Percent of children without health insurance.				

1. Discontinue reimbursement to LHDs for school entry physicals. Link children to Medicaid/HealthWave to establish a medical home.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Local health departments develop outcome-based plans to decrease the percent of children without health insurance in their regions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Convene representatives to assess the integration of the applications for the free/reduced school lunch program and the Medicaid/HealthWave programs for school-aged children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Link families with Medicaid/HealthWave by assisting with the enrollment application.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Promote outreach activities in local education agencies by school nurses, school social workers, and school psychologists to enroll Medicaid eligible women and children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Healthy Start Home Visitors will assist families to enroll in Medicaid/HealthWave programs.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Link students with Medicaid/HealthWave coverage through Comprehensive School Health Centers	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Promote local coordination and collaboration between agencies to link hard-to-reach populations to Medicaid/HealthWave programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Train childcare professionals to link uninsured children to Medicaid/HealthWave programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Assist local health agencies to create a community plan for providing care for those uninsured children who remain ineligible for Medicaid/HealthWave programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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. Followup with LHDs on Child Health Assessment at School Entry billings and services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Support use of Medicaid/SCHIP services by enrolled students through Comprehensive School Health Centers.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Support use of Medicaid/SCHIP services for enrolled infants and children by the Healthy Start Home Visitors.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Support use of services by Medicaid/SCHIP enrolled infants and children through MCH grants to local agencies.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Support use of services by Medicaid/SCHIP enrolled children in Services for Children with Special Health Care Needs	<input type="checkbox"/>	<input checked="" 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

15) The percent of very low birth weight infants among all live				
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births.				
1. Education of M&I providers about LBW risk factors and prevention.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Healthy Start Home Visitors continue to link families to essential health care and social services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Partnership with OLRH to provide second annual Public Health Nurse Conference	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Partnership with Perinatal Association of Kansas in planning conference with mental health focus.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. WIC-Medicaid-Vital Statistics to analyze birth records matching data to better identify high-risk pregnant women.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Distribute Perinatal Casualty Report to all in-patient obstetrical facilities for management and referral of high-risk pregnancies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Education for Healthy Start Home Visitors on risk factors associated with LBW outcomes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Partner with Migrant Farm Worker Health Program and other Primary Care Projects to link high-risk women to services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Partner with March of Dimes in promoting prematurity campaign and continue folic acid promotion.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Partner with KPC to determine existing program/system effectiveness in reducing numbers of LBW/PLBW infants.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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. Participate in Suicide Prevention State Steering Committee.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide suicide prevention education at the Annual Summer School Nurse Conference.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Provide public education and youth education through the Suicide Prevention Poster contest.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Referrals for mental health counseling through the Comprehensive School Health Initiative.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Continue to finalize Kansas' Statewide Suicide Prevention Plan through the Suicide Prevention statewide steering committee.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Provide family therapist counseling in one of the Comprehensive School Health Initiatives	<input checked="" 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. Ongoing professional education activities in partnership with hospitals,	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

PAK and other health care providers.				
2. Distribution of Perinatal Casualty Report to providers for evaluation of high-risk case management.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Ongoing partnerships with PAK, KHA and KPC in assessing need for improved transfer systems and protocols.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Begin PPOR process in Wichita and Kansas City.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Define designation process with KPC for perinatal care centers.	<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
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				
1. Coordinate with public and private partners to promote early and comprehensive prenatal care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide Make A Difference Information Network toll free line for access prenatal care information.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. APNCU index and Perinatal Casualty reports provided to all in-patient obstetrical providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Technical assistance in area of translation services for various providers.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Collaborative approach to identify women at risk of late entry or noncompliance with prenatal care.	<input type="checkbox"/>	<input checked="" 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"/>

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Ratio of Kansas Adequacy of Prenatal Care Utilization (APNCU) to Densely-Settled Rural Hispanic APNCU*

a. Last Year's Accomplishments

Direct Health Care Services:

Continued support of M&I and Family Planning programs with development of new service emphasis within existing projects.

Enabling Services:

Support education and outreach efforts provided by Teen Pregnancy Projects and Disparity

projects in Wichita and in SW Kansas to improve pregnancy outcomes for Hispanic women.

Provide educational materials to pregnant and pre-pregnant Hispanic women through all possible channels in collaboration with the Migrant Farm Worker Program.

Infrastructure Building Services:

Provide educational materials on the KDHE website: <http://www.kdhe.state.ks.us/bcyf>

Distribute the APNCU and the Perinatal Casualty Report to local in-patient obstetrical providers to underscore the need for increasing and assuring the access to early and comprehensive prenatal care to the Hispanic population.

b. Current Activities

Enabling Services:

Update of materials on the KDHE website to address the need for Spanish language materials and information to improve utilization of prenatal care.

Continue education and outreach efforts provided by Teen Pregnancy Projects and the Disparity projects in Wichita and SW Kansas to improve pregnancy outcomes for Hispanic women of reproductive age.

Improve utilization of prenatal care by Hispanic women in collaboration with the Migrant Farm Worker Program.

Infrastructure Building Services:

Provided the Perinatal Casualty Report and the APNCU index to all in-patient obstetrical providers to promote data based decision-making.

In collaboration with PAK develop strategies to reduce the disparity (ratio) between Hispanic access to prenatal care in the Densely-Settled Rural Counties and the Kansas APNCU index.

Revised local agency monitoring tool to address capacity and access issues related to improving utilization of prenatal care by Hispanic women.

c. Plan for the Coming Year

Enabling Services:

Ongoing update of educational materials on KDHE website.

Ongoing support of education and outreach efforts provided by Teen Pregnancy Projects and Disparity projects in Wichita and SW Kansas to improve pregnancy outcomes for Hispanic women.

Improve access to prenatal care for Hispanic women of reproductive age through collaboration with the Migrant Farm Worker Program.

Infrastructure Building Services:

In collaboration with KPC, conduct PPOR analyses for the State and for the metropolitan areas of Wichita and Kansas City to identify potential barriers to prenatal care to idencate potential

interventions at the community level.

Continue to provide APNCU and Perinatal Casualty Report to all in-patient obstetrical providers to aid in their decision-making processes.

Ongoing collaboration with PAK.

State Performance Measure 2: The degree to which the MCH Program addresses data capacity.

a. Last Year's Accomplishments

Kansas scores from 1999 to 2003 have ranged from 23 to 38, with a perfect score of 64 (72 previously). Kansas is over halfway towards achieving its target. This measure relates to State Priority #3: Increase data infrastructure, epidemiological capacity and products of analysis for improved state and community problem-solving. Epidemiological capacity will also be enhanced through the addition of a second MCH epidemiologist who started November, 2003.

Infrastructure Building:

MCH programs have vital statistics, hospital discharge, and other data resources available through the Center for Health and Environmental Statistics with personal identifiers removed. The hospital discharge data from the Kansas Hospital Association represents approximately 97% of Kansas community hospitals.

Utilizing funds from a State Improvement Grant, ITS and the Dept of Education has developed an information system that will enable tracking of children with disabilities between Part C of IDEA in the Department of Health and Part B of IDEA in the Department of Education. This system tabulates reports for Office of Special Education Program (OSEP), other funding sources, public awareness efforts, measuring improvement and effectiveness of services and grants.

Newborn screening in BCYF has linkages with the Neonatal Screening Section, Health and Environmental Laboratory, which links births in Kansas with children screened for the required conditions. Kansas has a passive birth defects reporting system. This child specific data is not available for use in program service delivery. The current legislature has passed and the governor signed a bill establishing a birth defects registry. Unfortunately, no funding was attached. When this law is funded, our birth defects registry will allow us to identify children who have special needs and link them early with appropriate services.

The current information system for CSHCN has been in place since 1993 with relatively few changes. Since the source code is no longer available, implementing changes is a cumbersome process. During August - October 2003, the CSHCN system was evaluated to determine the viability of implementing a new system, and to identify potential vendors and system to meet program needs. The evaluation conducted by EnVisage Consulting recommended bids for a new system.

In July 2000, three HRSA-funded programs within KDHE (MCH/CSHCN, Primary Care Services within the Office of Local and Rural Health, and HIV/AIDS within the Bureau of Epidemiology and Disease Prevention) completed a comprehensive statewide needs assessment and identified ten MCH priority needs to receive a statewide emphasis over the next five years. During 2002 and 2003, a Mid-Course Review of the MCH 10 priorities was conducted by EnVisage Consulting with the goals of updating quantitative indicators and determining how well the priorities have been implemented into state and local planning. The final report was presented January, 2004

b. Current Activities

Last year's work continues into the current year including the development of databases for each program that meet federal and state reporting and accountability requirements.

Infrastructure Building Ser:

MCH programs are developing capacity to link databases between programs (MCH, WIC, Part C, CSHCN). MCH continues to support the Kansas State Department of Education (KSDE) in getting a representative sample of school districts to participate in the YRBS survey.

CSHCN has an electronic linkage with the Medicaid information systems at the Central and Field offices. It is anticipated that this capability will be available for other state level MCH programs needing client based data.

MCH programs include two oral health screening projects. For the school year 2003-2004, school nurses conducted an innovative oral health screening project using a Non-invasive Laser Fluorescent Dental Device on students in grades 3 and 6. If abnormalities were detected, students were referred to their dental health provider for an evaluation. The final report will be available in June 2004. Additionally, a population based open mouth survey of Kansas third grade children is nearing completion, which provides baseline information on the oral health status of children in the State. The results will be disseminated to policy makers and to program decision-makers. These will help to guide development of MCH/CSHCN program interventions.

A descriptive survey has been developed in collaboration with the Mid-America Poison Control Center (MAPCC) to provide Kansas data on childhood poisoning relative to their grandparents' medications. This call-back survey, to be carried out by the MAPCC specialists received IRB approval in May, 2004. After survey completion, MCH epidemiologists will provide data analysis. The Kansas data gained from the analysis will be used to design educational strategies for preventing accidental poisonings.

In May 2004, WIC finished the roll-out of a 5.8 million dollar automated statewide data system which will include risk and other information useful in epidemiological studies. This data system is available for data linkage with other programs and vital statistics data system.

In May 2004, the Kansas Perinatal Council has decided to proceed with phase I of Perinatal Periods of Risk (PPOR) at the state level. MCH epidemiologists will provide support for this project through data analysis of linked birth and death Vital Statistics files.

The next 5 yr MCH Needs Assessment (NA) has been initiated with projected completion date of January 2005. The MCH epidemiologists will work with panels of experts to conduct the NA, establish future MCH priorities, and select indicators to measure progress. The epidemiologists will also produce the MCH annual summary reports designed to describe the public health importance of the priorities, update quantitative indicators, and determine how well the priorities have been implemented into state and local planning.

c. Plan for the Coming Year

MCH programs will continue with the above activities.

Infrastructure Building Services:

Completion of four projects: 1) Childhood poisoning survey, 2) Oral health surveys, 3) PPOR

(Phase I), and 4) NA.

Explore the capability of data linkage with the new WIC data system, other BCYF programs, and the vital statistics data system.

State Performance Measure 3: Percent of children under age 4 in motor vehicle crashes using proper child safety equipment.

a. Last Year's Accomplishments

Unintentional injury is the leading cause of death for Kansas children ages 1 to 4. Kansas statutes (KSA 8-1344 through 8-1347) require that children under age 4 use a child safety seat. The Office of Health Promotion provides leadership for the agency in injury prevention. MCH collaborates with OHP and SAFE Kids Coalition in addressing this issue.

Please see accomplishments in NPM #10

b. Current Activities

Direct Health Care Services:

Over 4,727 Child Passenger Safety Seats have been distributed to families with 65 of these supplied through local public health departments.

Enabling Services:

In Kansas 568 Child Passenger Safety Seat (CPS) technicians, a 191 member increase, and 28 volunteer CPS technician instructors work with local and state SAFE Kid Coalitions and other community organizations to promote occupant safety education. There are 74 counties that now have permanent child passenger safety fitting stations throughout the state.

Kansas SAFE Kids assisted General Motors with the BM Autoshow in Motion, with 36 volunteers working more than 480 hours installing seats for participating children.

Healthy Start Home Visitors provide injury prevention and education activities including motor vehicle injury prevention. There are currently 42 HSHV's trained as CPS technicians across the state.

Population-Based Services:

The American Academy of Pediatrics "Car Safety Seats: A Guide for Families 2004" was recommended for all local public health departments to distribute to families in their counties. This guide was also recommended for distribution by Healthy Start Home Visitors to all families during home visits.

Infrastructure Building Services:

The Kansas trauma system is requesting a change in the current trauma system criteria to include all injured children admitted to a hospital, regardless of length of stay or transfer to a hospital, which should depict a more accurate picture of the number of children injured in Kansas and how injuries were sustained.

c. Plan for the Coming Year

Direct Health Care Services:

5,000 Child Passenger Seats will be distributed to families.

Enabling Services:

A decrease in the number of counties with CPS technicians was identified, from 101 Kansas counties last year to 86 counties this year. MCH is collaborating with the Kansas Department of Transportation to facilitate training for the Kansas Healthy Start Home Visitors to ensure all 105 Kansas counties have a CPS technician.

Infrastructure Building Services:

MCH participates on the newly formed Emergency Medical Services Coalition to coordinate pediatric injury treatment and prevention educational programs across the state and targeting local community public health and school nurses.

Share Kansas Department of Transportation observation survey information with local communities.

Monitor the use of child (age 0-4) safety seat data by the local health departments. Ensure the provision of education and service linkages targeting reduction of motor vehicle injuries through on-site visits and review of year end grant reporting documentation.

State Performance Measure 4: *Violent acts per 100 enrolled students, 6th through 9th grades.*

a. Last Year's Accomplishments

For the school year 2002-2003, the Kansas school violence rate (2.8 per 100 students) for 6th through 9th grades has slightly increased from the school year 2001-2002 (2.5 per 100 students). This rate includes all malicious acts against students and staff which results in the student receiving an out-of-school suspension or expulsion.

Kansas schools have adopted zero tolerance of weapons and developed formal policies of expulsions for any violations. Many schools have implemented alternative learning environments where education is delivered to a disruptive student in a completely separate setting from that of the peers. Many schools have implemented conflict resolution education for students and have developed peer counseling groups to help students resolve issues of conflict.

Direct Health Care Services

Two of the Comprehensive School Health projects provided counseling and referrals as needed to meet the needs of the adolescents and their families.

Population-Based Services

School nurses were encouraged to increase their knowledge and become involved in the areas of Bullying and Violence.

Infrastructure Building Services:

Issues regarding violence and healthy relationships were not addressed specifically. Goals were set to increase education in this arena.

b. Current Activities

Direct Health Care Services:

Two of the Comprehensive School Health projects provide counseling and referrals as needed to meet the needs of the adolescents and their families.

Infrastructure Building Services:

The monthly MCH newsletter (ZIPS) provides information to local health department nurses, social workers, Healthy Start Home Visitors, and school nurses on information and resources (such as websites and curricula) to promote healthy relationships.

All public health staff who work with children and families were encouraged to attend the Governor's Conference for the Prevention of Child Abuse and Neglect. Workshop topics included: "Building Positive Relationships with Children" discussed strategies that help children develop through emotional literacy; "The Management of Anger in Adult-Child Relationships: The Fireworks Approach" presented a new extension program on anger management called Fireworks; "Picture This: Nurturing Positive Mental Health in Children" discussed the importance of building and maintaining close social relationships with peers, family members, and other significant adults in a child's life; "Adults and Children (ACT) Together Against Violence" discussed the program that offers knowledge and skills to professionals who work with families and children in preventing the development of aggressive behaviors in young children;

"Using Conflict Resolution & Negotiation Skills in Child Welfare" focused on the skills social workers and other community workers can use in their everyday work with families; "Understanding Discipline: Encouraging Self-Discipline and Avoiding Self Destructive Behaviors and Potential Abuse" highlighted specific approaches to child discipline and the avoidance of self-destructive behaviors and avoidance of abusive potential; "Healthy Boundaries Equal Stress Management" informed professionals it is important to create a healthy boundary system and to teach and model boundaries to challenged families; "Multidisciplinary Response to Truancy of Children and Teens" discussed the cause of and interventions used to address truancy issues and to educate participants on the risk factors, legal ramifications, and familial dynamics associated with school failure.

c. Plan for the Coming Year

Direct Health Care Services:

Two of the Comprehensive School Health projects will continue to provide counseling and referrals as needed to meet the needs of the adolescents and their families.

Enabling Services:

Local health department staff including the Healthy Start Home Visitors will receive training to identify violent relationships and how to initiate referrals.

Infrastructure Building Services:

To increase the knowledge of nurses working in a school setting, a presentation on violence will be conducted at the Annual School Nurse Summer Conference. The first presentation is entitled, "Bullies and Their Victims: Strategies to Help Both" which discusses how adults can help kids learn to more effectively deal with bullying by discussing what the behavior is and how to stop it.

Information will be provided to the Healthy Start Home Visitors during their Regional Training on how to recognize violence and how to promote healthy relationships.

Upon release of the document, "Improving the Health of Adolescents and Young Adults: A Guide for States and Communities" technical assistance will be provided to incorporate concepts into daily interaction in all systems of care with adolescents.

State Performance Measure 5: *Percent overweight WIC children, aged 36-59 months.*

a. Last Year's Accomplishments

The Kansas measure follows the national trend. There is an increase in obesity among Kansas children and adolescents. The Kansas target has not been achieved. In 2003, 12.6% of WIC children aged 24 to 59 months were overweight.

Enabling Services:

The project funded by the Sunflower Foundation was implemented. The project plan is to evaluate four different strategies for delivering physical activity and health eating behavior messages. The curriculum Nutrition: Good For You has been adapted, new classes and handouts have been developed, and the different strategies implemented in four Kansas counties. Preliminary data collection has occurred with the final report expected in the fall of 2004.

Infrastructure Building Services:

The goal and action plan developed by members of Kansas USDA nutrition programs including School Lunch, School Breakfast, Nutrition Network, Expanded Food and Nutrition Education Program, CSFP and WIC has been implemented. Kansas's goal was to "Educate individuals, families and communities about healthy dietary patterns and regular physical activity, based on the Dietary Guidelines for Americans". The community wide event that coordinated activities for all the USDA nutrition programs around increasing physical activity and the consumption of fruits and vegetables was held. BCYF/Nutrition & WIC Services staff supported this event by providing incentives, handouts and ideas for nutrition and physical activity displays.

KDHE/ Bureau of Health Promotions grant to evaluate the height and weight of approximately 4,000 children (K through 12) in randomly selected schools got underway. This is an age group where Kansas height and weight data is missing. BCYF staff has been consulted on a variety

of topics for this grant including being a member of the advisory committee. The age range for this state performance measure was selected due to lack of Kansas data in school age children. This grant will aid to reevaluate the age range of this state performance measure. The name of this grant is Kansas Child Health Assessment and Monitoring Project.

The WIC automation system has incorporated the new CDC Pediatric Nutrition Surveillance questions. One of particular interest is the question related to television and video viewing. This will give us both state wide and county data to evaluate

b. Current Activities

Enabling Services:

The 2003-04 Nutrition Services Action Plan focus is childhood obesity with an emphasis on educating community leaders about ways to support healthier lifestyles within the community and to educate WIC families on how to encourage behaviors that will aid children in maintaining a healthy weight.

Infrastructure Building Services:

The Kansas Child Health Assessment and Monitoring Project is working with the YRBS and Youth Tobacco Survey to coordinate the sampling of schools. CDC is helping so that each school district in Kansas will only need to participate in 1 of the three surveys.

c. Plan for the Coming Year

Enabling Services:

Infrastructure Building Services:

The CDC Pediatric Nutrition Surveillance question on television and video viewing will be evaluated on both a statewide and county level.

The goal and action plan developed by members of Kansas USDA nutrition programs including School Lunch, School Breakfast, Nutrition Network, Expanded Food and Nutrition Education Program, CSFP and WIC will be expanded to hold a community wide event in additional Kansas counties. The community wide event will have coordinated activities for all the USDA nutrition programs around increasing physical activity and the consumption of fruits and vegetables. BCYF/Nutrition & WIC Services staff supports these events.

The Kansas Child Health Assessment and Monitoring Project will start collecting heights and weights in the spring of 2005. In August of 2004 a pilot will be conducted including focus groups. BCYF staff will continue to help with this very worthwhile project.

State Performance Measure 6: *Percent of Kan-Be-Healthy (Medicaid-EPSDT) - eligible children aged 6 through 9 who have received at least one dental screen.*

a. Last Year's Accomplishments

Direct Health Care Services:

CSHCN reimbursed dental providers for dental services provided to uninsured special health

care needs children as part of an overall health plan.

Enabling Services:

The CSHCN program provided case management services to special needs children who required dental services as part of an overall health plan. MCH oral health staff coordinated with Medicaid in assuring that school nurses receive training appropriate for identification of oral health problems and referral to providers.

Population-Based Services:

MCH staff provided outreach/public education relating to oral health through school nurses, public health nurses, Healthy Start home visitors who serve in an outreach role for local health departments.

Infrastructure Building Services:

MCH obtained federal funding for an open mouth survey of Kansas 3rd graders. The oral health consultant provided training to school nurses at their annual conference. MCH posted information on the KDHE/Oral Health Initiative website for school nurses relating to oral health. MCH served as a resource person to the new Oral Health Kansas coalition.

b. Current Activities

Current Activities:

Direct Health Care Services:

CSHCN provides dental services for uninsured special health care needs children as part of an overall health plan.

Enabling Services:

CSHCN provides case management services for uninsured special health care needs children who need dental services as part of an overall health plan. Staff are coordinating with Medicaid in assuring that school nurses receive training appropriate for identification of oral health problems and referral to providers.

Population-Based Services:

Staff are providing outreach/public education relating to oral health through school nurses, public health nurses, Healthy Start home visitors who serve in an outreach role for local health departments.

Infrastructure Building Services:

MCH is outsourcing to the Kansas Health Institute the analyses of results of our first open mouth survey of Kansas 3rd graders. Training in oral health issues will be provided to school nurses at their annual conference. Staff are keeping the KDHE/Oral Health Initiative website up to date for school nurses. MCH staff continue to serve as resource persons to the new Oral Health Kansas coalition. Mch coordinates with the Kansas Dental Association and Dental Hygienist Association to troubleshoot issues between Medicaid and dental providers.

c. Plan for the Coming Year

Direct Health Care Services:

CSHCN will provide dental services for uninsured special health care needs children as part of an overall health plan.

Enabling Services:

CSHCN will provide case management services for uninsured special health care needs children who need dental services as part of an overall health plan. Staff are coordinating with Medicaid in assuring that school nurses receive training appropriate for identification of oral health problems and referral to providers.

Population-Based Services:

Staff are providing outreach/public education relating to oral health through school nurses, public health nurses, Healthy Start home visitors who serve in an outreach role for local health departments.

Infrastructure Building Services:

Outsourcing to the Kansas Health Institute for analyses of results of our first open mouth survey of Kansas 3rd graders. The KHI will write the report which will be printed and disseminated throughout the state. Training for school nurses in oral health issues will be continued. Staff will maintain the KDHE/Oral Health Initiative website. MCH will serve in a lead role on the Oral Health Kansas coalition. The MCH oral health consultant will work with the professional associations, Kansas Dental Association and Dental Hygienist Association, to assure enrollment of dental professionals as Medicaid providers.

State Performance Measure 7: *Behavioral health infrastructure - Discontinued*

a. Last Year's Accomplishments

b. Current Activities

c. Plan for the Coming Year

State Performance Measure 8: *Observed to expected Kan-Be-Healthy (Medicaid-EPSDT) screening ratio for infants under age 1.*

a. Last Year's Accomplishments

Only 67.6% of Medicaid infants received a screening compared to a goal of 92%. Although the number of infants participating in the Medicaid program is increasing and the number of infants receiving KBH screens is increasing for the past three years, there has been a steady decline in this performance measure. Infants participating in the Medicaid program get fewer than the

recommended number of visits.

Striving to provide each child with a medical home, Kansas has embraced the managed care model of care for the Medicaid population. However, most primary care physicians lack the capacity to provide the additional outreach and family support services, which allow families to adhere to the traditional private, care office protocol of clients making and keeping appointments. A 1997 report released by the Office of the Inspector General (OIG) of DHHS provides evidence that the problem worsened as the states endorsed managed care as a cost control strategy. The OIG reports that only 28 percent of Medicaid managed care children receive all of the screens required by their state periodicity schedule and that sixty percent receive no EPSDT services.

Enabling Services:

Local health departments and other local agencies link families with newborns to KAN-Be-Healthy services through the primary care physician or other Medicaid provider (either physician, PA, ARNP, or registered nurse). Referrals were made by the local MCH programs (M&I nurses, Healthy Start Home Visitors, as well as by CSHCN staff). MCH staff collaborated with others such as WIC staff, Infant/Toddler (Part C of IDEA) early childhood staff, and Parents as Teachers staff to make referrals and remind parents of the importance of their child's periodic screening schedule.

Infrastructure Building Services:

Tracking of state data regarding KHB screenings on the 0-1 yr. periodicity for KBH screens.

b. Current Activities

Enabling Services:

Healthy Start HomeVisitors (HSHV) advocates for families and inform them about the importance of enrolling children in Medicaid/HealthWave and receiving KAN-be-Healthy screenings according to recommended periodicity schedule.

Local health departments assist families in assessment of income data, and referral for enrollment into the Medicaid/HealthWave program to support availability of KAN-be-Healthy screenings.

Infrastructure Building Services:

The local health department staff ensures that children who present for care are screened for eligibility and that families are assisted with application completion. Medicaid/HealthWave applications are initiated and submitted for all eligible children within the family. Case managers, public health nurses and outreach workers ensure that children are appropriately enrolled, and linked with a service provider. The local health department bills Medicaid for services provided to eligible children.

Local health department staff provides community outreach to all identified pregnant Medicaid women and other Medicaid-eligible pregnant women and inform them of available services. HSHV and M & I staff work with individual families to decrease the barriers in obtaining healthcare services (i.e., transportation, child care, lack of information about Medicaid/HealthWave.

KDHE/BCYF staff monitor the availability of KAN-be-Healthy (KBH) providers and provide

opportunities for providers to receive in-service to update basic screening skills.

c. Plan for the Coming Year

Enabling Services:

Participation on the KBH Advisory Committee in order to advocate for quality standards, provider availability and access for children/families.

Infrastructure Building Services:

Form interagency committee to meet and monitor participation in Medicaid/HealthWave and coordinate activities related to improving usage of services available for children.

Negotiate contracts with Medicaid managed care providers to add MCH contract agencies as preferred providers for care coordination to provide outreach and family support or in other ways partner to ensure that Medicaid clients make and keep appointments for KBH services.

Provide in-service trainings at HSHV regional meeting for local health department administrators, HSHV nurse managers, and HSHVs in billing and follow up for KBH screenings.

Collaborate with Kansas Child Care Regulation staff members to assess child health care access. Design standards to measure each child's health record for presence of medical home, health insurance status, and care received per EPSDT periodicity schedule. Children with identified needs will be referred to local care coordinators for assistance in accessing health care.

Disseminate information about Kan Be Healthy screenings and periodicity schedules to daycare providers through their newsletters within other training opportunities.

Inform other community partners about eligibility guidelines and enrollment procedures for Medicaid through local contract agencies and encourage Kan Be Healthy screenings according to the recommended periodicity schedule.

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

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) Ratio of Kansas Adequacy of Prenatal Care Utilization (APNCU) to Densely-Settled Rural Hispanic APNCU				
1. Distribution of perinatal casualty reports to obstetrical providers to promote data based decision-making.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Work with PAK to develop strategies to reduce prenatal care disparity for Hispanic women.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Collaboration with Migrant Farm Worker Program to increase access to perinatal care.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

4. Targeted approach to prenatal issues through use of PPOR analyses.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Education about importance of early prenatal care through Disparity projects.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Provide educational materials on KDHE website	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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) The degree to which the MCH Program addresses data capacity.				
1. Infant Birth/Death Certificates Linkage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Medicaid Eligibility/Paid Claims Linkage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. WIC Eligibility Linkage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Newborn Metabolic Screening Data Linkage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Hospital Discharge Data Linkage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Birth Defects Surveillance System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Survey of recent mothers (such as PRAMS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Survey of adolescent health and behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Mid-course review of Joint State Needs Assessment including inclusion of qualitative data	<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
3) Percent of children under age 4 in motor vehicle crashes using proper child safety equipment.				
1. Participation in Kansas SAFE Kids Coalition.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Collaboration with Kansas Department of Transportation (KDOT) data collection to target injury prevention efforts to match community needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Participation on the Emergency Medical Services for Children Coalition.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Support Kansas trauma system's revision of criteria for reporting all children injured and admitted to a hospital.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Child Death Review Board analysis of deaths of children ages 0-4 years that are involved in motor vehicle crashes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Train Kansas Healthy Start home visitors as child passenger seat technicians in counties that have not identified personnel for this service, with distribution of car seats at a no-cost or low-cost rental rate.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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"/>
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STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) Violent acts per 100 enrolled students, 6th through 9th grades.				
1. Provide education to school nurses regarding student violence and healthy relationships.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Collaborate with the Kansas State Department of Education on mental health/violence reduction initiatives.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Provide counseling and referrals to students and families through the Comprehensive School Health Initiative.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Provide education/resource information (such as curricula and websites) on promoting healthy relationships to LHDs, social workers, HSHVs, and school nurses.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Provide education for all LHD staff through the Governor's Conference for the Prevention of Child Abuse and Neglect.	<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
5) Percent overweight WIC children, aged 36-59 months.				
1. Support the nutrition education and/or nutrition assistance programs of the KNN and the Early Childhood Action Team.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Support of the Kansas Council on Physical Fitness annual Kansas Kids Kitness Day.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Support the Early Childhood Action Team's goal on physical activity and nutriiton.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provide consultation for the Kansas Child Health Assessment and Monitoring Project.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Support local health department's nutrition action plan on childhood obesity through the WIC Program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Support the Success by Six Nutrition Task Force Initiative to increase physical activity and healthy eating behaviors in preschoolers.	<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"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) Percent of Kan-Be-Healthy (Medicaid-EPSDT) - eligible children aged 6 through 9 who have received at least one dental				

screen.				
1. Open mouth survey for 3rd grade children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Oral health website to educate professionals about normal and abnormal conditions/pathology of the mouth.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Education in oral assessment/screening, anticipatory guidance and fluoride varnish application.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Child care provider education in caries prevention and referrals to dental professionals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Collaboration with other agencies and associations to introduce program strategies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Leadership role in development of an Oral Health Coalition and Board Development.	<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"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Behavioral health infrastructure - Discontinued				
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input 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"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) Observed to expected Kan-Be-Healthy (Medicaid-EPSDT) screening ratio for infants under age 1.				
1. Referrals from local M&I, Healthy Start, WIC, CSHCN programs, screenings and other community partners for EPSDT and KBH.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Collaborate with programs such as Infant/Toddler Services, and Parents as Teachers, daycare providers to assess infants for eligibility and inform parents of importance of the regular KBH assessments for their infants.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Monitor the availability of KBH providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Review the KBH data, utilizing the core public health functions as a basis.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Negotiate contracts with Medicaid managed care providers to add MCH				

contract agencies as preferred providers for care coordination to provide outreach and family support.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Form interagency committee to meet and monitor participation in Medicaid/HealthWave and coordinate activities related to improving utilization of services by children.	<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"/>

E. OTHER PROGRAM ACTIVITIES

OTHER PROGRAM ACTIVITIES

The WIC program is finishing the final testing of a new Management Information System. In late July, 2003 roll out will begin with Lyon County as pilot. Food instruments will be negotiable bank instruments (checks) instead of the current vouchers. Participating WIC vendors will realize major time and cost savings which will increase vendor satisfaction with the program. The major impact at the state level will be more timely access to participation and budget information, risk data for evaluation purposes, and annual unduplicated counts. ***/2005/ Rollout was completed in May of 2005. //2005//***

The Kansas Information for Communities (KIC) system allows data users to prepare their own queries for vital event data such as births and pregnancies. The KIC system is accessible through the Internet at: <http://kic.kdhe.state.ks.us./kic/>. The system is an evolving one with additional data sets and years of data added when they become available.

This system has improved access to data and has impacted one of the MCH priorities for Kansas which is to improve data infrastructure, epidemiologic capacity and analyses for state and community problem solving. KIC is a Kansas SPRANS project supported by MCHB.

Kansas Infant-Toddler Services at KDHE purchased three PhotoScreeners? and conducted a pilot project to determine the effectiveness of the new technology in detecting vision problems not detected using traditional tools and methods outlined in the Kansas Vision Screening Guidelines. This research project was expanded to additional sites with funding from the Kansas Lions Club.

A grant submitted to the Sunflower Foundation by NWS has been funded to address nutrition and physical activity in young children. The project will evaluate four different strategies for delivering physical activity and healthy eating behavior messages in four county WIC programs. The grant funding period will begin July, 2003.

The Sunflower Foundation funded a project to link three databases: birth certificate, WIC, Medicaid. The linked data will be used for evaluation purposes: prenatal outcomes, mutual referrals, indicators of obesity, etc. The completion date for this data matching project is December 31, 2003. ***/2005/ This project was completed and data is available. //2005//***

The BCYF is collaborating with the BRFSS staff to conduct a women's health survey to identify barriers to care, attitudes, knowledge and opinions on women's health issues. The surveys will begin following the approval of the IRB in early Summer, 2003 and at least 2,000 telephone surveys will be conducted. Survey results will be used for program and policy development purposes. ***/2005/ Data has been collected and will be available pending analysis. //2005//***

BCYF staff have been involved in the internal review process for the revision of Vital Statistics

Certificates (Birth, Death, Marriage and Divorce). In the spring of 2003 MCH participated in meetings regarding suggested changes and merging of current certificates with the US Standard Certificates.

The focus of Kansas RWJ Turning Point project is development of capacity to address disparities in health status among racial and ethnic minorities in the state. A key element in that effort is better understanding of health data related to minority health status, coupled with partnership with minority communities to improve the documentation of health and disease in those communities. Over the coming year, there will be a new training program for minority community representatives to assist their efforts to use the health data to improve health and well being in their communities.

Kansas MCH participates in the Rhode Island Kids Count School Readiness Initiative. MCH participates on a five member state team and BCYF staff participate in a number of early childhood/school readiness work groups.

//2005/The Children with Special Health Care Needs (CSHCN) program contracted with Envisage to undergo an evaluation of their current data system. The system being used is inadequate to the needs of the program. Envisage provided the program with recommendations for a new data system which will be considered as part of the CSHCN strategic plan.

Newborn Screening, Emporians for Drug Awareness, the Perinatal Association of Kansas and Part C Infant-Toddler Services are planning a conference that will address pre-pregnancy, infant, toddler and early childhood mental health issues. The conference will cover the mental health screening process, family systems/support, drug abuse, Fetal Alcohol Syndrome and referral sources.

A program manager was hired to assist with the coordination of the Kansas MCH Early Childhood Comprehensive Systems Grant Program (ECCS) and to assure the development of the Strategic Plan for Early Childhood Services in Kansas that was initiated by forty-five (45) state and community participants at a January 2003 strategic planning retreat. The manager works in the Children's Cabinet Office under the guidance and leadership of the KDHE MCH Director and the Early Learning Coordinating Committee (ELCC) that includes members from multiple agencies.

Kansas is a recipient of the Champions for Progress Incentive Award. The award will be used to convene a statewide stakeholder's meeting that focuses on Children with Special Health Care Needs (CSHCN) and their families.

KDHE staff is involved in discussions with SRS to ensure referral for evaluation to Part C Infant-Toddler Services of all children birth to three years of age who have been victims of a substantiated case of abuse or neglect. KDHE plans to work with SRS and Part C providers across the state to assure appropriate evaluation/intervention for children identified with social/emotional/mental health needs through this process.

Five percent of all children enrolled in KDHE, Part C Infant-Toddler Services are in foster care. Local early intervention networks, under contract with KDHE, provide services to these Part C eligible children. Some networks make agreements to cross boundaries ensuring that appropriate services are provided. To ensure that intervention services continue without interruption when a child moves from one foster home to another home, networks work collaboratively across geographical boundaries. In order to avoid duplication of services and the "loss" of a child during transition, KDHE is working with SRS regarding notification of networks when a foster child moves and sharing of case management/family services coordination responsibilities. //2005//

F. TECHNICAL ASSISTANCE

FFY 04, Completed Technical Assistance on the PPOR Approach

"Perinatal Periods of Risk Approach" (PPOR) is a systematic approach to the study of fetal and infant mortality data to improve health outcomes for mother and baby.

PPOR approach is a tool to improve the health of women and children, to describe and encourage best practices in using PPOR as a community tool, and to assure strategic linkage of PPOR with existing efforts (eg. Healthy Start). There was considerable interest in PPOR by MCH stakeholders for a Kansas pilot. While large cities such as Kansas City use this approach, a statewide analysis and a regional approach had not been attempted.

Kansas Perinatal Council will utilize the training they received in the past year to complete statewide analyses and Kansas City and Wichita analyses.

FFY 05, Planned Technical Assistance Request, Steps in Establishing a Birth Defects Information System

Senate Bill 418 passed in the 2004 Kansas legislative session. It creates, pending the availability of funding, a birth defects information system. The statutory language is similar to that of model statutes for the State of Ohio. The MCH/CSHCN staff need assistance to develop a plan which would be submitted to potential funding sources. We would like to request assistance from the State of Iowa or the State of Ohio for this technical assistance.

V. BUDGET NARRATIVE

A. EXPENDITURES

EXPENDITURES FFY 03

Comparing FFY 02 and FFY 03 federal MCH expenditures, there were increases noted in Child Care Licensing (initiation of new information system), Immunization Program (incentives for local health departments), Children with Special Health Care Needs (shift of some salaries to MCH), and Indirect Costs (the agency implemented collection of full indirect costs from all grants per federal rate agreements). There were decreased expenditures for the Injury Prevention Program (phasing out of support for local interventions through SAFE Kids), Aid-to-Local payments (Healthy Start, M&I, Comprehensive School Health Centers shifted from 50-50 to 25-75 allocation) and School Entry Physicals (requiring local health departments to assess income, refer for Title XIX or XXI or use sliding fee scale). State fiscal year (July 1 to June 30) Aid-to-Local contractual payments were shifted. Previously they had been paid 50% from one federal fiscal year and 50% from the next federal fiscal year. The shift was made to 25% and 75% to coincide with the federal fiscal year of October 1 to September 30. This change is an accurate representation of the state's spending and allows for more accurate projections of balances.

Comparing FFY 02 and FFY 03 state match expenditures, there was a decrease of about \$900,000. This is due to decreased state dollars for Pregnancy Maintenance Initiative, CSHCN program, and Comprehensive School Health Centers. The August and November allotments in the Fall of 2002 by the former state administration account for these decreases to MCH/CSHCN programs.

State expenditures include \$250,000 Tobacco Settlement funds in the Healthy Start Home Visitor program. The total state expenditures of \$3,898,357 is within the required federal match of \$3,863,528. Adding the local matching funds of \$1,799,964, a total of \$5,663,493 is matched to the MCH Block Grant. In addition, the State of Kansas is within the required maintenance of effort requirement of \$2,352,511.

Information about the Federal-State Title V Block Grant Partnership is provided on the spreadsheet in the attachments.

B. BUDGET

BUDGET FFY 05

The full amount of the federal Title V award, \$4,963,545 is budgeted for FFY 05. This is a decrease of 3.7% (\$187,825) from that awarded and budgeted for 04. For the ten-year period, from FY 95 through FY 04 there have been slight decreases in MCH Block Grant funding to Kansas (from \$4,986,175 in FY 95 to \$4,963,545 in FFY 04). Using a consumer price index calculator, the MCH Block Grant has lost 20% of its value over the last 10 years to inflation.

For FY 05, federal MCH dollars have been budgeted in conformance with the 30-30 requirement for Title V of the Social Security Act. Administrative costs are in compliance with the 10% limit. Kansas maintenance of effort requirement for State dollars is \$2,352,511 and Kansas is in compliance with the requirement. Kansas uses both State and local matching dollars to meet its federal 75% matching requirement for FY 05.

When SFY 04 appropriations (July 1, 2003 through June 6, 2004) were inadequate for the conduct of State business, the Governor reduced state funding to State agencies. The budget projection for FY 05 includes these reductions in State dollars to BCYF programs. The programs affected by the reductions included the following: CSHCN program (contracts and professional services), reductions in the number of Comprehensive School Health Centers, reductions in amount of funding for contracts with local agencies for MCH services. In previous years, all budget reductions were absorbed at the

State level. Local agencies had been held harmless from budget reductions. In FY 05, after two years of reductions, it was no longer possible to continue to absorb all cuts at the State level.

The MCH/CSHCN Directors provide input into the process of prioritizing programs for reduced resources and/or elimination. Input is provided after completion of analyses to determine continued compliance with the requirements of the federal legislation governing Title V. At this time Kansas is in compliance with all requirements of the law.

The Kansas economy has been slow to rebound compared to the U.S. The State revenue projections through the date of this grant submission continue to be lower than anticipated. KDHE continues its plans for rightsizing in order to sustain essential services and focus efforts on priorities. The five-year State MCH Needs Assessment process is expected to be useful in this process.

State dollars were reduced through the legislative appropriations process (notably \$300,000 for the Pregnancy Maintenance Initiative program), but the BCYF gained \$250,000 for a new Pregnancy Smoking Cessation program from Tobacco Settlement funds. Part C Infant Toddler program having achieved steady net gains in funding from all sources from SFY 02 to SFY 04, lost some ground in SFY 05 (\$7,123).

While the reductions seem to be slowing to some extent, there is still cost shifting from time to time in order to meet immediate needs.

The BCYF budget for FY 05 includes eleven CSHCN contracts as follows: UKSM, Wichita Medical Practice Assoc - \$83,500; KUMC, Dept of Pediatrics - \$125,362; Via Christi Regional Medical Center - \$65,700; KUMC, Developmental Disabilities Center - \$129,000; Cerebral Palsy Research Foundation, Wichita - \$35,000; Salina-Saline Department of Community Health - \$14,400; KUSM, Wichita - \$245,373; KUMC, Developmental Disabilities Center - \$146,000; Families Together - \$45,000; Wesley Medical Center - \$20,250; SIDS Network of Kansas \$25,000. In addition, Wichita Medical Research and Educational Foundation is reimbursed \$14 per sickle cell lab test. The Kansas State Department of Education and the Kansas Department of Social and Rehabilitation Services provide federal funding of \$31,000 total to support the Make a Difference Information Network. The State Department of Education provides \$7,000 for Special Child Clinics (rural outreach clinics (e.g., Oakley).

BCYF's Children & Families Section maintains contracts covering: perinatal and reproductive health services, and children and adolescent services. The contracts for this section include: comprehensive MCH services 85 contracts with local health departments and 4 other local agencies for coverage of all 105 counties; Family Planning 53 contracts with local health departments and 4 other local agencies for coverage of all counties; six contracts for the Section 510 Abstinence Education program; eleven teen pregnancy prevention projects; two disparity projects for youth; and, five contracts for comprehensive school health clinics.

For more detail about the breakdown of the Federal-State Title V Block Grant partnership, please see the attachment to this section.

A list of MCH contracts with local agencies for SFY 05 follows:

Barber Co Health Dept -- \$4,725
Barton Co Health Dept (multi county) -- \$65,569
Butler Co Health Dept -- \$43,000
Chase Co Health Dept -- \$2,551
Chautauqua Co Health Dept -- \$7,610
Cherokee Co Health Dept -- \$19,098
Cheyenne Co Health Dept -- \$3,300
Clay Co Health Dept -- \$41,133
Cloud Co Health Dept -- \$3,584

Coffey Co Health Dept -- \$2,000
Cowley Co Health Dept -- \$21,569
Crawford Co Health Dept -- \$30,701
Dickinson Co Health Dept -- \$39,967
Doniphan Co Health Dept ? \$10,694
Douglas Co Health Dept -- \$75,376
Edwards Co Health Dept -- \$6,609
Ellsworth Co Health Dept -- \$3,095
Finney Co Health Dept -- \$139,395
Ford Co Health Dept -- \$47,928
Franklin Co Health Dept -- \$9,761
Geary Co Health Dept -- \$105,100
Gove Co Health Dept ? \$3,115
Grant Co Health Dept -- \$9,039
Gray Co Health Dept - \$5,000
Greeley Co Health Dept - \$3,000
Greenwood Co Health Dept -- \$8,000
Hamilton Co Health Dept -- \$7,028
Harper Co Health Dept -- \$5,220
Harvey Co Health Dept -- \$47,958
Haskell Co Health Dept -- \$7,821
Hodgeman Co Health Dept -- \$3,600
Jefferson Co Health Dept -- \$18,427
Johnson Co Health Dept -- \$209,128
Kearny Co Health Dept -- \$5,640
Kingman Co Health Dept -- \$6,333
Kiowa Co Health Dept -- \$5,677
Labette Co Health Dept -- \$34,000
Lane Co Health Dept -- \$5,342
Leavenworth Co Health Dept -- \$76,000
Lincoln Co Health Dept -- \$4,714
Logan Co Health Dept -- \$4,720
Lyon Co Health Dept -- \$79,461
Marion Co Health Dept -- \$8,218
Marshall Co Health Dept ? \$13,713
McPherson Co Health Dept -- \$27,874
Meade Co Health Dept -- \$3,793
Miami Co Health Dept -- \$11,827
Mitchell Co Health Dept -- \$17,475
Montgomery Co Health Dept -- \$44,422
Morris Co Health Dept -- \$4,435
Morton Co Health Dept -- \$3,501
NEK (multi county) -- \$99,182
Nemaha Co Health Dept -- \$12,213
Neosho Co Health Dept -- \$20,260
Ness Co Health Dept ? \$3,535
Osage Co Health Dept -- \$15,913
Ottawa Co Health Dept -- \$9,500
Pawnee Co Health Dept -- \$6,321
Phillips Co Health Dept -- \$10,000
Pottawatomie Co Health Dept -- \$32,710
Pratt Co Health Dept -- \$9,000
Rawlins Co Health Dept -- \$1,792
Reno Co Health Dept -- \$112,650
Republic Co Health Dept -- \$7,240
Rice Co Health Dept -- \$8,860

Riley Co Health Dept -- \$123,355
Rooks Co Health Dept -- \$52,190
Rush Co Health Dept -- \$4,607
Saline Co Health Dept -- \$79,891
Scott Co Health Dept ? \$3,214
Sedgwick Co Health Dept -- \$596,657
SEK (multi county) -- \$56,984
Seward Co Health Dept -- \$95,098
Shawnee Co Health Dept -- \$486,666
Sheridan Co Health Dept -- \$3,000
Stafford Co Health Dept -- \$6,290
Stanton Co Health Dept -- \$4,178
Stevens Co Health Dept -- \$6,660
Sumner Co Health Dept -- \$15,489
Thomas Co Health Dept -- \$29,108
Wabaunsee Co Health Dept -- \$7,000
Washington Co Health Dept -- \$9,651
Wichita Co Health Dept ? \$2,990
Wilson Co Health Dept -- \$8,485
Wyandotte Co Health Dept -- \$754,423
CHC of SE Kansas -- \$64,912
Dodge City Family Planning Inc -- \$23,201
Hays Area Children's Center -- \$19,437
Mercy Hospital -- \$75,229

Teen Pregnancy Prevention Contracts for SFY 05

City of Arkansas FACT Project -- \$50,000
Wichita Family Services Institute -- \$54,000
YWCA of Salina -- \$50,000
YWCA of Topeka -- \$57,000
Crawford Co Health Dept -- \$30,000
Four Co Mental Health Center - \$76,274
Hunter Health Clinic -- \$73,034
Geary Co Health Dept -- \$81,567
Douglas Co Health Dept -- \$77,557
KUMC Project Hope -- \$98,034
Wichita Family Services Institute -- 54,204
Disparity SW Kansas -- Ford Co Kids Count -- \$94,558
Disparity Wichita -- Wichita Family Services Institute -- \$74,557

Comprehensive School Health Centers Contracts for SFY 05

Atchison Co Health Dept -- \$16,979
Geary Co Health Dept -- \$24,797
Stafford Schools USD #349 -- \$23,000
Sedgwick Co Health Dept -- \$42,385
St. John Schools ? \$69,583

Pregnancy Maintenance Initiative contracts for SFY 05

Gerard House -- \$0
Family Life Services -- \$0
Catholic Charities - \$0
Bethlehem House -- \$0

SIDS Network of Kansas contract for SFY 05-- \$25,000

Women's Right to Know budget for SFY 05-- \$36,000

Detailed information about the Title V budget is provided in the attached spreadsheet.

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.