

State of Kansas

Needs Assessment for Maternal, Infant and Early Childhood Home Visiting Program

September 20, 2010

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www.kdheks.gov/bcyf/home_visiting.htm

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Introduction

This mandatory document contains information that is supplemental to the Kansas grant under the "Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program." On July 15, 2010, Kansas was awarded FY 2010 funding through this 5-year program. This funding is conditional upon the State giving service priority to families residing in at-risk communities identified in this state needs assessment. The needs assessment also constitutes a condition for receiving FY 2011 Title V Maternal and Child Health Services Block Grant funds.

This document is the first step in a multi-step process to: (1) identify high risk communities for home visiting services; (2) assess current capacity in the state to provide services in high risk communities. This document contains only the required information preliminary to development of a more detailed needs assessment. The more detailed information will be submitted as the final step, (3) in the Kansas updated state plan to address home visiting needs in targeted high risk communities.

The Kansas home visiting program is designed: (1) to strengthen and improve the programs and activities carried out under Title V MCH; (2) to improve coordination of services for at risk communities; and (3) to identify and provide comprehensive services to improve outcomes for families who reside in at risk communities. Home visiting is viewed as one of several service strategies in a comprehensive high-quality early childhood system that promotes maternal, infant, and early childhood health, safety, and development and strong parent-child relationships. Home visiting services are promoted that rely on best available research evidence to inform and guide practice. Close collaboration across multiple agencies and programs in Kansas at both the State and local levels is essential to effective home visiting and early childhood systems.

The Kansas program envisions child development within the framework of life course development and a socio-ecological framework. Life course points to broad social, economic, and environmental factors as underlying contributors to poor health and development outcomes for children as well as to persistent inequalities in the health and well-being of children and families. The socio-ecological framework emphasizes that children develop within families, families exist within a community, and the community is surrounded by the larger society. These systems interact with and influence each other to either decrease or increase risk factors or protective factors that affect a range of health and social outcomes.

This document contains the concurrence through letters of support of the following individuals:

- Director of the State's Title V agency - Roderick L. Bremby, Secretary, Kansas Department of Health and Environment;
- Director of the State's agency for Title II of the Child Abuse Prevention and Treatment Act (CAPTA) - James Redmon, Executive Director, Children's Cabinet and Trust Fund;
- Director of the State's Single State Agency for Substance Abuse Services - Don Jordan, Secretary, Kansas Department of Social and Rehabilitation Services; and
- Director of the State's Head Start State Collaboration Office - Don Jordan, Secretary, Kansas Department of Social and Rehabilitation Services.
- Director of the State Education Agency - Diane DeBacker, Interim Commissioner of Education

In order to ensure that home visiting is part of a continuum of early childhood services within Kansas, to the extent possible and within existing time limits, this needs assessment has been coordinated with the strategic plans of the Head Start Act's State Advisory Council, the Kansas child care agency (SRS), the State education agency (KSDE), the child welfare agency (SRS), and the Kansas Part C (KDHE) and Part B (Kansas State Department of Education - KSDE) lead agencies.

Section 1: Statewide Data Report

The first step in the needs assessment for the Kansas Home Visiting Program is to identify areas of the state with populations of pregnant women, infants and children with the highest risks for poor birth outcomes, child neglect, abuse and maltreatment, low school readiness, not graduating from high school, crime and domestic violence, unemployment and poor family economic self-sufficiency, and use of tobacco, alcohol, and other substances.

The methodology used to prioritize communities at highest risk involves ranking communities on indicators of (a) the overall health of each community (i.e., behavioral, social and environmental determinants of health and poor health outcomes); and (b) the health and well-being of pregnant women, infants, and children.

Data Sources - Indicators of High Risk for Poor Community Health

The *Kansas County Health Rankings* are used to prioritize communities at highest risk. In 2009, the Kansas Health Institute (KHI) ranked all 105 Kansas counties based on a summary measure of the health of their residents www.khi.org/news/2009/may/07/kansas-county-health-rankings-2009/. This health index was calculated by analyzing two sets of indicators — health determinants and health outcomes. The health determinant indicators include the multiple social, environmental, and behavioral factors that influence the health and well-being of a child, and those determinants of low birth weight and preterm birth. The logic model and weighting scheme are illustrated in Figure 1. The technical report for these indicators is available at http://media.khi.org/news/documents/2009/09/03/KansasCountyHealthRanking2009DataElements_.pdf.

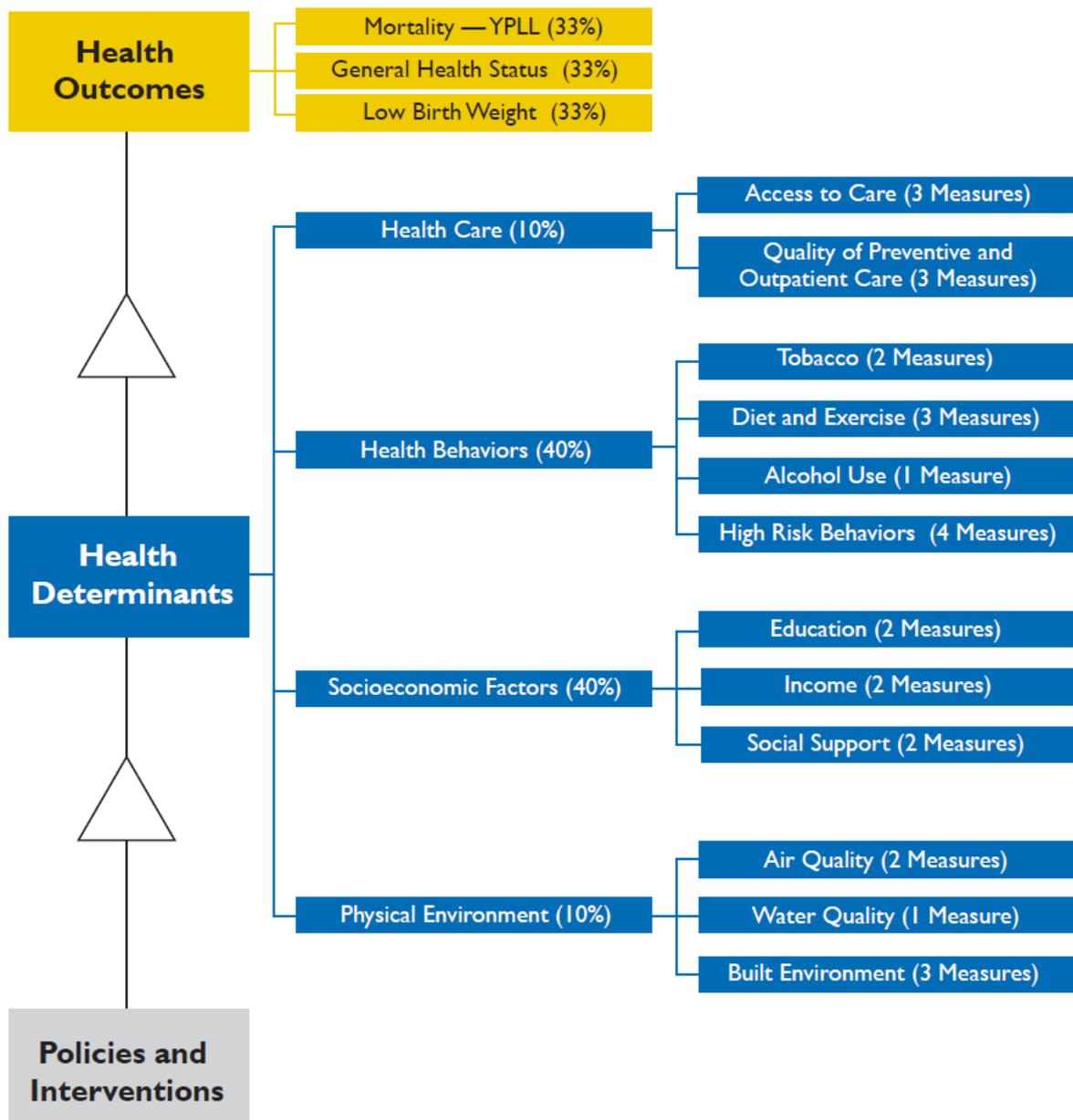
Data Sources - Indicators of High Health Risk for Pregnant Women and Children from Birth to Age 8 Years

The following data sources are used to compute key indicators of (i) premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health; (ii) poverty; (iii) crime; (iv) domestic violence; (v) high rates of high-school dropouts; (vi) substance use disorder; (vii) unemployment; or (viii) child maltreatment, as described in section 511(b)(1) and in the first two paragraphs of the "Full Needs Assessment Guidance" section under Award Information, Summary of Funding (II.2.2).

- Kansas certificate of live birth
- Kansas certificate of death and linked birth/infant death data
- U.S. Census Bureau, Bridged-Race Population Estimates 2000-2008
- U.S. Census Bureau, Small Area Income and Poverty Estimates (SAIPE)
- Kansas Bureau of Investigation, Adult and Juvenile Arrests by Agency Reports
- Kansas Bureau of Investigation, Report on Domestic Violence and Rape Statistics in Kansas As Reported By Law Enforcement Agencies
- Kansas Department of Social and Rehabilitation Services (SRS), Child and Family Services program data, Family and Child Tracking System (FACTS)

- Kansas State Department of Education, 5-year public school dropouts (2003-2004 through 2007-2008)
- Department of Social and Rehabilitation Services (SRS), Child and Family Services program data on substantiated child maltreatment victims, Family and Child Tracking System (FACTS)
- Department of Social and Rehabilitation Services (SRS), Addiction and Prevention Services program data
- Kansas Department of Labor, Annual Labor Force Statistics Report and Affirmative Action Report

Figure 1. Logic Model for the “Kansas County Health Rankings 2009”²



TOP QUARTILE		UPPER MIDDLE QUARTILE		LOWER MIDDLE QUARTILE		BOTTOM QUARTILE	
RANK	COUNTY	RANK	COUNTY	RANK	COUNTY	RANK	COUNTY
1	Gove	27	Douglas	53	Morton	80	Greenwood
2	Sheridan	28	Washington	54	Wallace	81	Osage
3	Johnson	29	Edwards	55	Stafford	82	Neosho
4	Greeley	30	Stanton	56	Sumner	83	Sherman
5	Logan	31	Graham	57	Kingman	84	Grant
6	Pottawatomie	32	Rooks	58	Rice	85	Sedgwick
7	Mitchell	33	Gray	59	Cloud	86	Cowley
8	Nemaha	34	Trego	60	Phillips	87	Brown
9	McPherson	35	Clay	61	Republic	88	Wichita
10	Jewell	36	Marshall	62	Linn	89	Hamilton
11	Kiowa	37	Miami	63	Saline	90	Seward
12	Lane	38	Haskell	64	Rush	91	Finney
13	Riley	39	Ottawa	65	Harper	92	Chautauqua
14	Smith	40	Butler	66	Doniphan	93	Anderson
15	Chase	41	Cheyenne	67	Russell	94	Allen
16	Scott	42	Ellis	68	Lyon	95	Elk
17	Wabaunsee	43	Clark	69	Reno	96	Atchison
18	Decatur	44	Stevens	70	Franklin	97	Crawford
19	Rawlins	45	Barber	71	Jackson	98	Cherokee
20	Meade	46	Morris	72	Pawnee	99	Wilson
21	Harvey	47	Ness	73	Pratt	100	Bourbon
22	Hodgeman	48	Jefferson	74	Dickinson	101	Woodson
23	Thomas	49	Coffey	75	Kearny	102	Geary
24	Comanche	50	Leavenworth	76	Ford	103	Labette
25	Marion	51	Norton	77	Osborne	104	Montgomery
26	Ellsworth	52	Lincoln	78	Shawnee	105	Wyandotte
				79	Barton		

Rankings Based on High Health Risk for Pregnant Women and Children, Birth to Age 8 Years

The second step is to rank all 105 counties by rates of poor child, infant, and maternal health in the specific categories (i-viii). The method for this step is as follows. First, available data sources and indicators for each of the eight federal risk categories are evaluated to identify the subset of ‘best’ indicators for each category (i–viii), taking into account face validity, data source, data availability for each county, and stability of estimate for rural and frontier counties. See Table 1 for a description of the indicators and their data sources.

Next, each county is ranked (1 to 105) on each federal indicator variable. To obtain county rankings *within* each of the eight federal categories (i-viii), median ranks of the indicators within each category are computed. Lastly, median ranks are computed *across* the federal categories for each county, yielding the “federal indicator overall rankings” reported in Table 2.

Table 1. Indicators of High Health Risk for Pregnant Women and Children

Indicator	Data Source
(i) Premature birth, low-birth weight infants, and infant mortality , including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health	
Percent Preterm Births , defined as live births that occurred before the 37th week of pregnancy (2005-2008)	Kansas Certificate of Live Birth Data. Kansas Department of Health and Environment, Bureau of Public Health Informatics
Percent Low Birth Weight Births , defined as infants born weighing less than 2,500 grams (2005-2008)	Kansas Certificate of Live Birth Data. Kansas Department of Health and Environment, Bureau of Public Health Informatics
Infant Mortality Rate per 1,000 Live Births (2005-2008)	Kansas Annual Summary of Vital Statistics. Kansas Department of Health and Environment, Bureau of Public Health Informatics
Percent Out-of-Wedlock Births , defined as live births born to unmarried women (2005-2008)	Kansas Certificate of Live Birth Data. Kansas Department of Health and Environment, Bureau of Public Health Informatics
Percent Mothers with Less than High School Education (2005-2008)	Kansas Certificate of Live Birth Data. Kansas Department of Health and Environment, Bureau of Public Health Informatics
Percent Mothers Smoking During Pregnancy (2005-2008)	Kansas Certificate of Live Birth Data. Kansas Department of Health and Environment, Bureau of Public Health Informatics
Teen Birth Rate per 1,000 Teenage Females Age 10 – 19 (2005-2008)	Kansas Certificate of Live Birth Data. Kansas Department of Health and Environment, Bureau of Public Health Informatics
Percent Uninsured Delivery , defined as self-pay for principal payment source (2005-2008)	Kansas Certificate of Live Birth Data. Kansas Department of Health and Environment, Bureau of Public Health Informatics
Percent Delayed Prenatal Care , defined as mothers that did not begin prenatal care in the first trimester (2005-2008)	Kansas Certificate of Live Birth Data. Kansas Department of Health and Environment, Bureau of Public Health Informatics
Percent First Time Mothers (2005-2008)	Kansas Certificate of Live Birth Data. Kansas Department of Health and Environment, Bureau of Public Health Informatics
(ii) Poverty	
Percent of Children age 0 – 17 in Poverty (2008)	Small Area Income and Poverty Estimates. US Census Bureau
(iii) Crime	
Adult Total Crime Index , defined as arrests per 1,000 adult population age 18 - 64 (2004-2008)	Adult Arrests By Agency. Kansas Bureau of Investigation

Indicator	Data Source
Juvenile Total Crime Index , defined as arrests per 1,000 children age 5 – 17 (2004-2008)	Juvenile Arrests By Agency. Kansas Bureau of Investigation
(iv) Domestic Violence	
Domestic Violence Incidence Rate per 1,000 Population Age 5 – 64 (2004-2008)	Domestic Violence And Rape Statistics. Kansas Bureau of Investigation
(v) High School Dropout	
High School (grades 7 – 12) Dropout Rate per 1,000 High School Enrollees (School Year 2003/04 – 2007/08)	Kansas K-12 reports. Kansas State Department of Education
(vi) Substance Use Disorder	
Number of Methamphetamine Seizures (2004-2009)	Methamphetamine Seizures by County. Kansas Bureau of Investigation
Adult Total Drug Arrests Rate per 1,000 (2004-2008)	Adult Arrests By Agency. Kansas Bureau of Investigation.
Juvenile Total Drug Arrests Rate per 1,000 (2004-2008)	Juvenile Arrests By Agency. Kansas Bureau of investigation.
Substance Abuse Pregnant Women Rate per 1,000 Women Age 15 – 44 (SFY 2003-2009)	Substance Abuse Admission program data. Department of Social and Rehabilitation Services, Prevention Treatment Services.
(vii) Unemployment	
Percent Unemployed (2004-2008)	Annual Unemployment by County. Kansas Department of Labor
(viii) Child Maltreatment	
Child Maltreatment Incident Rate per 1,000 Children (SFY 2005-2008)	Family and Child Tracking System (FACTS). Department of Social and Rehabilitation Services, Children and Family Services Data Unit

Findings

Table 2 reports the county health rankings (column 2) and the rankings across (column 3) and within each of the eight federal risk categories (columns 4 to 11). The counties in the poorest health quartile of the *County Health Rankings* (ranked 80 to 105) are listed in Table 2 along with two additional counties, Shawnee (ranked 78 in *County Health Rankings*) and Saline (ranked 63 in *County Health Rankings*).

With the exception of Shawnee County, the yellow highlight denotes counties with *both* the highest median rankings across the federal home visiting at-risk categories *and* in the poorest health quartile of the *County Health Rankings*. Shawnee County is included because it has the highest federal home visiting at-risk ranking and is just outside the poorest health quartile of the *County Health Rankings* (i.e., ranking 78 versus 80). Three of the highlighted counties, Bourbon, Crawford, and Montgomery, are rural counties in Southeast Kansas, as are Cherokee and Labette, which also have high rankings for the federal home visiting at-risk measures. These data point to rural Southeast Kansas along with the counties of Sedgwick, Shawnee, and Wyandotte, that have urban cores, as high risk communities for purposes of this assessment. For the purposes of assessing capacity, Kansas will focus on Sedgwick, Shawnee and Wyandotte, as well as select counties in the Southeast region.

Table 2. Kansas Home Visiting Priority Communities

County	County Health Ranking	Federal Indicators (i - viii) Overall Ranking	(i) Birth (High Risk)	(ii) Poverty	(iii) Crime	(iv) Domestic Violence	(v) High School Dropout	(vi) Substance Use	(vii) unemployment	(viii) Child Maltreatment
Shawnee	78	105	72.5	52	100	98	96	90.5	88	93
Montgomery	104	102	85.5	81	93	78	89	92	96	98
Bourbon	100	102	82	101	69.5	89	102	92	77	95
Crawford	97	102	75.5	97	90	91	61	76.5	93	102
Sedgwick	85	100	72	47	101	103	97	98.5	83	54
Saline	63	100	81	56	104.5	93	99	95	62	87
Wyandotte	105	99	86	103	91	82	103	80.5	105	84
Cherokee	98	98	81.5	102	47	76	91	79.5	98	101
Cowley	86	97	75.5	90	87.5	102	81	90.5	80	83
Labette	103	95	77	93	66	100	66	73.5	99	96
Finney	91	95	86	84	96.5	95	93	78	50	21
Atchison	96	94	62.5	60	103	79	100	83	86	86

Geary	102	93	71.5	27	99	104	86	82.5	91	76
Barton	79	92	86.5	77	80.5	99	62	90.5	49	91
Wilson	99	91	81.5	87	62.5	60	84	91	73	94
Allen	94	90	81.5	100	77.5	94	78	82	78	100
Brown	87	88	59.5	94	87.5	80	95	79	71	79
Neosho	82	87	68	91	44.5	69	88	82.5	74	105
Seward	90	85	81.5	68	103	101	104	61.5	33	29
Sherman	83	84	75	92	86	74	90	61	13	71
Wichita	88	81	88.5	86	71	57	75	13.5	19	74
Chautauqua	92	79	75	94	59	66	64	57.5	84	89
Anderson	93	75	50	89	62	67	79	62	92	42
Grant	84	73	77	38	73	90	98	53.5	15	17
Woodson	101	71	53.5	105	37	45	70	35.5	103	99
Osage	81	70	59.5	40	39	59	63	71	102	82
Greenwood	80	55	62	98	27.5	43	46	30	90	65
Elk	95	49	76	104	34.5	52	21	40.5	94	37
Hamilton	89	2	77	68	11	7	4	1	25	1

The statewide data report was completed using data as available from the Title V, CAPTA, Head Start, and SAMHSA Sub-State Treatment Planning data reports, plus additional sources as available. The State Data Report follows. State data is presented as a reference point for a review of county-level data.

Table 3. State Data Report

Kansas

<u>Indicator</u>	<u>Title V</u>	<u>CAPTA</u> ¹	<u>Head Start</u> ²	<u>SAMHSA</u> ³	<u>Other</u>	<u>Comments</u>
<u>Premature birth</u> -Percent: # live births before 37 weeks/total # live births	9.3% (3873/41815)	--	--	--		2008, Data source: Kansas Dept of Health and Environment Birth Stats Query
<u>Low-birth-weight infants</u> -Percent: # resident live births less than 2500 grams/# resident live births	7.2% (3014/41815)	--	--	--		2008, Data source: Kansas Dept of Health and Environment Birth Stats Query
<u>Infant mortality (includes death due to neglect)</u> -# infant deaths ages 0-1/1,000 live births	7.25 (303/41815)	--	--	--		2008, Data source: Kansas Dept of Health and Environment Vital Stats Annual Summary
<u>Poverty</u> -# residents below 100% FPL/total # residents		--		--	11.3%	2008, Data Source: US Census QuickFacts: Persons below poverty level, percent
<u>Crime</u> • # reported crimes/1000 residents	--	--	--	--	36.8	2008, Data Source: Kansas Bureau of Investigation (KBI) Crime Index
• # crime arrests ages 0-19/100,000juveniles age 0-19					2178.6 (15,352/	2008, Data Source: Kansas Bureau of

¹ CAPTA information is often qualitative rather than quantitative and may be most usefully addressed in the narrative section to provide information on existing home visiting programs and resources.

² Data collected by Head Start and Early Head Start grantees for their community-wide strategic planning and needs assessments may not be present in every identified at-risk community (especially for Early Head Start). Second, Head Start and Early Head Start grantees are not required to use uniform data sources or metrics so there is likely to be wide variation in the data.

³ SAMHSA Sub-State Treatment Planning Data Report

					704,687*)	Investigation (KBI) Juvenile Arrests by *2009, Data Source: US Agency Census QuickFacts: estimate
<u>Domestic violence</u> -As determined by each State in conjunction with the State agencies administering the FVPSA	--	--		--	22,465	2008, Data Source: KBI "A Report On Domestic Violence and Rape Statistics In Kansas"
<u>School Drop-out Rates</u> -Percent high school drop-outs grades 9-12 -Other school drop-out rates as per State/local calculation method		--	--	--	9.9% (3537/358 91)	2007-2008, Data Source: Kansas Dept of Education, Kansas K-12 Reports
<u>Substance abuse</u>		--	--		31.8%	2008-2009, Data Source: Southeast Kansas Education Service Center, "Kansas Communities that Care"
• <u>Past 2 week binge drinking – 12th grade</u>						
• <u>Past month marijuana – 12th grade</u>					16.7%	
• <u>Past month prescription pain relievers – 12th grade</u>					6.88%	*2009-2010, Data Source: Southeast Kansas Education Service Center, "Kansas Communities that Care"
• <u>Past month methamphetamine – 12th grade</u>					1.8%	
• <u>Past month cocaine/crack – 12th grade</u>					2.4%	
• <u>Past month heroin – 12th grade*</u>					1.49%	

<u>Unemployment</u> -Percent: # unemployed and seeking work/total workforce	--	--		--	6.9%	2009, Data Source: Bureau of Labor Statistics
<u>Child maltreatment</u> -# of substantiations/1,000 children	--			--	2.9 (2020/704,687*)	2009, Data Source: SRS *2009, Data Source: US Census QuickFacts: estimate
-Assigned reports of maltreatment by type <ul style="list-style-type: none"> • Emotional Abuse • Lack of Supervision • Physical Abuse • Medical Neglect • Physical Neglect • Sexual Abuse • Abandonment 					1396 1540 410 3296 1496 1047 56	2009, Data Source: SRS, CINC Reports Assigned to Investigate Alleged Maltreatment Note: A CINC report can be assigned for more than one maltreatment reason thus these numbers are not unduplicated cases.
<u>Other indicators of at risk prenatal, maternal, newborn, or child health</u> - As available				--		

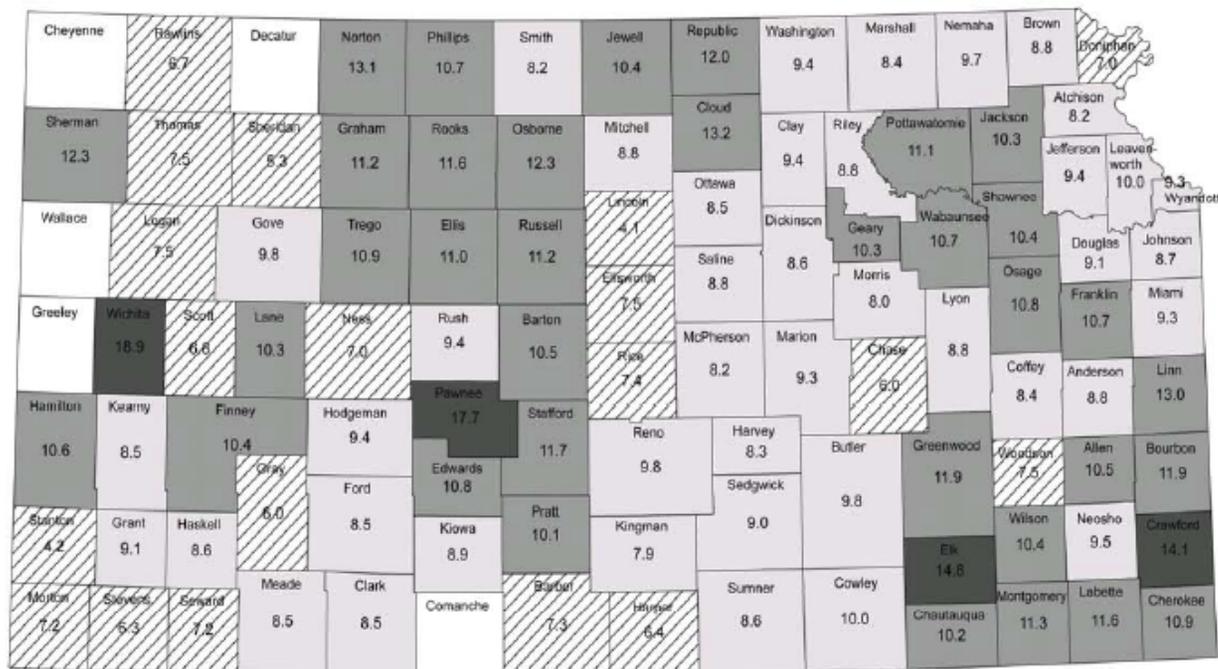
Section 2: Unit Selected as Community

County-level data (105 counties) were used for this phase of the needs assessment process. In Kansas, most data are collected and reported at the county level.

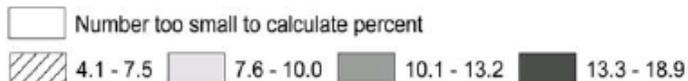
Two of the counties identified as "at risk communities" in Section 1 include large metropolitan areas (Wyandotte and Sedgwick). Zip code and census tract data will be used during the State plan phase to target areas within the counties for home visiting services. For purposes of the updated state plan, a regional/area or multi-county approach will be used for the high-risk rural counties of Southeast Kansas. Therefore, the unit selected as community will be county except for large metropolitan counties where zip code and/or census tract will be selected as community and for rural areas where region or multi-county will be selected as community.

Figures 3-12 map out the federally required data on a county-level for this needs assessment. These maps provide additional justification for the units selected as high risk.

Percent Preterm Births* Kansas, 2005-2008



County	Percent Preterm Birth 2005-2008	Ranking (1=Highest)
Kansas	9.4	
Crawford	14.1	4
Montgomery	11.3	16
Sedgwick	9.0	57
Shawnee	10.4	33
Wyandotte	9.3	53



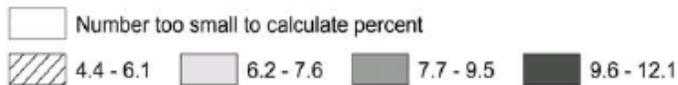
Kansas: 9.4

*Defined as live births that occurred before the 37th week of pregnancy.

Note: Missing, unknown and not stated are excluded from the denominator.

Source: Kansas Certificate of Live Birth Data. Kansas Department of Health and Environment, Bureau of Public Health Informatics

Percent Low Birth Weight* Live Births Kansas, 2005-2008



Kansas: 7.2

*Defined as infants born weighing less than 2,500 grams.

Note: Missing, unknown and not stated are excluded from the denominator.

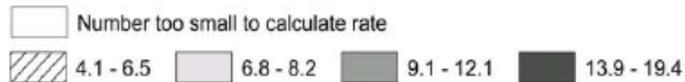
Source: Kansas Certificate of Live Birth Data. Kansas Department of Health and Environment, Bureau of Public Health Informatics

County	Percent Low Birth Weight 2005-2008	Ranking (1=Highest)
Kansas	7.2	
Crawford	8.5	15
Montgomery	9.2	10
Sedgwick	8.0	31
Shawnee	7.7	34
Wyandotte	8.2	25

Infant Mortality Rate per 1,000 Live Births Kansas, 2005-2008

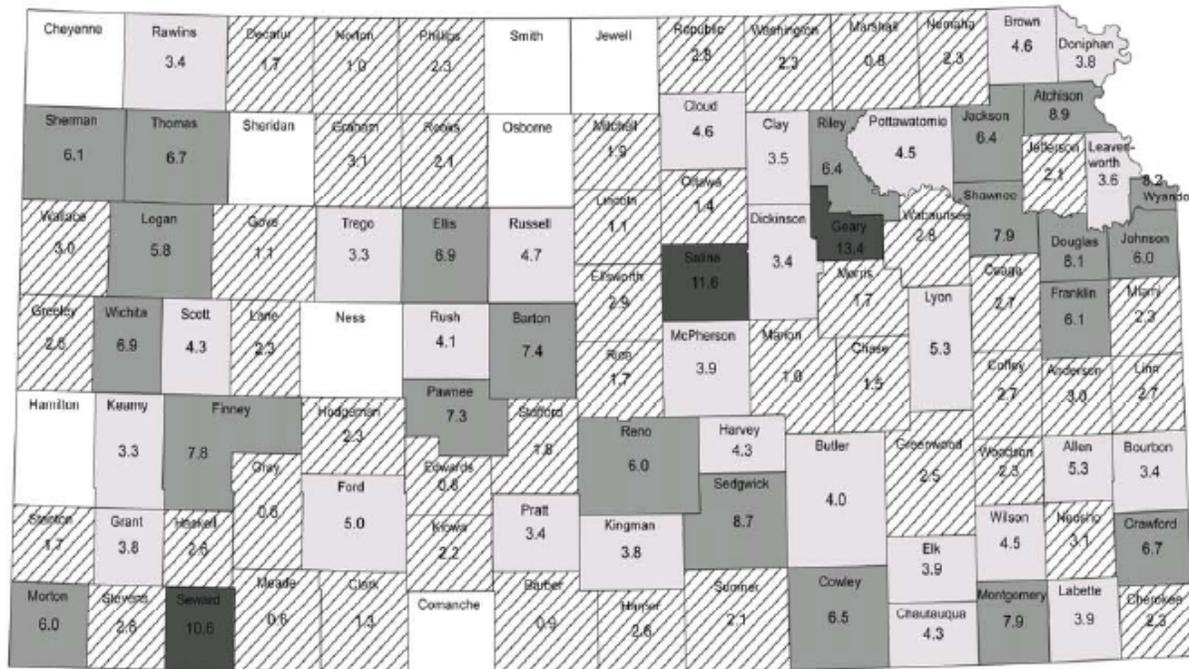


County	Infant Mortality Rate 2005-2008	Ranking (1=Highest)
Kansas	7.5	
Crawford	7.9	17
Montgomery	6.5	22
Sedgwick	8.2	14
Shawnee	9.3	11
Wyandotte	9.5	10

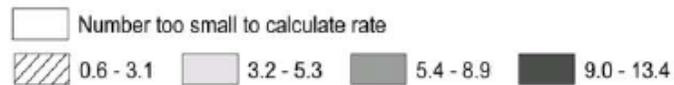


Kansas: 7.5

Adult Total Crime Index Arrests per 1,000 Adult Population Ages 18-64 Kansas, 2004-2008



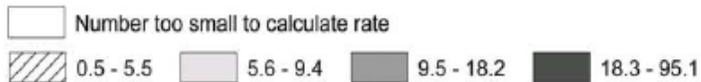
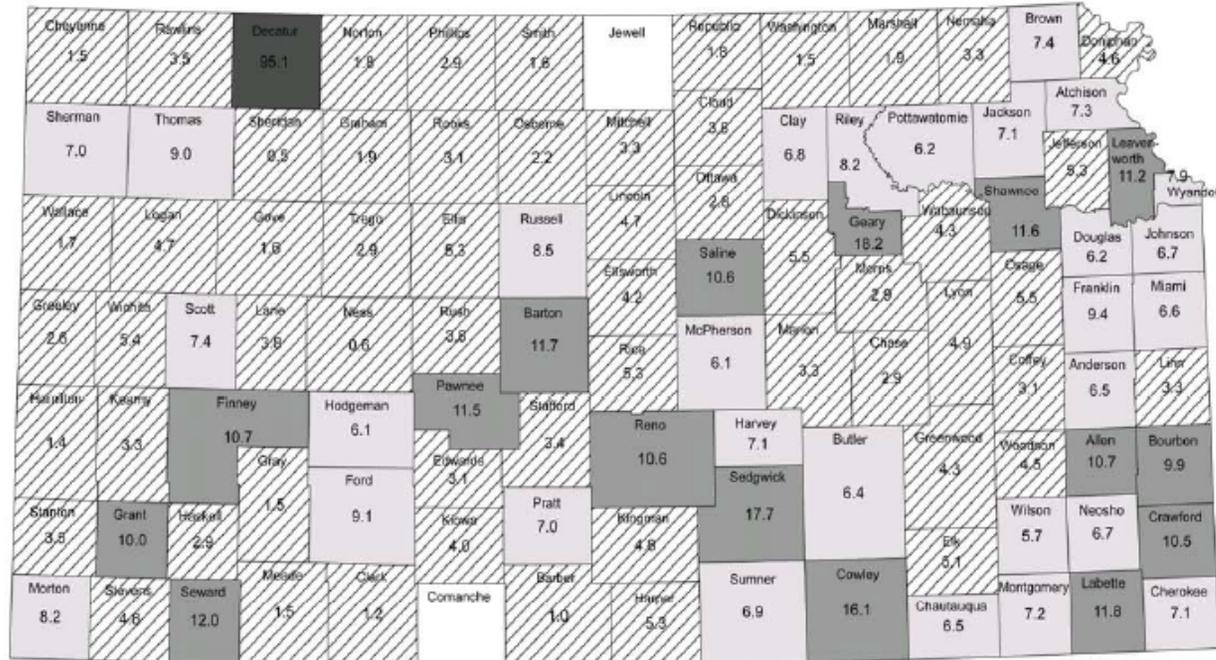
County	Adult Total Crime Index Rate 2004-2008	Ranking (1=Highest)
Kansas	6.3	
Crawford	6.7	16
Montgomery	7.9	8
Sedgwick	8.7	5
Shawnee	7.9	8
Wyandotte	8.2	6



Kansas: 6.3

Source: Adult Arrests By Agency, 2004-2008. Kansas Bureau of Investigation

Domestic Violence Incidence Rate per 1,000 Population Ages 5-64 Kansas, 2003-2008

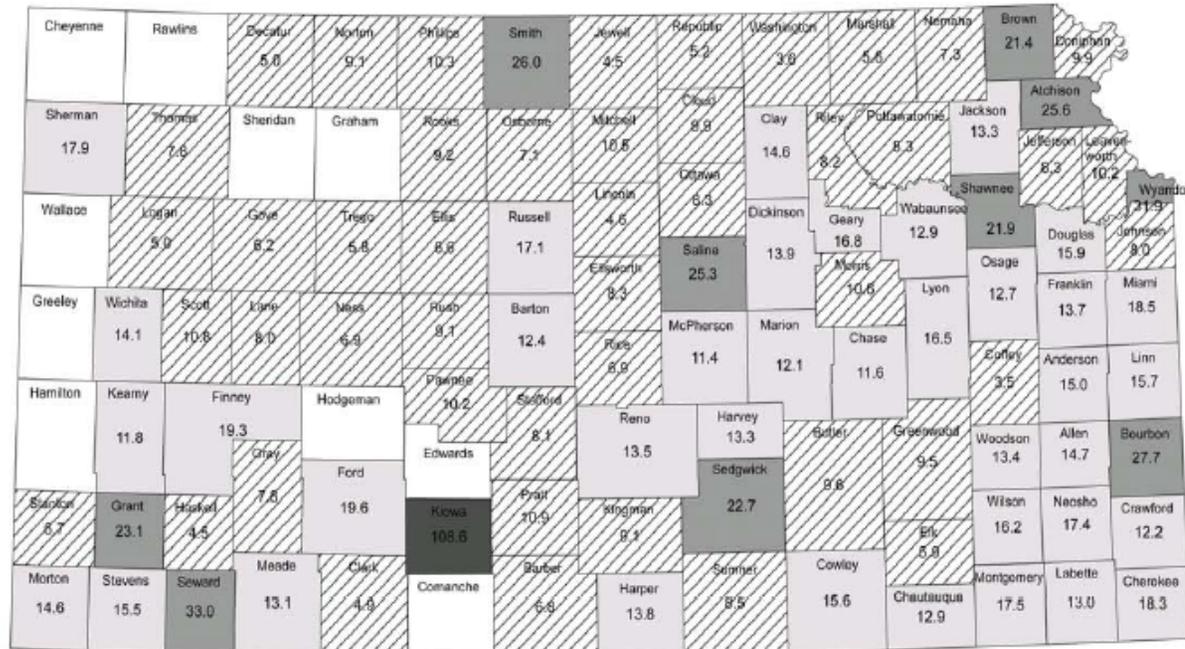


Kansas: 9.5

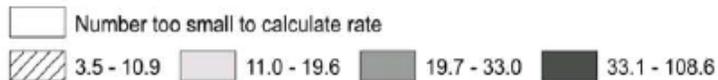
County	Domestic Violence Incidence Rate 2003-2008	Ranking (1=Highest)
Kansas	9.5	
Crawford	10.5	15
Montgomery	7.2	28
Sedgwick	17.7	3
Shawnee	11.6	8
Wyandotte	7.9	24

Source: Domestic Violence and Rape Statistics, 2003-2008. Kansas Bureau of Investigation

High School (Grades 7-12) Dropout Rate per 1,000 High School Enrollees Kansas, School Year 2004/05 - 2008/09



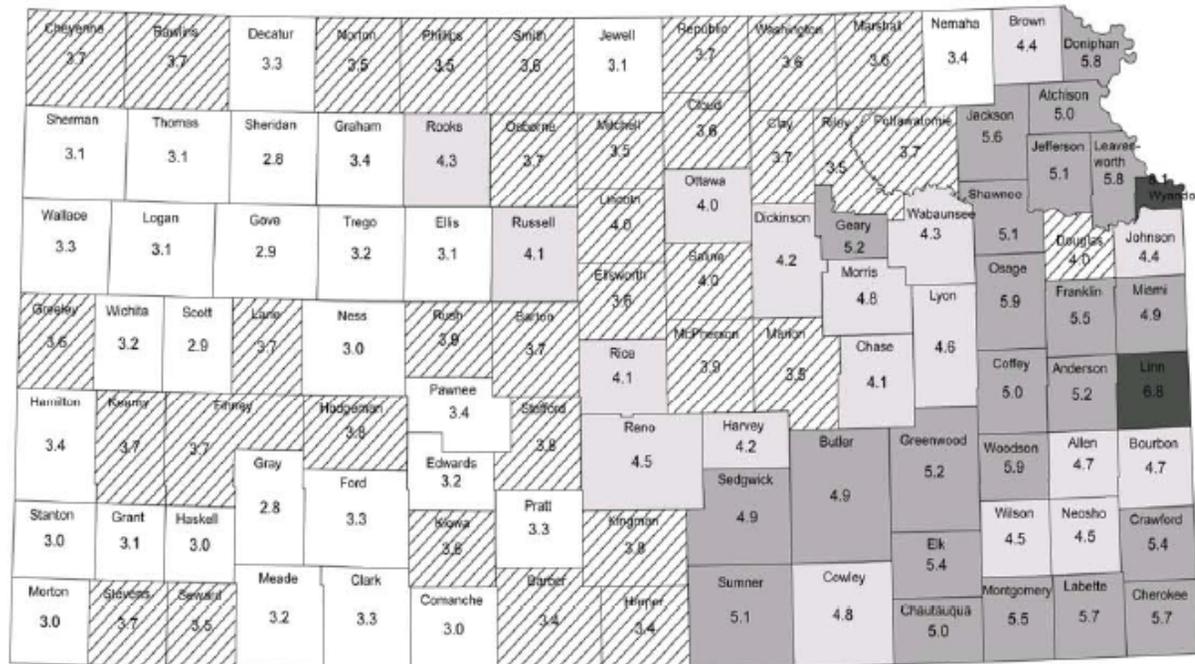
County	High School Dropout Rate 2004/05-2008/09	Ranking (1=Highest)
Kansas	15.7	
Crawford	12.2	45
Montgomery	17.5	17
Sedgewick	22.7	9
Shawnee	21.9	10
Wyandotte	31.9	3



Kansas: 15.7

Source: Kansas K-12 Reports. Kansas State Department of Education

Percent Unemployed Labor Force Kansas, 2004-2008



2.8 - 3.4
 3.5 - 4.0
 4.1 - 4.8
 4.9 - 5.9
 6.0 - 8.1
 Kansas: 4.7

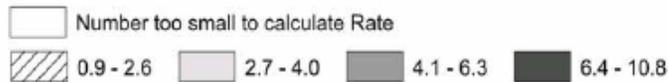
County	Percent Unemployed 2004-2008	Ranking (1=Highest)
Kansas	4.7	
Crawford	5.4	13
Montgomery	5.5	10
Sedgwick	4.9	23
Shawnee	5.1	18
Wyandotte	8.1	1

Source: Annual Unemployment by County, 2004-2008. Kansas Department of Labor

Child Maltreatment Incident Rate per 1,000 Children (Ages 0-17) Kansas, SFY 2005-2008



County	Child Maltreatment Rate SFY 2005-2008	Ranking (1=Highest)
Kansas	3.6	
Crawford	8.4	4
Montgomery	8.0	8
Sedgwick	2.8	53
Shawnee	6.3	13
Wyandotte	4.6	22



Kansas: 3.6

Source: Family and Child Tracking System (FACTS).
 Department of Social and Rehabilitation Services, Children and Family Services Data Unit

There are four federally recognized Indian tribes in Kansas. All these are located in extreme northeastern Kansas with a population totaling 9,599 (Bureau of Indian Affairs website). The tribal office for the Prairie Band of Potawatomie is located in Mayetta (Jackson Co). The tribe has 12 Early Head Start slots and 32 Head Start slots, all of which are federally funded. The Kickapoo of Kansas tribal office is in Horton (Brown Co). The tribe has a Head Start program with 30 federally funded slots and 10 Early Head Start slots funded by federal ARRA expansion. The HS/EHS center is located in White Cloud (Doniphan Co). The Iowa of Kansas tribal office is also in White Cloud. The Iowa of Kansas reservation straddles state borders in Brown Co, and the Nebraska county of Richardson. The Sac and Fox Tribe of Missouri in Kansas and Nebraska tribal office is located in the town of Reserve (Brown Co). Data for Kansas tribes are included in the Kansas needs assessment in the data for Jackson, Brown, and Doniphan counties.

Section 3: Community Data Reports

A community data report was completed for county identified in Section 1 using the federally required indicators and the Appendix A format from the August 19, 2010 Supplemental Information Request (SIR).

The community data reports are provided in Tables 4-8. A description of the data used to populate the tables is provided in the comments sections.

Crawford

<u>Indicator</u>	<u>Title V</u>	<u>CAPTA</u> ⁴	<u>Head Start</u> ⁵	<u>SAMHSA</u> ⁶	<u>Other</u>	<u>Comments</u>
<u>Premature birth</u> -Percent: # live births before 37 weeks/total # live births	11.9% (63/529)	--	--	--		2008, Data source: Kansas Dept of Health and Environment Birth Stats Query
<u>Low-birth-weight infants</u> -Percent: # resident live births less than 2500 grams/# resident live births	6.8% (36/529)	--	--	--		2008, Data source: Kansas Dept of Health and Environment Birth Stats Query
<u>Infant mortality (includes death due to neglect)</u> -# infant deaths ages 0-1/1,000 live births	5.7 (3/529)	--	--	--		2008, Data source: Kansas Dept of Health and Environment Vital Stats Annual Summary
<u>Poverty</u> -# residents below 100% FPL/total # residents		--		--	18.3%	2008, Data Source: US Census QuickFacts: Persons below poverty level, percent
<u>Crime</u> • # reported crimes/1000 residents	--	--	--	--	50.9	2008, Data Source: Kansas Bureau of Investigation (KBI) Crime Index
• # crime arrests ages 0-19/100,000juveniles age 0-19					1,174.8 (100/8512*)	2008, Data Source: Kansas Bureau of

⁴ CAPTA information is often qualitative rather than quantitative and may be most usefully addressed in the narrative section to provide information on existing home visiting programs and resources.

⁵ Data collected by Head Start and Early Head Start grantees for their community-wide strategic planning and needs assessments may not be present in every identified at-risk community (especially for Early Head Start). Second, Head Start and Early Head Start grantees are not required to use uniform data sources or metrics so there is likely to be wide variation in the data.

⁶ SAMHSA Sub-State Treatment Planning Data Report

						Investigation (KBI) Juvenile Arrests by Agency *2009, Data Source: US Census QuickFacts: estimate
<u>Domestic violence</u> -As determined by each State in conjunction with the State agencies administering the FVPSA	--	--		--	296	2008, Data Source: KBI “A Report On Domestic Violence and Rape Statistics In Kansas”
<u>School Drop-out Rates</u> -Percent high school drop-outs grades 9-12 -Other school drop-out rates as per State/local calculation method		--	--	--	3.8% (16/426)	2007-2008, Data Source: Kansas Dept of Education, Kansas K- 12 Reports
<u>Substance abuse</u> • <u>Past 2 week binge drinking – 12th grade</u>	--	--			33.3%	2008-2009, Data Source: Southeast Kansas Education Service Center, “Kansas Communities that Care” *2009-2010, Data Source: Southeast Kansas Education Service Center, “Kansas Communities that Care”
• <u>Past month marijuana – 12th grade</u>					16.9%	
• <u>Past month prescription pain relievers – 12th grade</u>					8.4%	
• <u>Past month methamphetamine – 12th grade</u>					1.9%	
• <u>Past month cocaine/crack – 12th grade</u>					.8%	
• <u>Past month heroin – 12th grade*</u>					.76%	

<u>Unemployment</u> -Percent: # unemployed and seeking work/total workforce	--	--		--	8.7%	2009, Data Source: Bureau of Labor Statistics
<u>Child maltreatment</u> -# of substantiations/1,000 children	--			--	12.5 (106/8512*)	2009, Data Source: SRS *2009, Data Source: US Census QuickFacts: estimate
-Assigned reports of maltreatment by type <ul style="list-style-type: none"> • Emotional Abuse • Lack of Supervision • Physical Abuse • Medical Neglect • Physical Neglect • Sexual Abuse • Abandonment 					100 133 207 29 132 68 2	2009, Data Source: SRS, CINC Reports Assigned to Investigate Alleged Maltreatment Note: A CINC report can be assigned for more than one maltreatment reason thus these numbers are not unduplicated cases.
<u>Other indicators of at risk prenatal, maternal, newborn, or child health</u> - As available				--		

Montgomery

<u>Indicator</u>	<u>Title V</u>	<u>CAPTA</u> ⁷	<u>Head Start</u> ⁸	<u>SAMHSA</u> ⁹	<u>Other</u>	<u>Comments</u>
<u>Premature birth</u> -Percent: # live births before 37 weeks/total # live births	10.7% (54/504)	--	--	--		2008, Data source: Kansas Dept of Health and Environment Birth Stats Query
<u>Low-birth-weight infants</u> -Percent: # resident live births less than 2500 grams/# resident live births	8.7% (44/504)	--	--	--		2008, Data source: Kansas Dept of Health and Environment Birth Stats Query
<u>Infant mortality (includes death due to neglect)</u> -# infant deaths ages 0-1/1,000 live births	2.0 (1/504)	--	--	--		2008, Data source: Kansas Dept of Health and Environment Vital Stats Annual Summary
<u>Poverty</u> -# residents below 100% FPL/total # residents		--		--	12.4%	2008, Data Source: US Census QuickFacts: Persons below poverty level, percent
<u>Crime</u>	--	--	--	--	36.1	2008, Data Source: Kansas Bureau of

⁷ CAPTA information is often qualitative rather than quantitative and may be most usefully addressed in the narrative section to provide information on existing home visiting programs and resources.

⁸ Data collected by Head Start and Early Head Start grantees for their community-wide strategic planning and needs assessments may not be present in every identified at-risk community (especially for Early Head Start). Second, Head Start and Early Head Start grantees are not required to use uniform data sources or metrics so there is likely to be wide variation in the data.

⁹ SAMHSA Sub-State Treatment Planning Data Report

• # reported crimes/1000 residents						Investigation (KBI) Crime Index
• # crime arrests ages 0-19/100,000juveniles age 0-19					3285.7 (269/8187*)	2008, Data Source: Kansas Bureau of Investigation (KBI) Juvenile Arrests by Agency *2009, Data Source: US Census QuickFacts: estimate
<u>Domestic violence</u> -As determined by each State in conjunction with the State agencies administering the FVPSA	--	--		--	194	2008, Data Source: KBI “A Report On Domestic Violence and Rape Statistics In Kansas”
<u>School Drop-out Rates</u> -Percent high school drop-outs grades 9-12 -Other school drop-out rates as per State/local calculation method		--	--	--	11.1 % (48/432)	2007-2008, Data Source: Kansas Dept of Education, Kansas K- 12 Reports
<u>Substance abuse</u>	--	--			30.1%	2008-2009, Data Source: Southeast Kansas Education Service Center, “Kansas Communities that Care”
• <u>Past 2 week binge drinking – 12th grade</u>					15.4%	
• <u>Past month marijuana – 12th grade</u>					9.28%	
• <u>Past month prescription pain relievers – 12th grade</u>					1.6%	*2009-2010, Data Source: Southeast Kansas Education Service Center, “Kansas Communities that Care”
• <u>Past month methamphetamine – 12th grade</u>					2%	
• <u>Past month cocaine/crack – 12th grade</u>					1.49%	
• <u>Past month heroin – 12th grade*</u>						

<u>Unemployment</u> -Percent: # unemployed and seeking work/total workforce	--	--		--	10.7%	2009, Data Source: Bureau of Labor Statistics
<u>Child maltreatment</u> -# of substantiations/1,000 children	--			--	7.3 (60/8187*)	2009, Data Source: SRS *2009, Data Source: US Census QuickFacts: estimate
-Assigned reports of maltreatment by type <ul style="list-style-type: none"> • Emotional Abuse • Lack of Supervision • Physical Abuse • Medical Neglect • Physical Neglect • Sexual Abuse • Abandonment 					97 103 153 27 101 57 1	2009, Data Source: SRS, CINC Reports Assigned to Investigate Alleged Maltreatment Note: A CINC report can be assigned for more than one maltreatment reason thus these numbers are not unduplicated cases.
<u>Other indicators of at risk prenatal, maternal, newborn, or child health</u> - As available				--		

Sedgwick

<u>Indicator</u>	<u>Title V</u>	<u>CAPTA</u> ¹⁰	<u>Head Start</u> ¹¹	<u>SAMHSA</u> ¹²	<u>Other</u>	<u>Comments</u>
<u>Premature birth</u> -Percent: # live births before 37 weeks/total # live births	9.1 % (752/8262)	--	--	--		2008, Data source: Kansas Dept of Health and Environment Birth Stats Query
<u>Low-birth-weight infants</u> -Percent: # resident live births less than 2500 grams/# resident live births	8.4% (694/8262)	--	--	--		2008, Data source: Kansas Dept of Health and Environment Birth Stats Query
<u>Infant mortality (includes death due to neglect)</u> -# infant deaths ages 0-1/1,000 live births	6.7 (55/8262)	--	--	--		2008, Data source: Kansas Dept of Health and Environment Vital Stats Annual Summary
<u>Poverty</u> -# residents below 100% FPL/total # residents		--		--	12.3%	2008, Data Source: US Census QuickFacts: Persons below poverty level, percent

¹⁰ CAPTA information is often qualitative rather than quantitative and may be most usefully addressed in the narrative section to provide information on existing home visiting programs and resources.

¹¹ Data collected by Head Start and Early Head Start grantees for their community-wide strategic planning and needs assessments may not be present in every identified at-risk community (especially for Early Head Start). Second, Head Start and Early Head Start grantees are not required to use uniform data sources or metrics so there is likely to be wide variation in the data.

¹²SAMHSA Sub-State Treatment Planning Data Report

<u>Crime</u> • # reported crimes/1000 residents	--	--	--	--	53.9	2008, Data Source: Kansas Bureau of Investigation (KBI) Crime Index
• # crime arrests ages 0-19/100,000 juveniles age 0-19					2533.4 (3370/13 3024*)	2008, Data Source: Kansas Bureau of Investigation (KBI) Juvenile Arrests by Agency *2009, Data Source: US Census QuickFacts: estimate
<u>Domestic violence</u> -As determined by each State in conjunction with the State agencies administering the FVPSA	--	--		--	6,929	2008, Data Source: KBI "A Report On Domestic Violence and Rape Statistics In Kansas"
<u>School Drop-out Rates</u> -Percent high school drop-outs grades 9-12 -Other school drop-out rates as per State/local calculation method		--	--	--	13.6% (816/598 2)	2007-2008, Data Source: Kansas Dept of Education, Kansas K-12 Reports
<u>Substance abuse</u> • <u>Past 2 week binge drinking – 12th grade</u>	--	--			28.5%	2008-2009, Data Source: Southeast Kansas Education Service Center, "Kansas Communities that Care" *2009-2010, Data Source: Southeast Kansas Education Service Center, "Kansas Communities that Care"
• <u>Past month marijuana – 12th grade</u>					16.5%	
• <u>Past month prescription pain relievers – 12th grade</u>					7.64%	
• <u>Past month methamphetamine – 12th grade</u>					1.7%	
• <u>Past month cocaine/crack – 12th grade</u>					2.5%	
• <u>Past month heroin – 12th grade*</u>					1.81%	

<u>Unemployment</u> -Percent: # unemployed and seeking work/total workforce	--	--		--	8.6%	2009, Data Source: Bureau of Labor Statistics
<u>Child maltreatment</u> -# of substantiations/1,000 children	--			--	1.9 (247/133024*)	2009, Data Source: SRS *2009, Data Source: US Census QuickFacts: estimate
-Assigned reports of maltreatment by type <ul style="list-style-type: none"> • Emotional Abuse • Lack of Supervision • Physical Abuse • Medical Neglect • Physical Neglect • Sexual Abuse • Abandonment 					645 613 1674 187 767 421 25	2009, Data Source: SRS, CINC Reports Assigned to Investigate Alleged Maltreatment Note: A CINC report can be assigned for more than one maltreatment reason thus these numbers are not unduplicated cases.
<u>Other indicators of at risk prenatal, maternal, newborn, or child health</u> - As available				--		

Shawnee

<u>Indicator</u>	<u>Title V</u>	<u>CAPTA</u> ¹³	<u>Head Start</u> ¹⁴	<u>SAMHSA</u> ¹⁵	<u>Other</u>	<u>Comments</u>
<u>Premature birth</u> -Percent: # live births before 37 weeks/total # live births	9.5% (245/2566)	--	--	--		2008, Data source: Kansas Dept of Health and Environment Birth Stats Query
<u>Low-birth-weight infants</u> -Percent: # resident live births less than 2500 grams/# resident live births	7.4% (190/2566)	--	--	--		2008, Data source: Kansas Dept of Health and Environment Birth Stats Query
<u>Infant mortality (includes death due to neglect)</u> -# infant deaths ages 0-1/1,000 live births	8.6 (22/2566)	--	--	--		2008, Data source: Kansas Dept of Health and Environment Vital Stats Annual Summary
<u>Poverty</u> -# residents below 100% FPL/total # residents		--		--	12.2%	2008, Data Source: US Census QuickFacts: Persons below poverty level, percent
<u>Crime</u> • # reported crimes/1000 residents	--	--	--	--	132.7 (57.3/431 82*)	2008, Data Source: Kansas Bureau of Investigation (KBI) Crime Index

¹³ CAPTA information is often qualitative rather than quantitative and may be most usefully addressed in the narrative section to provide information on existing home visiting programs and resources.

¹⁴ Data collected by Head Start and Early Head Start grantees for their community-wide strategic planning and needs assessments may not be present in every identified at-risk community (especially for Early Head Start). Second, Head Start and Early Head Start grantees are not required to use uniform data sources or metrics so there is likely to be wide variation in the data.

¹⁵ SAMHSA Sub-State Treatment Planning Data Report

• # crime arrests ages 0-19/100,000juveniles age 0-19					1075	2008, Data Source: Kansas Bureau of Investigation (KBI) Juvenile Arrests by Agency *2009, Data Source: US Census QuickFacts: estimate
<u>Domestic violence</u> -As determined by each State in conjunction with the State agencies administering the FVPSA	--	--		--	1,719	2008, Data Source: KBI “A Report On Domestic Violence and Rape Statistics In Kansas”
<u>School Drop-out Rates</u> -Percent high school drop-outs grades 9-12 -Other school drop-out rates as per State/local calculation method		--	--	--	14.9% (326/2188)	2007-2008, Data Source: Kansas Dept of Education, Kansas K-12 Reports
<u>Substance abuse</u>	--	--			36.1%	2008-2009, Data Source: Southeast Kansas Education Service Center, “Kansas Communities that Care” *2009-2010, Data Source: Southeast Kansas Education Service Center, “Kansas Communities that Care”
• <u>Past 2 week binge drinking – 12th grade</u>					22.2%	
• <u>Past month marijuana – 12th grade</u>					7.5%	
• <u>Past month prescription pain relievers – 12th grade</u>					2.3%	
• <u>Past month methamphetamine – 12th grade</u>					2.5%	
• <u>Past month cocaine/crack – 12th grade</u>					1.82%	
• <u>Past month heroin – 12th grade*</u>						

<u>Unemployment</u> -Percent: # unemployed and seeking work/total workforce	--	--		--	6.3%	2009, Data Source: Bureau of Labor Statistics
<u>Child maltreatment</u> -# of substantiations/1,000 children	--			--	3.0 (131/43182*)	2009, Data Source: SRS *2009, Data Source: US Census QuickFacts: estimate
-Assigned reports of maltreatment by type <ul style="list-style-type: none"> • Emotional Abuse • Lack of Supervision • Physical Abuse • Medical Neglect • Physical Neglect • Sexual Abuse • Abandonment 					191 293 562 71 191 297 10	2009, Data Source: SRS, CINC Reports Assigned to Investigate Alleged Maltreatment Note: A CINC report can be assigned for more than one maltreatment reason thus these numbers are not unduplicated cases..
<u>Other indicators of at risk prenatal, maternal, newborn, or child health</u> - As available				--		

Wyandotte

<u>Indicator</u>	<u>Title V</u>	<u>CAPTA</u> ¹⁶	<u>Head Start</u> ¹⁷	<u>SAMHSA</u> ¹⁸	<u>Other</u>	<u>Comments</u>
<u>Premature birth</u> -Percent: # live births before 37 weeks/total # live births	10.2% (292/2850)	--	--	--		2008, Data source: Kansas Dept of Health and Environment Birth Stats Query
<u>Low-birth-weight infants</u> -Percent: # resident live births less than 2500 grams/# resident live births	9.1% (259/2850)	--	--	--		2008, Data source: Kansas Dept of Health and Environment Birth Stats Query
<u>Infant mortality (includes death due to neglect)</u> -# infant deaths ages 0-1/1,000 live births	8.8 (25/2850)	--	--	--		2008, Data source: Kansas Dept of Health and Environment Vital Stats Annual Summary
<u>Poverty</u> -# residents below 100% FPL/total # residents		--		--	19.2%	2008, Data Source: US Census QuickFacts: Persons below poverty level, percent
<u>Crime</u> • # reported crimes/1000 residents	--	--	--	--	49.3	2008, Data Source: Kansas Bureau of Investigation (KBI) Crime Index
• # crime arrests ages 0-19/100,000 juveniles age 0-19					267.1 (116/43)	2008, Data Source: Kansas Bureau of

¹⁶ CAPTA information is often qualitative rather than quantitative and may be most usefully addressed in the narrative section to provide information on existing home visiting programs and resources.

¹⁷ Data collected by Head Start and Early Head Start grantees for their community-wide strategic planning and needs assessments may not be present in every identified at-risk community (especially for Early Head Start). Second, Head Start and Early Head Start grantees are not required to use uniform data sources or metrics so there is likely to be wide variation in the data.

¹⁸ SAMHSA Sub-State Treatment Planning Data Report

					424*)	Investigation (KBI) Juvenile Arrests by Agency, omits Kansas City Police Department figures *2009, Data Source: US Census QuickFacts: estimate
<u>Domestic violence</u> -As determined by each State in conjunction with the State agencies administering the FVPSA	--	--		--	125	2008, Data Source: KBI "A Report On Domestic Violence and Rape Statistics In Kansas", Omits KC PD reports (965 Incidents) because 2) Agency did not submit any offense or arrest reports for 2008 and 5) Agency submitted summary data
<u>School Drop-out Rates</u> -Percent high school drop-outs grades 9-12 -Other school drop-out rates as per State/local calculation method		--	--	--	18.8% (332/1768)	2007-2008, Data Source: Kansas Dept of Education, Kansas K-12 Reports
<u>Substance abuse</u>					27.8%	2008-2009, Data Source: Southeast Kansas Education Service Center, "Kansas Communities that Care" *2009-2010, Data Source: Southeast Kansas Education Service Center, "Kansas Communities that Care"
• <u>Past 2 week binge drinking – 12th grade</u>					19.1%	
• <u>Past month marijuana – 12th grade</u>					n/a	
• <u>Past month prescription pain relievers – 12th grade</u>					3.8%	
• <u>Past month methamphetamine – 12th grade</u>					6.9%	
• <u>Past month cocaine/crack – 12th grade</u>					n/a	
• <u>Past month heroin – 12th grade*</u>						

<u>Unemployment</u> -Percent: # unemployed and seeking work/total workforce	--	--		--	10.3%	2009, Data Source: Bureau of Labor Statistics
<u>Child maltreatment</u> -# of substantiations/1,000 children	--			--	4.3 (186/43424*)	2009, Data Source: SRS *2009, Data Source: US Census QuickFacts: estimate
-Assigned reports of maltreatment by type <ul style="list-style-type: none"> • Emotional Abuse • Lack of Supervision • Physical Abuse • Medical Neglect • Physical Neglect • Sexual Abuse • Abandonment 					363 398 700 96 305 204 18	2009, Data Source: SRS, CINC Reports Assigned to Investigate Alleged Maltreatment Note: A CINC report can be assigned for more than one maltreatment reason thus these numbers are not unduplicated cases.
<u>Other indicators of at risk prenatal, maternal, newborn, or child health</u> - As available				--		

Section 4: Quality and Capacity of Existing Programs

A multi-level, multi-method approach was used to assess the quality and capacity of existing programs in the State. The approach included quantitative and qualitative methods to determine the capacity of home visiting and better understand the number of families who may need services but are not receiving them and the service needs of those families. Data were gathered at the state and community levels, using existing data and new data collected specifically for the capacity assessment. Early childhood home visiting programs were defined as programs that are supported by State or Federal funds, utilize home visiting as a primary intervention strategy, and provide frequent and intensive services appropriate to the needs of families.

Data Sources Used for the Assessment of Quality and Capacity of Existing Programs

Existing Needs Assessments

Title V MCH Block Grant Needs Assessment

As a recipient of Title V funds, the Kansas Department of Health and Environment (KDHE) is required to complete a statewide needs assessment every five years to identify the need for 1) preventive and primary care services for pregnant women and infants, 2) preventive and primary care services for children, and 3) services for children with special health care needs (CSHCN). Kansas' five- year needs assessment, covering the period of federal fiscal years 2006 to 2010, has resulted in an identification of the priority needs of the maternal and child health (MCH) population over the next five years.

Head Start Collaboration Strategic Planning and Needs Assessment

The purpose of the Head Start Needs Assessment was to collect information from Head Start programs on cooperation, coordination, and collaboration within the priority areas: health care, services for children experiencing homelessness or disabilities, welfare/child welfare, child care, family literacy, community services, partnerships with local education agencies, transition and alignment with K-12, and professional development. Results were used to create a 5-year strategic plan that defines how the Head Start Collaboration Office will support Head Start programs in the key areas.

Community-based Child Abuse and Neglect Prevention (CBCAP) Needs Assessment

As part of the annual CBCAP Annual Report, Strengthening Kansas Families Plan, and application, a State level environmental scan was prepared that documents service capacity and identifies gaps. The review of statewide programs provides a snapshot of programs and services that support young children and their families. The scan helps to identify priority areas for program planning and funding.

Substance Use Disorder Needs Assessments

In 2006, Datacorp and the Paxis Institute completed a comprehensive needs assessment of the Addiction and Prevention Services AAPS service delivery system. The purpose of the assessment was to estimate treatment needs and understand county and population needs. The project design used synthetic estimates, social indicators, and gap and capacity analysis. The Kansas Comprehensive Treatment Needs Assessment describes availability of treatment services and gaps in accessing treatment services in the State.

New Data Sources

State Level Interviews

The directors of evidence-based home visiting programs were asked to complete a service matrix about their programs, including eligibility criteria, demographic information about the families actually being served, and waiting list status. Qualitative data from structured interviews were collected from key informants from the following: Early Head Start, Healthy Families, and substance use disorder treatment programs, Parents as Teachers, and Local Health Departments and Infant Toddler (Part C) services. The purpose of these interviews was: 1) to identify evidence-base of existing services and protocols in place to assess quality of services and fidelity to models; 2) to identify collaborative policies that support coordinated home visiting services; 3) to inform a public engagement strategy and coordinated policy agenda for home visiting; 4) to assess existing collaboration between home visiting and substance use disorder programs, and 5) to verify the current funding streams and sustainability plans of home visiting programs. Interviewers used a standardized protocol to gather information about these key components and to further understand perceived gaps, and issues with implementation and fidelity.

Community Level Focus Groups and Interviews

Based on the recommendations of the state home visiting program directors and the Home Visiting Workgroup, three to five key informants were identified who are directly involved with existing home visiting and maternal and infant and early childhood services in the high-risk communities. A standardized interview protocol covered topic areas such as the home visiting continuum in the local community, estimates of the number of individuals who are unserved or underserved, attributes of those who do not receive service and remain unconnected to community supports, the referral process, and professional development opportunities.

To supplement local key informant interview data, focus groups with 8-10 other community partners were conducted in each of the high-risk communities. The purpose of these focus groups was to: 1) provide greater and more nuanced input about the continuum of home visiting services available; 2) assess the extent to which the services are meeting the needs of children and families; 3) determine the infrastructure needed to expand services; 4) to identify critical technical assistance needs; 5) review quality assurance and fidelity measures and outcome measures; and 6) identify gaps in professional development and training.

Participant/Parent Level Focus Groups

The capacity assessment of services only describes one half of the equation. Parent voice is critical to understand supports and challenges to successful engagement in home visiting

services. Former and current participants in home visiting services and high-risk families who choose not to receive services were asked to provide input. A standardized protocol was used to solicit information from these families on: 1) perceived access to and understanding of home visiting services in their community; 2) key strategies that would facilitate and encourage participation in home visiting services; and 3) reasons for choosing or not choosing to participate in home visiting programs (e.g. accessibility, time, relationship with visitor, extent to which program meets needs).

Overall, 22 interviews (7 state and 15 local), eight focus groups (4 community with 67 participants and 4 parent with 52 participants) were conducted, resulting in over 45 hours worth of feedback on the capacity assessment questions. (Structured interview questions are available in the appendices and at http://www.kdheks.gov/bcyf/home_visiting.htm.)

Findings from the Capacity Assessment

Kansas has an array of existing maternal, infant and early childhood home visiting programs that support pregnant women and families with young children. There is not a state-specified home visiting model. Rather the State recognizes that families have needs on a continuum of risk and services should be provided along the continuum to meet their needs. The Centers for Disease Control and Prevention (CDC) defines levels of prevention that inform an existing continuum that is widely used in the child maltreatment field. Kansas uses the continuum to provide multiple levels of services based on risk factors defined as follows:

- Universal services apply to everyone and rely on policy interventions and broad social change techniques that treat everyone the same;
- Selected services are focused on those identified as “at risk” often through individualized programs that are intended to change those identified; and,
- Targeted/Indicated services include treatment with therapeutic goals for those who have experienced the problem (as victims and/or perpetrators), usually through one-on-one strategies.

Existing maternal, infant and early childhood home visiting programs in Kansas are identified on a services continuum in Figure 8. Families at all risk levels have opportunities for services across the continuum.

Figure 13: Pyramid of home visiting services by risk level in Kansas.



Specific services, population served, goals, intensity of services, and funding vary by home visitation program. Tables 9-11 and Figures 14-17 outline the service delivery characteristics, location, and funding streams for each program.

Table 9: Summary of Home Visiting Programs in Kansas

Name of program	Home visiting model or approach	Specific service provided	Intended recipient of the service	Targeted goals/outcomes of the intervention	Number of individuals or families served (2009)	Intensity of services
Early Head Start		Weekly home visits by trained person; socialization and playgroup opportunities; access to oral health, mental health, and nutrition services.	Pregnant women and families with infants and toddlers up to age four living at or below the federal poverty level	Pregnant women and newborns thrive; infants and children thrive; children live in stable and supported families; children enter school ready to learn	2,718	Individual contact weekly for 90 minutes
Family Preservation		In-home services to families based on the comprehensive assessment including safety planning and core support services such as day care, respite care, employment, housing and homemaking.	Families where one or more children are at risk of out of home placement	Reduction in substantiated abuse or neglect cases; reduction in out of home placements; increase in the number of babies born substance free to women referred to FPS for reason of substance abuse during pregnancy	2135 (FY09)	As needed
Healthy Families	Healthy Families America	HF worker provides home visits, information, and social-emotional support	Parents with multiple risk factors who are expecting or who have just had a new baby	Prevention of child maltreatment; optimized child development	351	Weekly to bi-weekly home visits of at least one hour duration initially, tapering off to every 4-6 weeks as family functioning improves
Healthy Start		Paraprofessional or lay home visitors are the primary home visitors providing outreach services to all pregnant women under the supervision of professional registered public health nurses. The HSHV program assists in identification of risk factors that lead to poor birth outcomes, risk factors for child abuse and neglect, and injuries to children. Further, home visitors also identify socioeconomic and social-emotional factors that warrant referrals to registered nurses and other	All pregnant women and women with infants up to age 1	Pregnant women improve health behaviors such as decreasing substance abuse; pregnant women access early prenatal care to reduce incidence of premature and low birth weight babies; mothers and their families utilize cost-effective preventive health care services; mothers and their families demonstrate enhanced parenting and problem solving skills	9675	As needed

		community supports.				
Infant Toddler Services	Early intervention	Family training, counseling, and home visits; special instruction; speech-language pathology and audiology services, and sign language and cued language services; occupational therapy; physical therapy; psychological services; service coordination services; medical services only for diagnostic or evaluation purposes; early identification, screening, and assessment services; health services necessary to enable the infant or toddler to benefit from the other early intervention services; social work services; vision services; assistive technology devices and assistive technology services; and transportation and related costs that are necessary to enable an infant or toddler and the infant's or toddler's family to receive another service	Children ages birth to three with an identified developmental delay	Positive social-emotional skills; acquisition and use of knowledge and skills; and, use of appropriate behaviors to meet their needs	7054	As needed
Parents as Teachers	Universal primary prevention model	Home visits by PAT trained Parent educator, play groups, and socialization opportunities Four service delivery components: personal visits, group meetings, screening, and resource network as part of <i>Born to Learn</i> curriculum	All families with children prenatal to age 5 regardless of their risk levels (<i>Programs can prioritize enrollment of at risk families because no eligibility requirements to reduce stigma</i>)	Parents are more knowledgeable about child development and child-rearing practices; children receive developmental screenings and have delays identified early; children are healthier	15197	Home visit every 4-6 weeks for 60 minutes

Community specific programs

Bright Beginnings (Shawnee Co.)	Based on Nurse Family Partnership		At-risk pregnant women and new moms	Education, guidance, nursing assessment with goals of promoting child and mom's health, attending to the developmental needs of children, making sure families live in stable housing, and helping families becoming self-sufficient are the main goals	101	Intensive and long term
Healthy Babies	Combination of Partners for Healthy Babies		Pregnant women and families with infants and toddlers up to age	Improve birth outcomes by reducing low birth weight births and decreasing infant mortality	617 moms 402 babies and	Group

(Sedgwick)	and Centering Pregnancy and Centering Parents curricula	twenty four months	rates.	toddlers
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Infant Toddler Services and Family Preservation are available statewide. Figures 14 through 17 detail the geographic areas currently served by Early Head Start, Healthy Families, Parents as Teachers, and Healthy Start Home Visitors.

Figure 14: Counties served by Early Head Start.

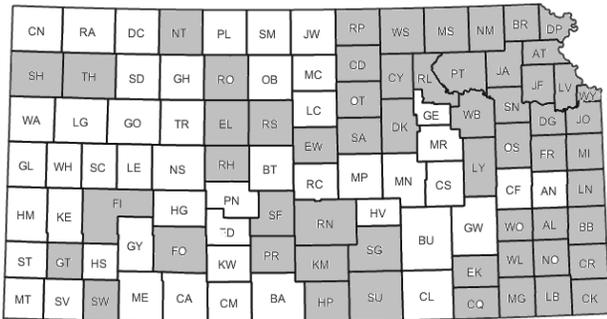


Figure 15: Counties served by Healthy Families.

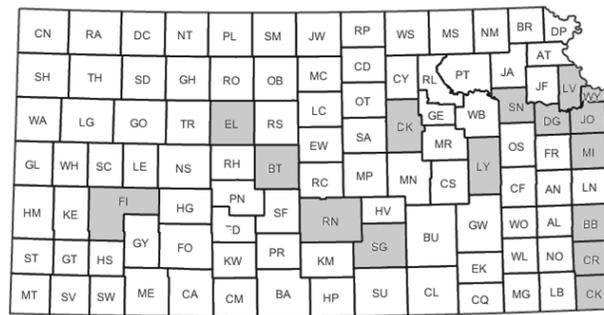


Figure 16: Counties served by Healthy Start.

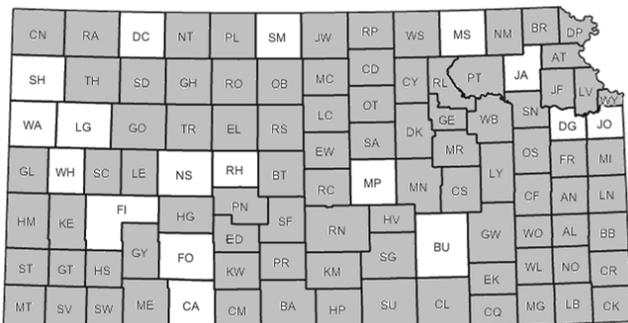


Figure 17: Counties served by Parents as Teachers.

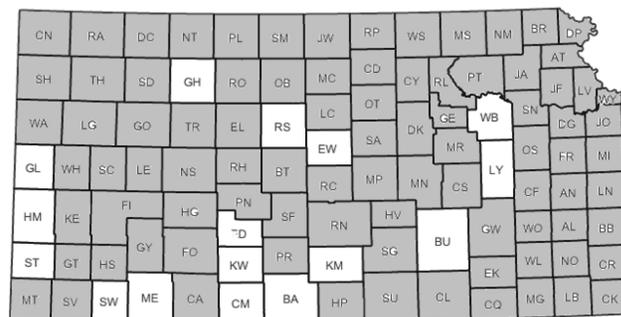


Table 10: Demographic Characteristics of Families Served by Home Visiting Program

Demographics	Home Visiting Program				
	Early Head Start	Healthy Families	Healthy Start	Parents as Teachers	Infant Toddler Services
Number served	2,718	351	9,675	15,197	7,054
Number on wait list	1,591	0		2,571	0
Successful completion (or dropouts)		28%			2,656
Residing in communities in need	Crawford Montgomery Sedgwick Wyandotte Shawnee	Sedgwick Crawford Wyandotte	Most		Statewide
Low income	90%	83%	State average of mothers in poverty: 30.3%	30%	Not collected
Pregnant before age 21		38%	20.15%	8%	Not collected
Families with history of CPS involvement	0.28%	8%	Not collected	1%	Not collected
Tobacco use		30%	Not collected		Not collected
Low student achievement		N/A	Not collected	9%	Not collected
Development delays or disability	10.43%	5%	Not collected	6% & 3%	100%
Premature birth			Not collected	N/A	Not collected
Low birth weight	9.14%	2%	Not collected	7%	Not collected
Infant mortality – neglect & other factors		0.28%	Not collected		Not collected
At risk prenatal/maternal/newborn /child health	19.24%	100%	Not collected	4% & 1%	Not collected
Crime		9%	Not collected	1%	Not collected
Domestic violence		31%	Not collected		Not collected
High school drop out		52%	Not collected		Not collected
Substance use disorder		17%	Not collected	1%	Not collected
Unemployment	17.79%	65%	Not collected	N/A	Not collected

*Family Preservation does not collect data according to these indicators.

Table 11: Preliminary Inventory of Home Visiting Programs (Information from 2010 CIF Accountability Survey)

Program	Federal Funding	Other State Funds	Children's Initiative Fund	Other	Total
Early Head Start (Kansas and federal)	\$7,889,771		\$3,452,626		\$11,342,397
Family Preservation	\$7,092,699	\$135,754	\$3,241,062		\$10,469,515
Healthy Families	\$980,700	\$461,530	\$1,176,900	\$599,635	\$3,218,765
Healthy Start Home Visitors	\$399,777	\$501,444	\$250,000		\$1,151,221
Infant Toddler Services	\$5,932,149		\$5,700,000		\$11,632,149
Parents as Teachers			\$7,539,500		\$7,539,500
Totals	\$22,295,096	\$1,098,728	\$21,360,088	\$599,635	\$45,353,547

In the broadest sense, funding for home visiting programs totals more than \$45 million. Excluding funding for Part C Infant and Toddler Services (does not have at its exclusive purpose provision of home visiting services) and Family Preservation (provision of services is not always voluntary) the current investment in home visiting services is approximately \$23 million.

Findings from the Capacity Assessment of Home Visiting Programs in Kansas

To examine the extent to which home visitation programs are meeting the needs of eligible families, data from the seven key informant interviews was used to identify key state themes. At the community level, data from the fifteen key informant interviews and focus groups and five parent/participant focus groups was used to identify community-level themes. Data from the needs assessments (Title V, Head Start, CBCAP, and Substance Use Disorders) was used to inform the interview and focus group process and for triangulation purposes. Triangulation of data - collecting data from a diverse group of stakeholders, using a variety of methods - is a recommended strategy to increase the validity of the findings and to better understand the generalizability of the results.

State-Level Findings

The following themes emerged from the state-level interviews which were conducted with directors of each of the home visiting programs as well as substance use disorder (SUD) management. Findings are particularly useful when designing a home visiting system for the State.

Capacity

Every county in the State, including the selected counties, has at least one home visiting program. Universal services, however, are not available in every county. Lacking the continuum of services, communities are not able to maximize resources to meet the needs of families. Home visiting programs in each of the communities operate at capacity. As a result, most families cannot receive full services from Early Head Start (EHS), Healthy Families (HF), and Parents as Teachers (PAT) programs immediately upon application. Many programs provide supports, such as play groups or referral to other community services, until slots are available. (Infant Toddler Services and Healthy Start are public health programs that serve all eligible families. Family Preservation has a limited number of slots; slots are monitored and referrals adjusted by SRS based on availability.) For these reasons, families do not always receive services at the intensity or frequency that is needed. For example, high risk families needing intensive services may have access to Parents as Teachers, but not to Early Head Start or Healthy Families due to lack of available slots and/or waiting lists. Moreover, in some programs, such as Healthy Start Home Visitors, a family may receive only one visit depending on the family situation. For others, such as EHS or HF, there are more prescribed, frequent, and longer term visits.

Eligibility

Eligibility criteria for home visiting services limit access for some families, particularly those that don't meet the income threshold. Working poor or families that struggle to make ends meet are negatively impacted by strict eligibility criteria and often cannot access services. On the other hand, programs that do not restrict eligibility may be stretched too thin to provide the more comprehensive services required.

Engagement

Engaging families in services is a challenge across programs. In many cases, families complete the enrollment process, but do not participate in service delivery. While the reasons for this are unclear, community level parent focus groups indicate that one reason may be a refusal to participate on the part of a spouse/partner. In addition, community partner focus groups indicated that the range of demands on the family (i.e. medical visits, work, child care, etc) limit their interest in engaging in home visiting.

Community Partnership

Home visiting partners in the State are generally well connected, sharing training (such as the Kansas Basic Home Visitation Training), partnering on grant-writing, and working together on our Kansas Early Childhood Comprehensive Systems (KECCS) Plan. Most home visiting programs in the state (including HF, EHS, PAT) use the Parents as Teachers *Born to Learn* curriculum for their parent education component.

Variability across At Risk Communities

While many of the same issues or themes were echoed across the state with home visiting programs, there is also significant variability across local communities. Three main differences emerged:

- Coordination of home visiting services. Home visiting programs are co-located in some communities to support smooth, facilitated transitions for families. Combined brochures in some communities provide families a quick reference guide to the home visiting services available. In other communities, there are less formal connections. At the state level, all programs referenced the importance of the Kansas Basic Home Visitation Training as a vital resource for their direct service staff. The Home Visitation Training provides for most programs ongoing professional development; for HSHV, the Home Visitation training is the core training for staff.
- Coordination between home visiting and other community agencies. Some home visiting programs are located in communities where there are extensive partnerships to support families, including partnerships with hospitals, law enforcement, substance use disorder treatment, health departments, and social service agencies. In other communities, organizations are still challenged to overcome barriers related to confidentiality/information sharing, referrals, and service coordination.
- Target population for services. Broad eligibility requirements are set by the program model, but each community can make eligibility determinations and/or target population decisions that may limit accessibility for families. For instance, PAT programs may choose to use their local overmatch dollars to fund services for ages 3-5; this service is not available in all communities. Likewise, EHS may choose to focus on a specific minority or high risk population, because of an identified community need, which limits accessibility to other families.

Availability of Home Visiting Programs and Related Services

Since the continuum of home visiting services is not available in every community, families are limited from accessing appropriate services because of artificial boundaries (i.e. county, school district, etc). In addition, as families move, there are many times not comparable services available in their new communities (i.e. Healthy Families or Early Head Start), and in most cases it is rare to have a facilitated transition between programs when a family moves.

Assessing Capacity and Data Availability

Finally, the assessment of home visiting capacity is limited by the data capabilities within the State. There is not consistent data describing the demographics/risk of the families being served. In particular, some programs (such as HSHV and ITS) track numbers served, but do not track demographics of families at the state level. Other programs (such as EHS and HF) collect detailed demographic and risk information for families served at

both the state and local levels. Without a coordinated, coherent data collection system across programs, our ability to know who is actually being served, and to make programming decisions based on need, is limited.

Local-Level Findings

The following section provides an overview of selected communities focusing on key themes that emerged from community interviews and focus groups. These themes identified needs in existing home visiting and other community support services and the coordination among those service systems, including child welfare, substance abuse, domestic violence, and healthcare. Additionally, input from past, current, and potential home visiting clients was included to provide valuable information on quality of home visiting services and barriers to accessing those services.

Montgomery and Crawford Counties (Southeast KS Region)

Montgomery and Crawford counties are located in the Southeastern region of the state and are a part of a multi-county SRS service region. These counties border the states of Oklahoma and Missouri and much of the area is rural. There are a few urban areas in this region and the largest cities include Pittsburg, KS (pop. 19,649) and Independence, KS (pop. 9,245).

Early childhood services for pregnant women and women with small children are centered in these two counties, but many clients must travel across counties or even state lines to access available services. While some coordination among service providers in the counties does occur, the availability of and transportation to needed services by at risk clients is limited. This area of the state is noted for its high poverty rate among all counties in Kansas and its rate of pregnancies to teens 15-19 years of age.

- Home visiting in Crawford and Montgomery counties
- At risk population is difficult to ‘find’. Mobility is challenge
- Staff travel time plays a factor in capacity to serve all
- Lack of transportation, particularly in expansive service area
- Lack of transportation options and bilingual staff
- Lack of comprehensive, wrap-around services/programs for substance-using pregnant women and mothers of young children
- Limited mental health services for young children; HV staff lack adequate training in supporting mental health needs
- Long waitlists for program services

Shawnee County (including Topeka, KS)

Shawnee County is an urban community located in Northeast Kansas, approximately 70 miles west of Kansas City, Missouri, and includes the state capital of Topeka as well as small suburban and rural enclaves. The total population of the county is 176,255. It is part of a large, multi-county SRS service region (24 counties total).

Although Shawnee County has many initiatives addressing issues that impact early childhood, the county has many significant challenges including the highest crime rate in the state, the highest number of out of home placements of children, the highest rates of binge drinking by 12th grade students, and the highest rates of past 30-day marijuana use by 12th grade students in the state. Collaborative efforts face challenges in part due to major philosophical differences between the court system and social service providers. One example of this is the mandated removal of all children testing positive for a substance at birth.

The following findings were identified through focus groups with parents and community stakeholders as well as interviews with representatives of key organizations in Shawnee County.

- Eligibility restrictions limit access for families
- Lack of slots limits appropriate referrals
- Lack of services for families when their children turn age three
- Lack of access to health care
- Programs not available in all locations (e.g. Silver Lake)
- Need for improved service provision to Spanish-speaking families
- Lack of coordination, communication, and information sharing
- Need for increased awareness of HV services
- Need for training related to substance use disorder, domestic violence, and referral information
- Lack of access to recovery services for women
- Protocol mandates removal of newborns testing positive for substances

Sedgwick County (including Wichita, KS)

Sedgwick County is located in the south central part of the state and is home to Kansas' largest city – Wichita, in addition to suburban communities. Wichita is home to multiple coalitions coordinating efforts around home visiting, early childhood services and programs for at-risk populations. Early childhood services for pregnant women and women with small children are centered in Wichita and while public transportation is available across the city, route and schedule limitations are a barrier to coordination for this population. Community coalition members feel strongly that one of the greatest community assets is the desire shared among community partners to ease complicated service coordination in order to enhance family participation. Sedgwick county has a high incidence of domestic violence and higher than average rates of low birth weight, families living in poverty, crime, unemployment, and high school dropout.

- Want centralized intake—need momentum created to sustain

- Need coordination of home visiting programs and services because many at-risk women and families participate in multiple programs.
- Lack of community understanding of HV purpose and resources
- Collaboration and referrals are community assets+.
- Misperceptions about the role of Home Visitors
- Lack of transportation options and bilingual staff
- Lack of comprehensive, wrap-around services/programs for substance-using pregnant women and mothers of young children
- Limited mental health services for young children; HV staff lack adequate training in supporting mental health needs
- Long waitlists for program services

Wyandotte County (including Kansas City, KS)

Wyandotte County is a large urban community located in eastern Kansas along the state line. It is part of the metropolitan area that includes Kansas City, Kansas and Kansas City, Missouri. Wyandotte County has a strong network of early childhood leadership through the local Interagency Coordinating Council. There have been coordinated efforts around home visiting, including a coordinated referral system through Project EAGLE's Connections program that provides screening of multiple risk factors in families to facilitate referrals to appropriate community supports. Despite this strong organizational/partnership structure, Wyandotte County continues to rank lowest in the state on critical health and wellness indicators, including the federal priority indicators identified through this FOA.

Several key themes emerged from the qualitative capacity assessment of home visiting in Wyandotte County:

- Strong coordinated referral system, but there are challenges with engaging families in services after referrals are made
- Mobility of the population creates difficulties for service delivery
- Lack of qualified staff, including bilingual/multilingual staff, to meet the needs of the families
- Changing demographics are changing the way services are delivered
- Waiting lists for services mean that some families are not matched with the most appropriate service for their needs
- Engaging families in services is limited by misconceptions of agencies, fear of punitive action, immigration status
- Need for further professional development for program staff
- Relationships between families and home visitors are of central importance to successful engagement in services

- Need more support services for pregnant women and mothers with newborns—strategies for engaging pregnant women
- Substance use disorder treatment services are available, but the number of slots and the funding to support family participation in treatment is limited. This is particularly true for residential treatment services for mothers with young children

Common Parent Themes across All At Risk Communities

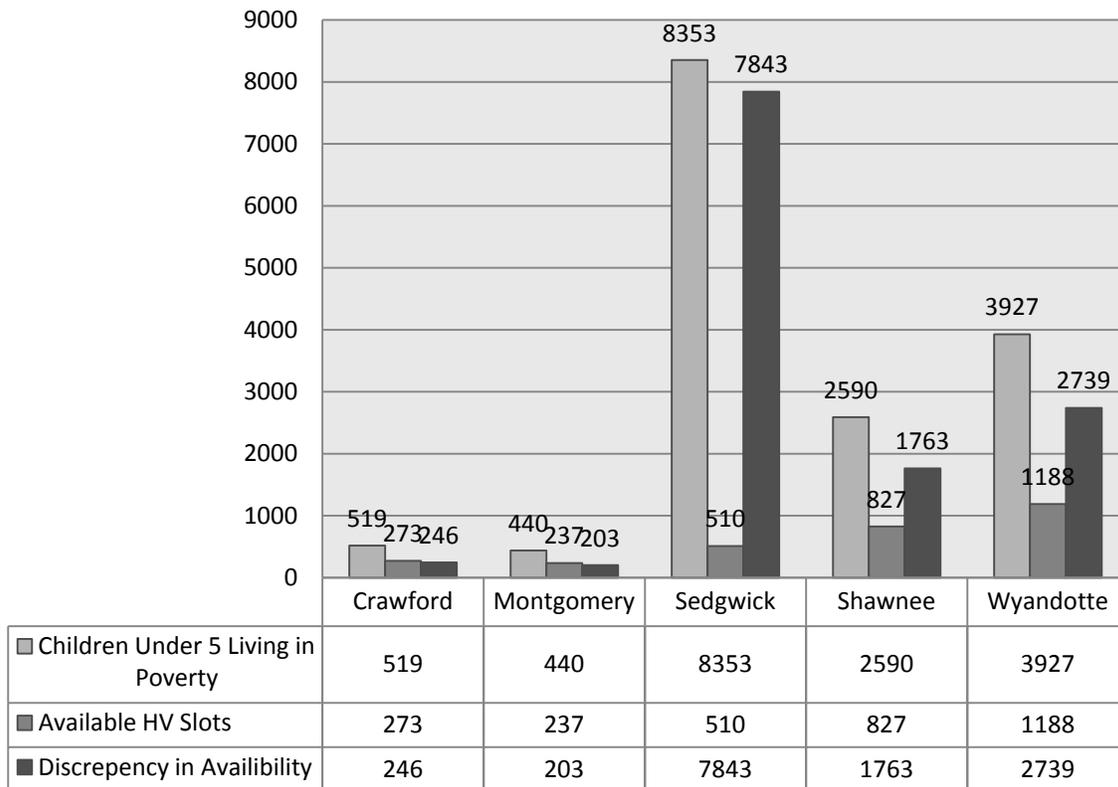
- Waiting lists with limited or no access to other services while waiting
- No services available after child turns age 3
- Eligibility criteria—many families needing services don't qualify
- Need for more regular visits (intensity and frequency)
- Need for more systematic way of finding out about services
- Misperceptions about services and fear of punitive action

Findings from the Gaps Analysis

To assess gaps in services, two sets of analyses were conducted. First, an examination of needs in the selected communities in relation to available slots was conducted to obtain a numerical sense of the gaps in services. Second, a synthesis of the needs assessment data (existing and new) was completed to identify clear and repeatedly-mentioned gaps in services.

To quantify the gaps in available services, the differences between children in poverty under the age of five and the number of available home visiting slots in each community was determined. At a basic level, Figure 13 highlights the gaps in availability of home visiting slots to meet the needs of eligible families in the identified high risk communities in Kansas. In sum, Crawford and Montgomery Counties are meeting approximately half the need (52% and 54% respectively); Sedgwick County less than a tenth of the need (6.1%); Shawnee a third of the need (32%), and Wyandotte 30% of the need.

Figure 18: Number of children in poverty and ith availability of home visiting services. .



Based on the quantitative and qualitative data on the state and community levels and the input from the Home Visiting Work Group and the Home Visiting Task Force, the following gaps in services were identified from a thematic analysis of the qualitative data collected at the state and local levels:

1. Family need is not always in line with available services. Due to a shortage of slots, the intensity and frequency of services does not always match the needs of families.
2. A coordinated referral process varies by community. The coordination of referrals alone is not enough to ensure that families are engaged. Mechanisms to support follow-up are lacking.
3. Local communities can prioritize eligibility to address the unique needs of their communities, resulting in families who are on the brink of eligibility not receiving services.
4. There is no centralized data system or common outcomes across home visiting programs. As a result, communities are not able to report as a continuum of home visiting services the impact they are having on high risk families. Because not all programs collect demographic data at the state level, it is difficult to know which families with which high risk factors are not being served.
5. There is a need for better linkage between home visiting and substance use disorder treatment providers and domestic violence advocates.

- a. Home visitors have inadequate training to address the issues of families experiencing substance use disorders, domestic violence, or mental health issues.
 - b. Substance use treatment providers and domestic violence advocates lack awareness and understanding of home visiting services.
 - c. The fear of having a child removed from the home due to substance use may prevent women from seeking services.
6. Treatment Services for substance abuse are lacking and do not meet the demand.
 - a. There are few residential treatment options for pregnant women and women with small children.
 - b. Some treatment programs serve multiple counties, requiring a 30 to 50 mile drive.
 - c. A lack of child care prevents some parents from accessing services.
 7. There is a misperception on the part of families that home visitors are a part of the child protective services system.
 8. Some entry points, such as hospitals, are reluctant to refer families at high risk of child maltreatment to services that are voluntary. For that reason, they refer to Family Preservation services.
 9. There is a lack of coordination between service providers attending to multiple needs of families, i.e. a family with a child with special health care needs, child welfare involvement, and families with multiple children. Some providers operate in isolation to address a particular need, leaving families confused or overwhelmed.
 10. Staff capacity is lacking at many entry points, such as hospitals, to adequately screen and refer families to appropriate home visiting services. This is a missed opportunity when families are open to supports.
 11. Transportation options are a challenge—the challenges vary in urban and rural settings.

These gaps were confirmed by the findings of the statewide needs assessments. Table 11 integrates the above gaps with those identified in each Needs Assessment.

Table 12. Integration of Gaps Identified in Needs Assessments

Gaps	Title V	Head Start	CAPTA
1. Shortage of slots—services not appropriate to needs of families		x	x
2. Lack of coordinated referral and follow-up			x
3. Eligibility limits access for families			
4. Lack of centralized data reporting and common outcomes across programs			x
5. Disconnect between substance use disorder providers and domestic violence advocates and HV			
6. Limited recovery services for pregnant women and women with small children			
7. Lack of understanding of distinction between home visitor and child protective services			
8. Voluntary vs. mandatory services for high risk families			
9. Lack of coordination between service providers attending to multiple needs of individual families			
10. Lack of dedicated staff at entry points to adequately screen and refer families			
11. Lack of transportation opportunities	x		

Section 5: State Capacity to Provide Substance Use Disorder Treatment Services

In addition to discussing all substance abuse and counseling services available through the State, this section discusses service gaps or duplications in each community identified as being at risk in terms of substance use.

Overview of Kansas Substance Use Disorder and Counseling Service Structure

Oversight of treatment services in Kansas is provided by Kansas Social and Rehabilitation Services Addiction and Prevention Services (AAPS). AAPS is committed to creating a system of care that is customer/community centered, outcome driven and consists of a highly competent workforce focused on best practices. AAPS utilizes strategic partnerships, is developing a new information technology system, and implementing targeted workforce development initiatives to remain responsive to the needs of our partners and those we serve. Their mission is to promote prevention and treatment in Kansas communities.

The treatment system in Kansas is based on the Recovery Oriented Systems of Care (ROSC) models that recognize substance use disorders as chronic health issues requiring management throughout a lifetime and embraces a continuum of care from prevention, treatment and recovery, to full engagement in one's family and community. The delivery system applies recovery principles to a full range of engagement, intervention, treatment, rehabilitative, and supportive services, including health promotion and prevention services for those at risk of substance use disorders. Efforts are made to ensure services are age and gender appropriate, culturally competent, and attend to trauma and other factors that impact recovery.

The Kansas Substance Abuse Prepaid Inpatient Health Plan (SA-PIHP) was created as a way to ensure the availability of effective substance use treatment services throughout the state. As the entity selected by the Kansas Department of Social and Rehabilitation Services in 2007, ValueOptions of Kansas manages the state's substance use disorder services.

The SA-PIHP covers substance use disorder treatment services for over 280,000 Medicaid individuals and families across the state. ValueOptions-Kansas also oversees the state's federal and state grant dollars serving more than 15,000 clients each year.

To fulfill their contractual agreement with SRS, ValueOptions –Kansas contracts with Regional Alcohol and Drug Assessment Centers (RADACs), which are private not-for-profit agencies that conduct substance use disorders assessments for treatment services. Assessment counselors evaluate clients' requirements for services and refer them to the State or Medicaid funded program that will best meet their needs. If a treatment opening is not available, pre-treatment services will be offered on an interim basis for Intravenous Drug Usage (IVDU) pregnant clients, pregnant clients and IVDU clients.

AAPS contracts with the RADACS on two other projects that are statewide initiatives for services. AAPS receives Temporary Aid for Needy Families (TANF) funds through an agreement with the Economic and Employment Services (EES) division of SRS to screen, assess, and provide intensive strength based case management to TANF recipients identified with substance use disorders. RADAC case managers provide support for these TANF participants to become involved in recovery and to reduce other barriers to successful participation in TANF. Outcomes from this initiative are that of engagement in recovery activities, retention in recovery activities, economic stability, and reduction in children placed out of the home. This program is referred to as the Solutions Case Management program and provides services to all SRS regions in the state. This program serves over 500 persons each year.

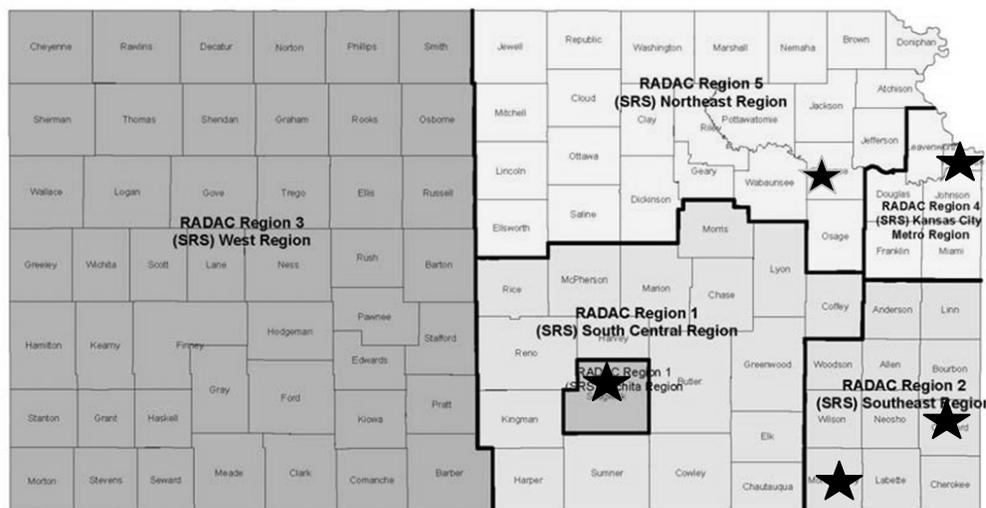
AAPS also contracts with the RADACs to provide case coordination, case management, and peer mentoring services to persons convicted of four or more Driving Under the Influence (DUIs) charges that have been sentenced and mandated to treatment. This project is a coordinated effort between the SRS and the Kansas Department of Corrections (KDOC). This program serves over 700 offenders each year.

There are three RADACs in Kansas:

- Substance Abuse Center of Kansas (SACK)--based in Wichita and serves Region 1 which includes Sedgwick County, one of the at-risk communities identified in this application
- Addiction Recovery Center (ARC)-- based out of Girard and serves Region 2 which includes Crawford and Montgomery Counties as well as the entire Southeast Region (one of the areas of focus of this application)
- Heartland RADAC—based in Kansas City and serves Regions 3, 4, and 5 which include Wyandotte and Shawnee Counties, two of the at-risk communities identified in this application

Figure 19 indicates the regions served by the Kansas RADACs. The identified high risk communities are denoted with a★ .

Figure 19. Regions served by Kansas RADACs.



To be eligible for no cost services funded through AAPS, an individual must be a resident of Kansas and have an income below 200% of the Federal Poverty Guidelines (FPG). There is never a charge for Medicaid clients unless the referral is a result of a DUI conviction. The individual must also meet the Federal Block Grant definition for a Federal priority client: Priority Populations include:

- a) Federal Block Grant Priority Populations:
 - i) Pregnant women who are IVDU.
 - ii) Pregnant women.
 - iii) Intravenous Drug Users (IVDU).
- b) State Specific Priority Populations (no order necessary):
 - i) Women with Dependent Children.
 - ii) Individuals diagnosed with HIV
 - iii) Involuntary Commitments.
 - iv) SRS clients (Family Preservation, Foster Care, etc).

Available Substance Use Disorder Services in Kansas

The array of substance use disorder services across the state of Kansas is extensive. However, the availability of all services within a given community varies. The following section describes the services:

Outpatient

- Individual and group counseling

Intensive Outpatient Treatment

Residential Treatment

- Reintegration

- Intermediate
- Social Detoxification

Medically Managed Intensive Inpatient Treatment

- Acute Detoxification
- Inpatient Treatment

Auxiliary Services

- Assessment/Referral
- Case Management
- Person-Centered Case Management (PCCM)
- Support Services
- Dependent Children-Overnight Boarding

Serving At Risk Populations – Capacity Assessment

As part of the capacity assessment process, the Kansas Comprehensive Treatment Needs Assessment Capacity/Gap Analysis was reviewed to determine availability of treatment services and gaps in accessing treatment services in the communities targeted in this application. Interviews were also conducted with staff of Kansas Social and Rehabilitation Services Addiction and Prevention Services for a state level perspective and with local treatment service providers in each of the targeted communities. The state profile focuses on how the state as a whole addresses services for at risk populations and the perceived gaps in serving this population. Given that the availability of specific home visiting programs varies by community, addressing coordination of services with those programs is described in the community profiles.

According to the analysis, approximately 10% of people in Kansas need treatment. An estimated 200,000 adults and 24,000 adolescents met the DSM-IV criteria for alcohol or drug abuse or dependence. However, more than 150,000 adults and more than 15,000 adolescents who needed treatment did not receive it. Further, approximately 63,500 adults (32% of those in need) and 7,000 adolescents (28% of those in need) were eligible for substance abuse services funded by AAPS. Of the more than 70,000 eligible for state funded treatment, only 15,000 received treatment, suggesting that the need for services for people in poverty is much greater than the supply. The graph below provides a breakdown of the number of people eligible for AAPS services in need of treatment in each of the target communities.

Figure 20: Number of AAPS Eligible in Need of Treatment

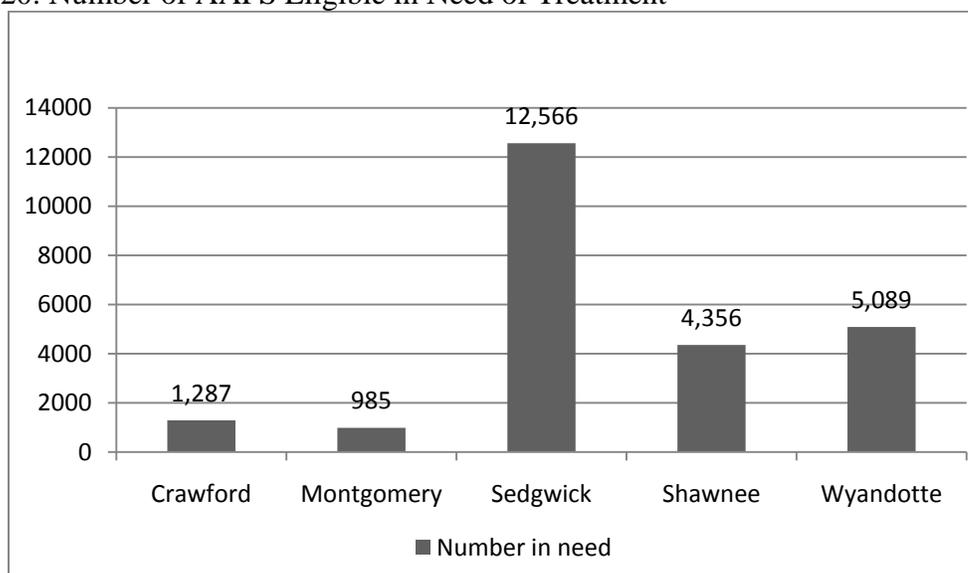


Table 13 provides data on the number of residential beds available for target communities (Kansas Comprehensive Treatment Needs Assessment Capacity/Gap Analysis, Final Report, July 2006). With the exception of the Wichita region, this data includes larger regions than just the target communities and so does not present an accurate measure of the number of beds available in those communities.

Table 13: Number of Residential Beds for Adults by Region.

Region	Detox	Intermediate	Reintegration
Kansas City Metro	18	81	90
Northeast	12	89	82
Southeast	4	20	14
Wichita	31	95	95

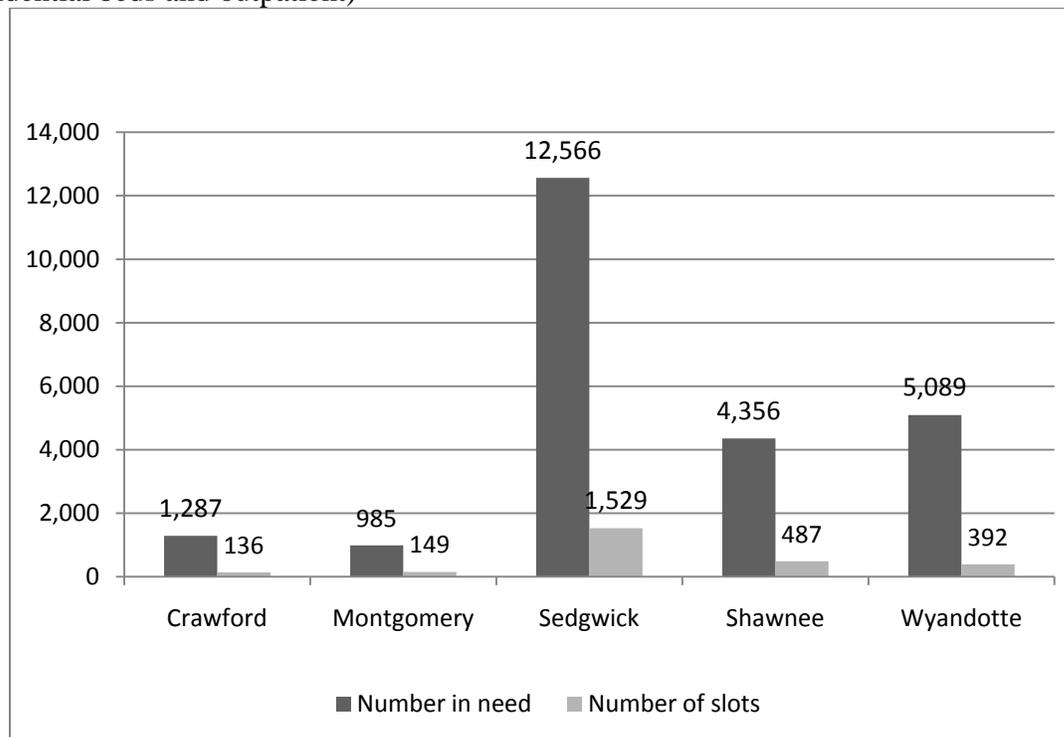
Table 14 provides estimates of the number of outpatient slots available in each of the targeted communities. Outpatient treatment capacity calculations are not as straightforward as other treatment modalities. Unlike detoxification and residential treatment where there are a fixed number of beds, outpatient service capacity is often in a state of flux. Staffing patterns, group size, agency hours, and clinical contact time are just a few of the factors that influence agency-level capacity. The data below represents the potential number of clients that could be seen in each county in any given week.

Table 14: Weekly Outpatient Capacity Index.

County	Outpatient-Group	Outpatient-Individual
Crawford	49	49
Montgomery	67	44
Sedgwick	988	320
Shawnee	207	67
Wyandotte	135	68

Figure 21 shows the significant gap between the number of slots available (both residential and outpatient) and the number of people in need of treatment in the targeted communities. When taking into account the fact that the residential slots are region-wide figures and not county specific, the gap in services is even larger than demonstrated.

Figure 21: Comparison of Number in Need of Treatment with Available Slots (Slots include residential beds and outpatient)



The following are other significant findings from the Kansas Comprehensive Treatment Needs Assessment Capacity/Gap Analysis that provide information important for the purpose of this capacity assessment:

Specific to target communities

- Significant outpatient and intensive outpatient service gaps for adolescents exist in two of the targeted communities, Shawnee and Wyandotte Counties
- There are a number of counties with severe, persistent substance problems including Crawford, Shawnee and Wyandotte.

- The southeastern corner of the state appears to have high need with a low supply of services, particularly in Cherokee, Crawford, Labette and Montgomery. However there are no intermediate programs and intensive outpatient treatment is available only in Crawford.

More general findings

- Although there are many treatment programs operating at reasonably high capacity levels, there remains a shortage of programs in counties where they are most needed.
- The more intense the modality (residential versus outpatient), the further people have to go from home to get treatment
- Detoxification services are only available in a few counties
- Intensive outpatient treatment, a relatively easy modality to implement, is only slightly more available than detoxification
- Residential/Reintegration is available in the most populated counties but needed in other areas
- There are very few Hispanic treatment programs
- Women's residential treatment programs are concentrated in a few parts of the state
- Providing family-based treatment will be challenging in many parts of the state because of long driving distances to the nearest program

Services for At Risk Pregnant Women or Women with Small Children

The number of children who were in the home of someone who went to treatment across the state of Kansas in FY 2010 was 15,238. One key gap in services identified in the Capacity/Gap Analysis and in the interviews with state level and all of the local providers is the lack of substance use disorder treatment services for women, including access to residential treatment where women can take their children. There was previous access to these services in both Shawnee and Wyandotte Counties. However, this is no longer the case. Women from these urban counties are required to seek treatment at First Step in Lawrence, Kansas if they wish to take their children. First Step lacks the capacity and the required slots to serve as the sole source of gender-specific treatment where women can take their children for these large, urban communities.

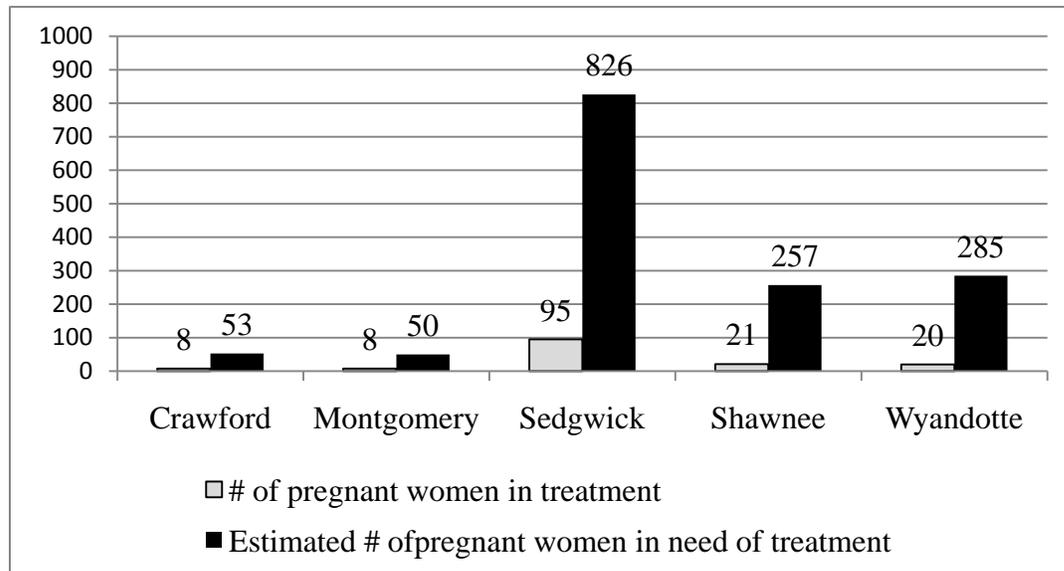
Gender specific programs, regardless of modality, tend to benefit women more than men because they provide an environment where the female client has to focus solely on herself. Generally speaking, detoxification programs can offer the most impact by encouraging clients to continue their treatment experience and ensuring these clients follow-up with appropriate treatment referrals. Outpatient and residential programs focus on treatment issues specific to women, especially employment, psychiatric treatment, and parenting. Counties identified as having high levels of women in need of treatment include all five of the at-risk communities targeted in this application (Crawford, Montgomery, Sedgwick, Shawnee, and Wyandotte) (Kansas Comprehensive Treatment Needs Assessment Capacity/Gap Analysis, Final Report, July 2006).

Residential treatment for women with children is a critical modality because it allows young children to remain with their primary caregiver while the mother learns treatment and parenting

skills in a supervised environment. These services are only available in one of the target communities, Sedgwick County, and are a tremendous need in the other targeted communities.

Figure 22 below shows the number of pregnant women who sought treatment from a state-funded treatment provider compared with estimated rates of pregnant women in need of treatment in each of the target communities. The chart clearly demonstrates the significant lack of capacity to address pregnant women with substance use disorder.

Figure 22: FY 10 Admissions for Pregnant Women Compared with Estimated Need by County



Additionally, Kansas had a program that targeted pregnant women using substances called Health in Pregnancy (HIP). HIP began in one community and was expanded by the Kansas Legislature to three other counties, including one of the targeted communities (Sedgwick). The program provided treatment services including intensive case management and incentives for remaining substance free. An evaluation of this program showed promising outcomes for both the women and children participating. In 2009, Kansas made services similar to HIP available statewide through Family Preservation services. This was done by requiring the Family Preservation contractors to include voluntary services to pregnant women using substances as part of their new contracts. One consequence of the statewide initiative was that funding was limited to continue services at the previous intensity in the four communities including Sedgwick County. The services provided to pregnant women using substances through Family Preservation were not well utilized in the first year (FY 2010) with only 26 women statewide participating in these services. Reasons given by state partners for the lack of participation include limited promotion of the services and the perception that utilization of services from a Family Preservation contractor may result in removal of their child.

Gaps in Providing Treatment Services and Coordinating with Home Visiting Programs

As part of the HV capacity assessment process, interviews were conducted with state level staff from Addiction and Prevention Services and local level treatment providers. The following is a synopsis of other key findings and themes from the interviews (See Appendix B for themes.)

State Findings on Capacity and Access

- Gaps in capacity to meet demand for treatment services
- Challenges include long waiting lists and high caseloads
- Need for services to target cultural populations
- Few residential treatment options for pregnant women and women with small children
- Pregnant women and women with young children are priority populations for treatment slots and access to services occurs within 48 hours
- Wait time is a few weeks for a residential bed for women with children but an outpatient slot is offered
- Transportation and child care are barriers to accessing and engaging in treatment services
- Pregnant women may have to travel to an available slot—no assistance is available
- Lack of coordination between treatment services and mental health

State Findings on Coordination of Home Visiting Programs with Treatment Services

- Lack of effective coordination between HV and treatment services
- No formal coordinated effort at the state-level to integrate home visiting programs within the existing treatment structure
- Treatment service providers are mostly unaware of home visiting programs, the purpose of them, and how to coordinate treatment services and home visiting services.
- Need for warm transfers between home visiting and treatment services
- Improved information sharing could be beneficial to home visitors and treatment providers
- Fear of having child removed due to substance use may prevent women from seeking services
- At-risk parents have a perception that HV programs are connected with child protective services
- Need for more training to support HV staff in understanding treatment and addiction
- This should include training in identification, the impact of trauma and the parenting dynamic in families affected by substances
- Confidentiality barriers exist and satisfying the federal level is difficult
- Federal confidentiality laws are stringent

Findings on Capacity and Access across All At Risk Communities

- Lack of treatment options for pregnant and parenting women (as previously discussed)
- Lack of transportation to and from services is a huge barrier

- Lack of wrap-around services for substance-using women (e.g., case management, housing, mental health, prenatal care, daycare, transportation, medical)
- Lack of childcare options for clients in treatment
- Large waiting lists (even for priority populations) (e.g. six week wait for residential beds—beds are available but funding is not (can't provide services that aren't reimbursed))
- Lack of detox and intermediate-level treatment services
- Gap in services for co-occurring disorders including lack of community case management for follow up and access to psychiatric services and medications
- Comprehensive training about substance use issues for SRS and other social service agencies is a need
- Need for improved communication among agencies serving families

Findings on At Risk Community-Specific Issues

Southeast Kansas

- Identifying and engaging women who are not receiving any services is difficult – lack of coordinated outreach to these women
- Lack of awareness of home visiting programs among substance use disorder treatment providers

Sedgwick

- Opportunities for services don't fit with schedules of consumers and are inflexible
- Lack of services for single men with children
- Lack of services for families who don't meet eligibility criteria (e.g. income, referral source, priority population)

Shawnee

- Lack of successful engagement of the Hispanic community among service providers
- Difficulty recruiting and retaining staff (especially physicians)

Wyandotte

- Parents are so overwhelmed they don't follow up on referrals or engage with the services
- Substance abuse assessments (RADAC) aren't available on nights and weekends and are sometimes scheduled for 2-3 days out--short window of time with patients at the hospital to get them connected
- After referrals are made, there is not communication back about what happens with the family

Summary

Substance use disorder services in Kansas offer a wide range of options for individuals seeking treatment services. Pregnant women and women with young children are a priority population for state funded treatment slots. However, the capacity assessment conducted in 2010 as part of this application and the Kansas Comprehensive Treatment Needs Assessment Capacity/Gap Analysis have identified several significant gaps and challenges with access to treatment services and coordination between treatment services and home visiting programs. One of the most crucial gaps is that treatment capacity does not meet the need in any of the targeted communities. Another significant issue is the lack of treatment services for pregnant and parenting women, especially where they can take their children, in all but one of the targeted communities. Additionally, the availability of transportation – public or private-- and childcare options while in services are two of the most common barriers to receiving services.

In the targeted communities, there is little formal coordination of services with existing home visitation programs, the TANF/SRS Solutions Case Management program and the SRS Family Preservation services often co-occur with treatment, there appears to be far fewer coordinated efforts at the community-level to link at risk women in treatment to home visiting programs or vice versa. The reasons for this vary from lack of awareness of the home visiting programs available to lack of formal referral protocols or mechanisms to limited involvement in early childhood efforts. In smaller communities, many of the service providers who work with at risk populations are informally aware of who is providing services to which families, but coordinated efforts are limited.

Additionally, clients and providers may struggle to coordinate treatment requirements with home visits, parent education groups, or other services an at-risk family may be receiving. Finding enough qualified staff who understands the unique needs of women in treatment and to address the needs of specific cultural populations can be challenging in many communities. Given the goals of home visiting services, ensuring that treatment staff understand early childhood development is critical and is lacking in many of the at risk communities. Similarly, home visiting program staff may not be well trained in identifying substance use, understanding the impact on the family, and knowing appropriate engagement strategies for those using substances. Without this background, an opportunity to engage at risk women in treatment may be missed. The support of a home visiting professional who has developed a relationship with the at risk woman can be critical in engaging her in treatment.

Based on results from this capacity assessment, all targeted communities could benefit from improved coordination and increased collaboration between home visiting programs, recovery providers and other available services.

Section 6: Summary of Results and Plan to Address Unmet Needs

Needs Assessment Process Summary

The State of Kansas completed the Maternal, Infant and Early Childhood Home Visiting Program Needs Assessment in a series of steps:

1. *Complete a statewide data report.* The statewide data report was completed, using the Title V, CAPTA, Head Start, and SAMHSA Sub-State Treatment Planning Data Reports, and additional sources on the State level. Original sources were sought to confirm accuracy of data on the eight Federal indicators—(i) premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health; (ii) poverty; (iii) crime; (iv) domestic violence; (v) high rates of high-school dropouts; (vi) substance use disorder; (vii) unemployment; or (viii) child maltreatment.
2. *Identify the unit selected as “community.”* To identify and rank communities in the state with concentrations of risk factors, the State utilized the *Kansas County Health Rankings* for indicators of health determinants and outcomes and identified 11 separate data sources to compile the most current risk indicators of (i) premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health; (ii) poverty; (iii) crime; (iv) domestic violence; (v) high rates of high-school dropouts; (vi) substance use disorder; (vii) unemployment; or (viii) child maltreatment. From this process, four communities at most risk were identified using median rank methodology.
3. *Complete a data report for each at risk community in the State.* Once at risk communities were identified, the State reviewed needs assessments completed for Title V, Head Start, and CAPTA, compiled program service data for each community on the continuum of home visiting programs available, and conducted state and community level interviews and focus groups. As with the statewide data report, original sources were consulted on the eight Federal indicators. This information was used to: 1) identify existing home visiting services statewide and at the community level; 2) gain input at all levels (administrative, program, and client) on the quality of existing home visiting programs and the coordination of services among community partner agencies; 3) identify underserved populations; and 4) conduct a capacity-need gap analysis in each community based on level of need in a community and home visiting program capacity to meet that need..
4. *Provide information on the quality and capacity of existing programs/initiatives for early childhood home visitation in each of the communities identified as being at risk.* A multi-

level approach was used to assess the quality and capacity of home visiting programs on the state level and within each high risk community. Table 8 shows the available services and characteristics, and Table 9 shows the demographic characteristics of families served by home visiting services in these communities. Although there are unique nuances of each community, the gap analysis identified several universal themes:

- Needs of families are not always met by the available services. Due to a shortage of slots, the intensity and frequency of services does not always match the needs of families.
- A coordinated referral process varies by community. The coordination of referrals alone is not enough to ensure that families are engaged. Mechanisms to support follow-up are lacking.
- Local communities can prioritize eligibility to address the unique needs of their community, resulting in families who are on the brink of eligibility not receiving services.
- There is no centralized data system or common outcomes across home visiting programs. As a result, communities are not able to report as a continuum of home visiting services the impact they are having on high risk families. Because not all programs collect demographic data, it is difficult to know which families with which high risk factors are not being served.
- There is no linkage between home visiting and substance use disorder treatment providers and domestic violence advocates.
 - Home visitors have inadequate training to address the issues of families experiencing substance use disorders, domestic violence, or mental health issues.
 - Substance use treatment providers and domestic violence advocates lack awareness and understanding of home visiting services.
 - The fear of having a child removed from the home due to substance abuse may prevent women from seeking services.
- Treatment Services for substance abuse are lacking and do not meet the demand.
 - There are few residential treatment options for pregnant women and women with small children.
 - Some treatment programs serve multiple counties, requiring a 30 to 50 mile drive.
 - A lack of child care prevents some parents from accessing services.
- There is a misperception on the part of families that home visitors are a part of the child protective services system.
- Some entry points, such as hospitals, are reluctant to refer families at high risk of child maltreatment to services that are voluntary. For that reason, they refer to Family Preservation services.
- There is a lack of coordination between service providers attending to multiple needs of families, i.e. a family with a child with special health care needs, child welfare

involvement, and families with multiple children. Some providers operate in isolation to address a particular need, leaving families confused or overwhelmed.

- Staff capacity is lacking at many entry points, such as hospitals, to adequately screen and refer families to appropriate home visiting services. This is a missed opportunity when families are open to supports.
 - Transportation options are a challenge—the challenges vary in urban and rural settings.
5. *Provide a narrative description of the State’s capacity for providing substance abuse treatment and counseling services to individual/families in need of these services who reside in communities identified as being at risk.* Substance abuse treatment service capacity across the state and within the identified communities was assessed via the Kansas Comprehensive Needs Assessment Capacity/Gap Analysis (July 2006) and interviews with state and community treatment providers. This information was integrated within all aspects of this report with particularly emphasis on coordinating services with existing home visitation programs serving at risk pregnant women or women with small children within each community. Following are the State and High Risk findings

State Findings on Coordination of Home Visiting Programs with Treatment Services

- Lack of effective coordination between HV and treatment services
- No formal coordinated effort at the state-level to integrate home visiting programs within the existing treatment structure
- Treatment service providers are mostly unaware of home visiting programs, the purpose of them, and how to coordinate treatment services and home visiting services.
- Need for warm transfers between home visiting and treatment services
- Improved information sharing could be beneficial to home visitors and treatment providers
- Fear of having child removed due to substance use may prevent women from seeking services
- At-risk parents have a perception that HV programs are connected with child protective services
- Need for more training to support HV staff in understanding treatment and addiction
- This should include training in identification, the impact of trauma and the parenting dynamic in families affected by substances
- Confidentiality barriers exist and satisfying the federal level is difficult
- Federal confidentiality laws are stringent

Findings on Capacity and Access across All At-Risk Communities

- Lack of treatment options for pregnant and parenting women (as previously discussed)
- Lack of transportation to and from services is a huge barrier

- Lack of wrap-around services for substance-using women (e.g., case management, housing, mental health, prenatal care, daycare, transportation, medical)
- Lack of childcare options for clients in treatment
- Large waiting lists (even for priority populations) (e.g. six week wait for residential beds—beds are available but funding is not (can't provide services that aren't reimbursed))
- Lack of detox and intermediate-level treatment services
- Gap in services for co-occurring disorders including lack of community case management for follow up and access to psychiatric services and medications
- Comprehensive training about substance use issues for SRS and other social service agencies is a need
- Need for improved communication among agencies serving families

Data Challenges

Few challenges were encountered in identifying and accessing the necessary data for this assessment. The majority of State agencies providing data were represented on the Kansas Home Visiting Work Group, consisting of individual representatives from the following state offices: maternal and child health, community-based child abuse prevention (Title II of CAPTA), child welfare, and substance use disorder services. In addition, representatives of other organizations with an interest in the process were present, including the Kansas Health Institute, local health departments, representatives of home visiting programs, the Head Start Association, and Part C of IDEA. Data from the required needs assessments was cross-referenced by going to the original sources, which are described in Section 1. While several data sources provided real-time data on some population risk factors, a few sources had data compiled during the early to mid 2000's, providing a slightly dated snapshot of current population trends. Additionally, not all existing home visitation programs across the State collected the same type and level of data on existing clients and services. This impacted the extent to which it was possible to comprehensively analyze and identify underserved populations and to use that information to inform the capacity-need gap analysis across all programs in all communities. Standardized data collection across all home visiting programs will assist in assessing the success of coordinated home visiting programs to meet the needs in each community.

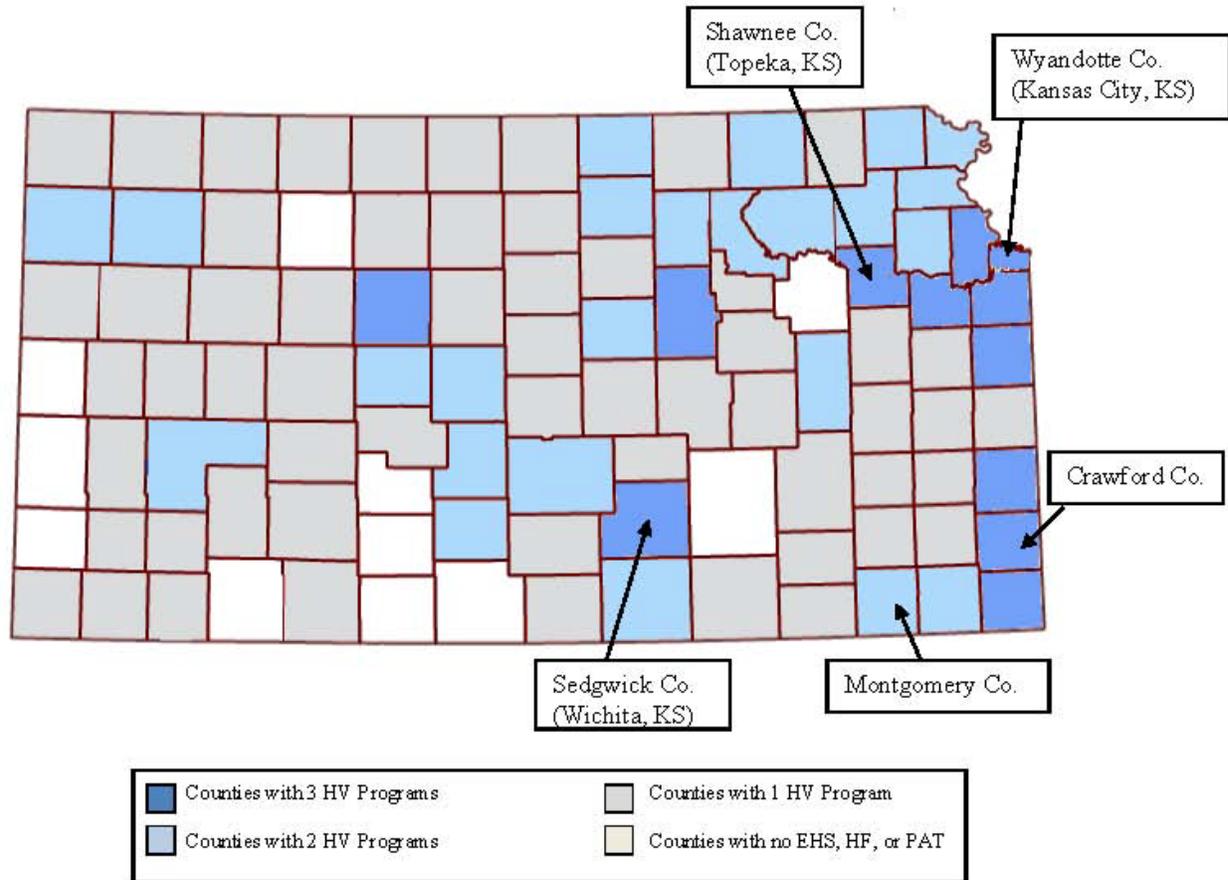
Communities Identified at Risk

The Kansas Home Visiting Work Group utilized the median ranking methodology to determine communities at risk (described in Section 1). Five high risk communities were identified:

- *Crawford County (Southeast KS Region)*
- *Montgomery County (Southeast KS Region)*
- *Sedgwick County (including Wichita, KS)*
- *Shawnee County (including Topeka, KS)*
- *Wyandotte County (including Kansas City, KS)*

Figure 23 depicts the high risk communities and the presence of Early Head Start, Healthy Families, and Parents as Teachers programs.

Figure 23: Density of home visiting services by Kansas county.



Gaps in services to individuals in high risk communities

Based on the community-specific themes and the calculation of number of needed slots, Table 15 shows the gaps and how they could be addressed in the state plan. Similar themes were identified in each community. However, to respect the unique voice in each community, their wording is retained.

Table 15: Potential approaches based on identified gaps by community.

<i>Crawford and Montgomery Counties (Southeast KS Region)</i>	
Gap	Approach
At risk population is difficult to ‘find’. Mobility is challenge	Explore ways to follow families across county and state lines.
Staff travel time plays a factor in capacity to serve all	Explore creative solutions, including adjusting case loads, to maximize service delivery in rural areas.
Lack of transportation, particularly in expansive service area	May not be addressed through this project.
Lack of bilingual staff to meet needs of eligible families	Explore models that involve recruiting and training bilingual paraprofessionals
Lack of comprehensive, wrap-around services/programs for substance-using pregnant women and mothers of young children	Explore coordination of services to ensure that all visitors to the home are coordinating services and not overwhelming families.
<i>Shawnee County (including Topeka, KS)</i>	
Gap	Approach
Eligibility restrictions limit access for families	Based on state allocations and zip code analysis, consider increasing number of slots in home visiting programs that serve families most at-risk.
Lack of slots limits appropriate referrals	
Lack of services when children turn three	Consider funding services for families with children ages three to five.
Lack of access to health care	Explore partnerships with the medical community and additional training for home visitors on access to health care.
Programs not available in all communities (e.g. Silver Lake)	Based on state allocations and zip code analysis, consider increasing number of slots in home visiting programs that serve families most at-risk.
Need for improved service provision to Spanish-speaking families	
Lack of coordination, communication, and information sharing	Explore further coordination of services to ensure that families are receiving appropriate services to meet their needs.
Need for increased awareness of HV services	Explore messaging campaigns to increase understanding and awareness of home visiting.

Need for training related to substance use disorder, domestic violence, and referral information	Explore expansion of professional development opportunities available to home visiting professionals.
Lack of access to recovery services for women	Explore methods for increasing the connections between home visiting and substance use disorder treatment programs.
<i>Sedgwick County (including Wichita, KS)</i>	
Gap	Approach
Want centralized intake—need momentum created to sustain	Explore further coordination of services to ensure that families are receiving appropriate services to meet their needs.
Need coordination of HV programs and services because many at-risk women and families have multiple groups to attend.	Explore coordination of services to ensure that all visitors to the home are coordinating services and not overwhelming families.
Lack of community understanding HV purpose and resources	Explore messaging campaigns to increase understanding and awareness of home visiting.
Misperceptions about the role of Home Visitors	
Lack of transportation options	May not be addressed through this project
Lack of bilingual staff	Explore models that involve recruiting and training bilingual paraprofessionals
Lack of comprehensive, wrap-around services/programs for substance-using pregnant women and mothers of young children	Explore methods for increasing the connections between home visiting and substance use disorder treatment programs.
Limited mental health services for young children; HV staff lack adequate training in supporting mental health needs	Coordinate with state ECCS and ECAC plans for Early Childhood Mental Health services.
Long waitlists for program services	Based on state allocations and zip code analysis, consider increasing number of slots in home visiting programs that serve families most at-risk.
Limited mental health services for young children; HV staff lack adequate training in supporting mental health needs	Coordinate with state ECCS and ECAC plans for Early Childhood Mental Health services.

<i>Wyandotte County (including Kansas City, KS)</i>	
Gap	Approach
Strong coordinated referral system, but there are challenges with engaging families in services after referrals are made	Explore further coordination of services to ensure that families are receiving appropriate services to meet their needs.
Mobility of the population limits service-delivery	Explore ways to follow families across county and state lines.
Lack of qualified staff, including bilingual/multilingual staff, to meet the needs of the families in the community	Explore models that involve recruiting and training bilingual paraprofessionals
Waiting lists for services mean that some families are not matched with the most appropriate service for their needs	Explore further coordination of services to ensure that families are receiving appropriate services to meet their needs.
Engaging families in services is limited by misconceptions of agencies, fear of punitive action, immigration status	Explore messaging campaigns to increase understanding and awareness of home visiting.
Need for further professional development for program staff	Explore expansion of professional development opportunities available to home visiting professionals.
Need more support services for pregnant women and mothers with newborns—strategies for engaging pregnant women	Based on state allocations and zip code analysis, consider increasing number of slots in home visiting programs that serve families most at-risk.
Substance use disorder treatment services are available, but the number of slots and the funding to support families in participating in treatment is limited. This is particularly true for residential treatment services for mothers with young children	Explore methods for increasing the connections between home visiting and substance use disorder treatment programs.
Strong coordinated referral system, but there are challenges with engaging families in services after referrals are made	Explore further coordination of services to ensure that families are receiving appropriate services to meet their needs.
Mobility of the population limits service-delivery	Explore ways to follow families across county and state lines.

Summary & Discussion of how the State will address needs and gaps

Through the capacity assessment process, Kansas has identified gaps and challenges at the State level and in each of the high risk communities. In the most basic terms, there are insufficient services in the selected communities to meet the needs of high risk families. Crawford and Montgomery serve approximately half of their resident families in poverty. Sedgwick County serves less than a tenth of families in poverty and Shawnee and Wyandotte less than a third.

Kansas will submit an application for funding from the Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program. In the development of the application, the Home Visiting Workgroup, in consultation with the Kansas Home Visiting Task Force, will follow a multi-step process to most effectively use the Home Visiting funding allocation:

- 1) Conduct a zip code analysis in Sedgwick and Wyandotte counties to identify pockets or neighborhoods where high risk families reside.
- 2) Assess the current home visiting program continuum in terms of the Federal Evidence-Based Practice determinations.
- 3) Consider new, promising, and innovative programs that address the identified gaps, particularly the need for better linkages between home visiting programs and substance use disorder recovery services and domestic violence advocacy.
- 4) Coordinate with other early childhood initiatives, including the Kansas Early Childhood Comprehensive Systems (KECCS) Plan and the Kansas Early Childhood Advisory Council to increase awareness of home visiting services, address misperceptions about the role of home visitors, and facilitate collaboration between home visiting services and other family serving agencies.

A PPENDICES

A - Concurrence Letters

B - Questions for Key Informants.