Approved Feb. 8, 1990 Ginger Barr
Date

MINUTES OF THE HOUSE COMMITTEE ON FEDERAL AND STATE AFFAIRS.

The meeting was called to order by Representative Ginger Barr at
Chairperson

1:38 ~~a.m.~~/p.m. on January 24, 1990 in room 526-S of the Capitol.

All members were present except:
Representatives Blumenthal
Cates
Peterson

Committee staff present:
Mary Galligan, Kansas Department of Legislative Research
Lynne Holt, Kansas Department of Legislative Research
Mary Torrence, Revisor of Statutes' Office
Juel Bennewitz, Secretary tot he Committee

Conferees appearing before the committee:
Janice Waide, Director, Division of Children in Need of Care, Social and Rehabilitative Services (SRS)
Richard Morrissey, Deputy Director, Division of Health, Kansas Department of Health and Environment (KDHE)
Robert Barnum, Commissioner, Youth Services, SRS

Chairman Barr directed the committee's attention to two notebooks provided by SRS containing information on children available for adoption and to the booklet, Home Visiting: Opening Doors for America's Pregnant Women and Children published by the National Commission to Prevent Infant Mortality, July, 1989, and on file at KDHE.

Janice Waide responded to various questions raised by the committee during the hearings on children's issues January 22-23, 1990, and gave an update on issues resulting from the committee's action during the 1989 legislative session, Attachment No. 1. Also provided by Ms. Waide were:

Attachment No. 1A - Chart reflecting the length of time children spend in SRS custody (as of June, 1989). CINC = Children in Need of Care JO = Juvenile Offender
Attachment No. 1B - Chart with the number of CINC placements (Note: These numbers only reflect the number of children who have left the system)
Attachment No. 1C - Adoption statistics July 1, 199 - June 30, 1989
Attachment No. 1D - Risk assessment matrix used by SRS to aid in staff determination of need
Attachment No. 1E - FY 1989 statistics regarding only CINC (JO not included) (green)

Committee discussion:

1. The committee requested the yearly figures for CINC placements.
2. Custody does not necessarily mean foster care.
3. Children in need of care other than child abuse and neglect investigations are defined as:
   a. truants;
   b. status offenders;
   c. children in conflict with the rules of the community, school or home; and
   d. children out of control
4. Usually two parent families have income above the standard for ADC and are therefore ineligible for such funds.
5. The Director of Child Enforcement would have knowledge of the rules and regulations regarding settlement or compromise of monies sued for collection by SRS.

6. re: Attachment No. 1C, Ms. Waide cautioned that numbers would not balance if totaled as a child may have more than one identifying factor.
7. There are a number of single parent family requests for adoption.
8. Minorities prefer to maintain their children within their own culture, if at all possible, a posture adopted by SRS. However, rather than allow a child to "languish" in foster care, bi-racial adoption may be permitted.
9. re: "bottlenecks" to the adoption system - biological parents' pleas throughout the court process may lengthen placement time by several years. In such cases, after parental rights are severed, a child may be placed in a "legal risk placement". The potential adoptive parents must be fully informed of the legal risk.

10. The Permanency Planning Task Force of the Supreme Court has discussed approaching the legislature regarding the acceleration of due process in adoption cases. Judge Davis, Court of Appeals, is the Chief Justice's representative on the Task Force.

    Adoption cases are usually heard in district, rather than magistrate court or the court of appeals. Commissioner Barnum stated SRS' general counsel would be consulted conerning streamlining the adoption process.
11. re: the removal of a child from his/her home - Ms. Waide explained immediacy of removal to be a judgment call on the part of law enforcement or SRS staff. A child may only be removed from the home by a court or its officers. SRS staff, not being court officers, cannot remove a hcild. The court also determines when the child may be returned home. SRS does have input into both decisions. Juvenile offenders may be returned to the home without court permission.

    Every abuse call generates an on-site visit and current SRS policy is that the child and alleged perpetrator are interviewed, if possible. Alleged abuse calls from ex-spouses are handled as any other call unless they are multiple and have not proven substantive. At that time, the ex-spouse may be asked to submit allegations in writing or by affidavit.

    SRS has appeal recourse if it feels reinstatement of the child to the home is inappropriate. Ms. Waide had no statistics on this.
12. Attachment No. 1E does not reflect the number of cases categorized as unconfirmed, unfounded or no reason for concern as SRS keeps no record of them. "Unconfirmed but in need of service" means that the SRS worker was concerned enought about the family to offer services even though the criteria for abuse was not met.
13. A family assessment is done when SRS determines a family needs immediate service, the children will have to be removed from the home or a child is to be reintegrated into the home. The family and SRS person work jointly on a service plan which the court often includes in its disposition. SRS policy is that only under extreme, extenuating cirumstances would the SRS social service chief use his authority to extend the plan beyond 12 months. Eighteen months is the outside limit at which time SRS evaluates its position in termination of service. Severance of parental rights may be sought. If the child is 14 years or older, the determination may be that he will stay in foster care, working toward independent living. The judicial process is:
    a. SRS can seek removal of the child on the basis of a sworn affidavit by the social worker or supervisor in an emergency.
    b. The court has 72 hours to set an intitial review which is usually reset two to three weeks.
    c. Refusal of the family to cooperate in drawing the family service agreement is reported to the court.
    d. Depending on the court, initial hearings to remove the child from the home may be conducted with no representation for the family.

Richard Morrissey introduced KDHE staff - Dr. Azzie Young, Director Bureau of Family Health; Coni Beshears, Director of WIC; Cassie Lauver, Director of Special Health Services and Chris Ross, Child Care Licensure Program. Mr. Morrissey discussed existing public health programs for children and families, specifically several preventive health programs, Attachment No. 2.

Committee discussion:

1. The Topeka-Shawnee County Get Fit Program is a preventive program based on a wellness model. It is funded with Maternal and Child Health block grant funds.
2. It was not known if there is a tie to income with the screening program. The M&I projects are tied to 200% of poverty level.
3. KDHE is working with SRS in income maintenance and medical programs to maximize MedicAid services. The federal government is taking the position that this may become a primary funding source primarily with women and children.
4. The Childhood Immunization Program provides polio; measles, mumps, rubella (MMR); and diptheria, pertussis, typhoid (DPT) vaccines. The polio and MMR vaccines are provided by the federal government. The total value of the vaccines is approximately $1.2 million. The vaccines are purchased by national contract. Contract cost has increased due to tort liability. The FY 1990 cost for DPT vaccine was $900,000 as compared to $146,000 in FY 1987. (Historically, the state had provided DPT vaccine which was relatively inexpensive.) There hs been federal legislation to cap the costs.
5. KDHE has date which it wil provide to the committee regarding the Healthy Start Program. Home visits are made and followups to high risk women are done by Public Health and Welfare.
6. Mr. Morrissey clarified that there was an increase between the 1989-90 budgets due to phase in funding but the 1991 budget is being maintained at the 1990 level.

Attachment No. 2A is a KDHE pamphlet outlining the Healthy Start Program.

Commissioner Barnum responded to Chairman Barr's question of January 2, 1990, concerning what would be necessary to provide the best possible program. He spoke about specific programs but offered no proposed budget figures.

A. The preventive aspect is well served by the Parents as Teachers and Health Start Programs. The latter should be statewide.
B. The Foster Care System is made up of many parts e.g. truant aspect, the non-abused but neglected, the rising expectations of the community and legislature, etc. which all impact the staff. He advocated changing the "mix" of staff to add paraprofessionals, clerical support, relief of social workers from roles such as drivers. Additional training would be necessary for staff and foster and adoptive parents to maintain a system responsive to children's needs.
C. Family efforts should be continued as it provides positive results. Data should be available this session to verify the effectiveness of those efforts.
D. Commissioner Barnum advocated rekindling of community resources which historically had positive results. He mentioned churches, schools, the YMCA and YWCA which are often not involved with families seen by SRS.
E. Interagency cooperation - he suggested some type of fund which could only be accessed by cooperation with another agency or unit as an incentive.
F. Diversification of services available to foster children. Commissioner Barnum did not advocate additional state institutions as a solution.
G. Flexibility with the courts - could help the chld and thus reduce state costs at some point in the continuum. The Child in Care Program does not have some of the options that the juvenile offender program has.
H. Repeated assessments are ineffective without follow-up.

February 9-10, 1990, there will be a retreat in Emporia involving SRS staff, private agencies, legislators and others which will address concerns heard during the January 22-24 hearings of this committee. Chairman Barr asked the commissioner to communicate results of the retreat.

The revisor requested the committee introduce some bills needing technical changes. Representative Gjerstad moved the introduction, seconded by Representative Wagnon. The motioin was adopted.

The meeting adjourned at 3:23 p.m. The next meeting of the committee will be January 25, 1990, 1:30 p.m. in Room 526-S.

GUEST LIST

FEDERAL & STATE AFFAIRS COMMITTEE

DATE January 24, 1990

(PLEASE PRINT) NAME	ADDRESS	WHO YOU REPRESENT
ANGELA M. FRANSON	Rt 4, CLAY CENTER, KS	SELF
NICOLE R. SPELTZ	2020 5th CLAY CENTER, KS	SELF
TRISTA WOODRUFF	1611 1st CLAY CENTER, KS	SELF
Susan Siebold	Rt. 4 Clay Center, KS	self
KEITH R LANDIS	TOPEKA	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS
Elva Coopman	5805 Slater Pl Merriam Ks 66202	Self
Joni Beshears	900 Jackson St	KDHE
Cassie Lauver	LSOB	KDHE
Richard Morrissey	Topeka	KDHE
Eunice L Mayo	LSOB	KDHE
Hezzie Young	LSOB	KDHE
Cathy Leonhart	300 SE 7th Suite 104	KACSO
Laura Lee Bonkey	420 Washington Clyde KS 66938	self
Barbara A Tillotson	PO Box 89 Clifton KS	Self
Chip Wheelen	Topeka	Ks Psychiatric Society
Donna Buchholz	715 West 10th Street Topeka, KS	Ks Child Abuse Prevention Council
DON LINDSEY	OSAWATOMIE, KS	UTU

DEPARTMENT OF SOCIAL & REHABILITATION SERVICES

Testimony before the

Federal & State Affairs Committee

January 24, 1990

Jan Waide, Director
Division of Children in Need of Care
Youth Services
Department of Social & Rehabilitation
Services
(913) 296-3282

Federal & State Affairs
Attachment No. 1
January 24, 1990

DEPARTMENT OF SOCIAL & REHABILITATION SERVICES
YOUTH SERVICES

FEDERAL AND STATE AFFAIRS COMMITTEE
January 24, 1990

Madam Chairman, I am pleased to have the opportunity to appear here before you in regard to children's programs. My intent today is simply to respond to the questions that have arisen in previous meetings of this committee this week. In addition I believe I am to update you on the current status of the issues resulting from the committee's action during the 1989 session.

My notes reveal there was interest expressed on Monday regarding the length of time children spend in custody and therefore I have copies of a chart showing children in SRS custody as of June 30, 1989 -- Length of Time in Custody. (Chart 1)

A second issue that interest was expressed on Monday was the number of placements that children experience while in custody and staff have provided me with Chart 2 which shows number of child in need of care placements by length of time from initial custody to time of closure.

Another question arising on Monday for which we do not have any data was average length of time in custody prior to termination of parental rights.

Interest was expressed in the Child Support Enforcement (CSE) program, specifically in regard to amount of money collected from natural parents of children in foster care. We contacted CSE and received the following figures:

FY 1989

$689,053 - from General Assistance Foster Care (GA-FC) parents.

$154,821 - from Aid to Dependent Children-Foster Care (ADC-FC) parents.

FY 1990

CSE reported to us that they have collected an average of $70,000 a month from GA-FC parents. No figures are available on ADC-FC cases.

FSA
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It should be noted that these collections include Social Security benefit payments to the agency for these children and any other benefits, such as Veterans benefits, etc. The amount of benefits accruing to foster care children are not broken out separately by CSE.

Interest in SRS adoption program sparked questions regarding the number of children with handicaps and other special needs being adopted. I have provided you with adoption statistics that address this issue for FY 1989. (Chart 3)

In yesterday's session the question was raised, "Where are the bottlenecks in the system that prevent a healthy three month old child from an expeditious placement into adoption?" I would like to discuss that situation with you informally because there is not a simple answer to that. The answers are difficult due to the number of actors who must act swiftly in order to speed the child through the system into an adoptive placement. Those actors include our own SRS staff, county and district attorneys, and courts. As you know, natural parents have the right to full due process and many times avail themselves of their appeal rights and therefore children can not go into adoptive placement speedily.

In addition, yesterday there were questions asked regarding a determination of which children to leave in their own homes, which children to remove temporarily, and which children to remove with parental rights termination occurring rapidly. In that regard I will be sharing with you information regarding a risk assessment matrix that our field staff are currently using to help them make these kinds of determinations. (Chart 4). In addition, in the Family Services program we have set time frames for the accomplishment of the family service plans. These time frames are designed with

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the child's best interest in mind because we recognize the need to resolve a child's situation quickly and move them into permanence. Service plans are written in the beginning for 90 days to 6 months maximum. If progress during the initial time frame shows that the plan is not completed, the parents can be given additional time to complete the plan, not to exceed another 6 months. Under very circumstantial situations our Social Service Chiefs may authorize an extension of a service plan after 12 months but this is to be done very judiciously in the interest of the child or children.

Yesterday there was an attempt to determine if any generalizations could be made in regard to the families of children in foster care, i.e., age, race, etc. It is very difficult to make any generalizations about the parents we serve. They come from every walk of life, all ages, all sizes and descriptions. Each individual family situation is unique just as there are no two children exactly alike in the system.

I would briefly like to respond to the questions about AIDS and crack and cocaine babies. We have not experienced a large increase in children entering the system who test HIV positive. We have had three or four in the system for quite some time. Basically, they are older children. The story is quite different with crack and cocaine babies. The metropolitan areas are experiencing many young children coming into the system due to crack and cocaine problems in families. We have received some crack and cocaine addicted babies at birth but the largest number of children come to us where the parent or parents are drug involved. These children, too, are very young and thus very vulnerable.

The recommendations that we recall coming out of this committee last year were 1) to support a study of the child welfare system by an outside authority in child welfare and 2) to support higher foster care reimbursement rates and 3) to support Representative Sughrue's bill, House Bill 2315. Let me briefly share with you the current status of those recommendations. As you know money was provided by the legislature for a child welfare study in Kansas, however by late summer it became apparent that there was not enough money to pay all the bills for costs that we were already obligated to pay. Therefore the decision was made not to obligate the state for any new costs thus no contract was extended for the child welfare study. As you know money was provided in the budget for an increase in foster care rates and providers did receive a 5% increase on July 1, 1989. However, again, by late fall or early December it was clear that in order to pay all of our obligations through June 30, 1990, we would not be able to give the providers the 10% increase that was to be effective January 1, 1990.

This concludes my prepared remarks and I would entertain any questions you may have.

Jan Waide, Director
Division of Children in Need of Care
Youth Services
Department of Social & Rehabilitation Services
(913) 296-3282

FSA
1-5
1-24-90

Cost of case is a follows:

Foster Family Rates:

Age:	Daily Rates:
0-6	$ 6.74
5-11	9.11
12+	11.55

Group/Residential Homes:

Placement:	Daily Rates:
Level III	$ 28.53
Level IV	48.11
Level V	63.01
Level VI	178.50
Emergency	63.01
Other	48.11
Detention	45.18
Emergency/Respite FC	28.53
Youth Centers	110.24

Children In SRS Custody as of June 30, 1989
Length of Time in Custody

	0-5 Mos.	6-12 Mos.	1-3 Yrs.	4-5 Yrs.	6+	TOTAL
CINC's	948 (22%)	797 (18%)	1943 (45%)	364 (8%)	310 (7%)	4362
J.O.'s	293 (19%)	318 (20%)	663 (43%)	162 (10%)	122 (8%)	1558
TOTALS	1241 (21%)	1115 (19%)	2606 (44%)	526 (9%)	432 (9%)	5920

Robert C. Barnum
Commissioner
Youth Services
Dept. of Social &
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Federal & State Affairs
Attachment No. 1A
January 24, 1990

Chart # 2.

KANSAS YOUTH SERVICES
CHILD TRACKING SYSTEM
Number of CINC Placements By
Length of Time From Date of Initial
Custody to Time of Closure

October 1989

Number Placement	Time in Custody					
	0–1 Year	2–3 Years	4–6 Years	7–9 Years	10 or More Years	Total
0–3	129	3	2	2	2	138
4–8	46	13	13	4	5	81
9–13	3	1	2	0	0	6
13 Plus	0	0	0	0	0	0
TOTAL	178	17	17	6	7	225

Adoption Statistics

FY89

July 1, 1988 - June 30, 1989

Children relinquished or committed	211
Children referred for adoption	166
Children placed for adoption	178
Children whose adoption was finalized	159

106 Of the children placed for adoption were over age five.

11 Of the children placed for adoption were age 15 and older.

39 Were of minority backgrounds.

54 Were identified as having severe emotional and/or attachment problems requiring on-going therapy.

12 Had severe physical handicaps or health problems requiring extensive medical treatment.

13 Were in the educable or trainable range of mental retardation.

30 Were identified as having learning disabilities.

18 Children were placed with families recruited by Kansas licensed child placing agencies.

112 Children were approved for adoption assistance.

Federal & State Affairs
Attachment No. 1C
January 24, 1990

CASE EXAMPLES OF SRS ADOPTIVE PLACEMENTS

Aryon, (Caucasian), age 10, was placed in a single parent adoptive home. Aryon has a new sister in her family, age 19 who is also adopted. Aryon and her adoptive mother report she is making continued progress with her acting out behaviors in school and arrangements for Aryon to be mainstreamed into regular classrooms are in process.

Kimberlee, (Caucasian), age 14, was adopted by a single parent. Her adoptive mother is employed as a family counselor and has no other children in her home. Kimberlee is currently involved in music lessons and participates in the church choir.

Clayton, (Caucasian), age 2, was placed in a two-parent adoptive home. The adoptive father is employed as a production worker and the adoptive mother is employed with an accounting firm. They have no other children in their home. Clayton is a healthy active child who continues to flourish in his development.

Robert, (Caucasian), age 12 and Kenneth, (Caucasian), age 7, are siblings who were adopted by their foster parents. The adoptive father, a salesman, and the adoptive mother, a dietician, have no other children in their home. The family is actively involved in their church and the boys keep busy with school and play activities.

Michael, (Black), age 5, was placed in an adoptive home with his two-year-old brother Desmond (Black). Michael and Desmond joined a family of six and they now have three new sisters and one new brother. Their adoptive father is the pastor for their church and their adoptive mother is a homemaker.

Angela, (Caucasian), age 7, has recently been adopted by her foster parents. Angela has one brother, who is also adopted, and a younger sister in the home to play with. Angela's adoptive father is employed at a local plant and her adoptive mother presently operates a day-care business.

Kelly, (Caucasian), age 13, was adopted by a two-parent family. Kelly's adoptive parents had adopted previously and Kelly gained two siblings upon joining her new family. Her adoptive father is a foreman and her adoptive mother is a nurse. Kelly is currently attending special education classes for (EMH) Educable Mentally Handicapped Children and is in the process of being mainstreamed into several regular classes during the day.

Shawn, (Caucasian), age 12, was recently adopted by his single parent family. Shawn's adoptive father is a retired electrician who continues to work part-time. The adoptive father and his wife cared for Shawn as foster parents prior to her death and Shawn's adoption. Shawn is mentally retarded and has been diagnosed with Leukemia (which is currently in remission). He is currently in a Special Education Program for the Trainable Mentally Retarded.

Karla, (Black), age 15, and Chad, (Black), age 13, are siblings who were placed with a single parent adoptive family. Their adoptive mother has two older children in her home and an adult child no longer living at home in addition to Karla and Chad. Both are anxious for school as they approach their high school years. Chad has a strong interest in sports, and is especially interested in playing football. Karla also enjoys ballgames and swimming.

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CHART #4

APPENDIX B

RISK ASSESSMENT MATRIX

Rev. 7/89

The matrix which appears below serves as a guide for decision making to determine the response time and level of agency effort. This is not a substitute for professional judgement and is intended only to supplement that judgement. It is recognized that any one factor might be so important that it alone would negate the remainder of the matrix.

	Risk Factor	Characteristics of the Report/Referral			
		High Risk	Intermediate Risk	Low Risk	Minimal Risk
CHILD	1. Child's Age	Infant to age 5	Elementary School Age	Junior High/High School Age	
CHILD	2. Child's Physical & Mental Abilities	Completely unable to care for or protect self without adult assistance.	Requires adult assistance to care for & protect self.	Can meet minimal level of self needs some adult assistance to protect self.	Cares for and protects self without assistance presents problem behaviors.
CARETAKER	3. Caretaker's Level of Cooperation	Doesn't believe there is a problem, refuses to cooperate.	Overly compliant with investigator or some hostility or not aware of problem, but some cooperation.	Aware of problem, unable to reach a resolution, placement may be an issue.	Aware of problem, works with social service agency to resolve problem and protect child.
CARETAKER	4. Caretaker's Physical, Mental and Emotional Abilities/Control	Poor conception of reality or severe mental or physical handicaps.	Poor reasoning abilities, may be physically or mentally handicapped, needs assistance to protect child.	Reasoning ability usually sound, may or may not have realistic expectations, lacks ability to correct problem	Sound reasoning abilities, realistic expectations of child, can plan to correct the problem.
CARETAKER	5. Presence of a Step-parent or Live-in Partner	Fairly new to the family, primary relationship with the parent. Relationship is conflictual, minimal attachment to the children, may provide child care.	Primary relationship is with parent, somewhat hesitant co-existance with the children, may be called upon to provide child care.	Fairly balanced relationship with the parent, children, may be somewhat conflictual, family aware of problems.	Been with the family unit for some time, balanced relationship with parent & children, atuned to relationship problems, work on these affectionate bond exists.
PERPETR	6. Rationality of Perpetrator's Behavior	Injury the result of desire to harm the child (irrational) or uses child as sexual object.	Child's injury results from excessive corporal discipline; disapproval is only method of control.	Child may have injury, possibly accidental, may involve inadequate supervision, not a persistant pattern of parental behavior.	No abuse involved, some degree of neglect or poor supervision may be present. Not a persistant pattern.
PERPETR	7. Perpetrator's Access to Child	In home, complete access to child.	In home, access to child is difficult.	Out of home, no access to child or abuse not an issue.	Abuse or serious neglect is not present.
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Federal & State Affairs Attachment No. 1D January 24, 1990

INCIDENT	8. Extent of Permanent Harm	Abuse/neglect may result in death or dysfunction of an organ or limb; failure to thrive.	Abuse/neglect may result in physical injury/discomfort, limit child participation in normal activity.	Abuse/neglect has limited or minor effect on child.	Abuse/neglect not an issue. Conflictual relationship with parent.
	9. Location of the Injury	Head, face, genitals; internal injury	Torso, arms or legs.	Bony body parts; knees elbows; buttocks.	Not applicable
	10. Previous History of Abuse/Neglect	Previous abuse/neglect of child involving allegations of a serious or life threatening nature.	Previous abuse/neglect of child not involving allegations of a serious or life threatening nature.	May or may not have previous referral, no previous reported history of abuse or neglect.	May or may not have previous referrals, no previous abuse or serious neglect.
ENVIRONMENT	11. Physical Condition of the Home.	Family homeless, utility shutoff (winter), child ill or hurt as result.	Structurally unsound, leaks, vermin, animal droppings in home, utility shutoff(summer)	Home reasonably clean no apparent serious safety/health hazards trash not disposed.	Presents no serious hazard.
	12. Support Systems	Caretaker/family has no relatives/friends and is geographically isolated from community services.	Family supportive but not in geographic area some support from friends, limited community resources.	May or may not have adequate support system, community resources.	Family, neighbors, friends available; good community resources.
	13. Stress	Experiencing serious stressors. Death of spouse, incarceration family violence, child removed.	Some stressors present Birth of child, utility shutoff, job loss substance abuse,moves, marital problems.	Some dysfunctional elements present in the family system. May have some stressors present.	No serious stressors present. Family experiencing some coping problems but fairly stable.
AGENCY RESPONSE					
	1. Response Time	Same day	Same day, 72 hours, 5 working days	5 working days to 30 calendar days	30 calendar days
	2. Service	CPS investigation, placement prevention , purchased or provided emergency placement (see criteria) removal of perpetrator, family support worker service court referral (see criteria) other purchased services, case management.	CPS or CINC investigation, placement prevention, purchased or provided, planned placement (see criteria), removal of perpetrator, family support worker service, court referral(see criteria) other purchased services, case management	Preliminary risk assessment placement prevention services (purchased or provided) family support worker service, case management, information and referral.	Information and referral, preliminary risk assessment family support worker, placement prevention focused, purchase of placement prevention service.

KANSAS DEPARTMENT OF SOCIAL & REHABILITATION SERVICES
YOUTH SERVICES
DIVISION OF CHILDREN IN NEED OF CARE

CHILD ABUSE & NEGLECT INVESTIGATIONS

FY 89 -- 23,437 reports
13,443 abuse (57.4%)
9,994 neglect (42.6%)
2,506 confirmed (10.7%)
8,049 unconfirmed, eligible for service/in need of corrective action (34.3%)
286 hospitalizations reported
134 hospitalizations as a result of confirmed abuse
6 deaths

CHILD IN NEED OF CARE

FY 89 -- 5,938 reports other than truancy
905 reports of truants under 13

FAMILY SERVICES

FY 89 -- 2,654 families served either FSW or POS (unduplicated count)
6,052 total number of children served
4,515 children = preventive services
1,431 children = reunification services
106 children = other family services

Average cost of service: $430/family/year
$188/child/year

FOSTER CARE

FY 89 -- 5,920 children in custody of SRS
4,363 children in need of care
1,557 juvenile offenders
3,209 children in paid placements
1,841 placements in family foster homes
1,368 placements in residential and group care

20% of children in custody with own families
31% of children in custody in family foster homes
23% of children in custody in residential and group care

1,938 children in need of care cases were closed
1,291 custody returned to parent (67%)
488 age 18, custody transferred to other, or other (25%)
159 adoption (8%)

A CINC is more likely than a juvenile offender to be under 13, more likely to be female, and more likely to come from a single parent household and therefore be eligible for ADC-FC. Of the 4,363 children in need of care, 2,054 (47%) were age 13 or over.

ADOPTION SERVICES

FY 89 -- 159 adoptions finalized
106 families assessed/approved
12 homes purchased from private agencies
164 children were referred for adoption
178 children were placed for adoption

CUSTODY & GUARDIANSHIP

FY 89 -- 211 children came into the guardianship of SRS and were thus free for adoption

INTERSTATE COMPACT ON PLACEMENT OF CHILDREN

FY 89 -- 1,209 children were protected when they were referred across state lines
278 were approved to be placed into Kansas
433 were approved to be placed outside Kansas

State of Kansas
Mike Hayden, Governor

Department of Health and Environment
Division of Health
Landon State Office Bldg., Topeka, KS 66612-1290

Stanley C. Grant, Ph.D., Secretary

(913) 296-1343
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Testimony Presented to

House Federal and State Affairs Committee

By

Kansas Department of Health and Environment

on Children's Issues

The health and well-being of children and families in Kansas continues to be a part of the Kansas Department of Health and Environment's agenda for the 1990's and beyond. In order to maximize health services for children and families in the state, we must target our efforts in the most effective ways, coordinate our activities, and strive to assure that all of our children receive basic health and developmental services.

My presentation today will focus on a number of existing public health programs and initiatives that we think are critical to the future of Kansas children and families. I will speak specifically to several KDHE preventive health programs that were mentioned yesterday.

First, I will address programs that focus on access to prenatal care.

1. Maternal and Infant Program

The program provides comprehensive prenatal care to high-risk mothers and newborns. This program provides: pre and postpartum supervision, including nursing, social work, and nutrition assessment, consultation and health maintenance. This state and federally funded program is designed primarily for the prevention of low birth weight, infant mortality, child abuse and neglect. The M&I program services are available in 44 counties. Nearly 80% of all births in the state occur in these 44 counties. In FY 89, 6,661 mothers and 4,834 infants were served. Thirty per cent of the women served were adolescents. Funding for this program for FY 91 is budgeted at $1.36 million including $700,000 in SGF and $657,056 in federal dollars.

We agree with the proposal to develop a plan to cover all women who do not have access to prenatal care. We estimate that there are approximately 1,341 unserved women statewide who are below 200% of poverty.

2. Special Supplemental Food Program for Women, Infants and Children (WIC)

This program is designed to improve the nutritional health status of low-

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income women who are pregnant, breastfeeding, or newly postpartum; infants, and children up to age five. Monthly food vouchers are issued that can be presented to any authorized grocery store for WIC foods that are selected on the basis of specific nutritional needs. Nutrition education is also provided. This statewide program currently serves approximately 40,000 participants each month which represents about 61% of the potentially eligible participants. On April 1, 1989, the WIC program implemented an Infant Formula Rebate Initiative that allowed expansion of the WIC caseload from approximately 50% in 1988 to 61% for 1990.

The Table below summarizes the growth of the WIC program since its expansion statewide in December, 1985.

Federal funds received from the United States Department of Agriculture (USDA) for the WIC program have increased from approximately $13,136,224 in 1986 to $18,483,560 in 1990. Monthly WIC participation increased from about 28,000 clients served in 1986 to about 39,800 in 1990. The percentage of potential eligible WIC clients served was 43% in 1986 compared to 61% in 1990. Between 1989 and 1990, the percentage of potential clients served by WIC is expected to increase 8% due to the implementation of an Infant Formula Rebate Program beginning April 1, 1989. Approximately $3.5 million of WIC food dollars spent on the purchase of infant formula in FY 90 will be returned to the state by two major infant formula companies. KDHE has three year contracts with Ross Laboratories and Mead Johnson Nutritionals which expire on March 31, 1992.

WIC Program Funding and Caseload History Federal Funding

FFY	Estimated Monthly Caseload	%Eligible Served (65,468)	Estimated Total Funding	Infant Formula Rebate
86	28,000	43%	$13,136,224	0
87	29,000	44%	14,373,653	0
88	32,000	50%	15,690,384	0
89	34,700	53%	16,872,481	$ 551,832
90	39,800	61%	18,483,560	$ 3,587,634

3. Healthy Start and Healthy Families Lay Home Visitor Program.

This program supports local health departments in 49 Kansas counties. Trained lay persons make home and hospital visits to expectant mothers, families with newborns and infants (under one year of age) under nursing

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supervision. Lay visitors identify at risk women and families, refer them to needed resources, and generally provide ongoing support and follow-up. Lay visitors are trained to educate mothers about proper nutrition, control of alcohol and tobacco consumption during pregnancy, physical fitness, stress management, and other factors which may affect health status. In FY 1988, visitors made over 27,000 visits to 14,000 families.

Funding for this program was $324,769 in FY 89 and was increased to $472,264 in FY90. A total of $236,505 is SGF. The FY90 increase is maintained in the FY91 budget.

A companion program called Healthy Families is a project that extends lay home visits to families with children ages one to four. This is the first year of a three-year project, funded by an MCH SPRANS (Special Projects of Regional and National Significance) Grant. The grant has provided funding in the amount of $125,000 for developing programs, training visitors, and the development of materials relevant to home visits for at risk families with toddlers. The project focuses on three key prevention areas: child abuse and neglect, immunization status, and home and automobile accidents. Training is provided in developmental stages of toddlers, child abuse prevention through early identification, working with parents to develop parenting, stress management skills and to follow safety measures. This program is located in eight counties.

These two programs are currently providing parenting education to families with young children. Preventive effects of these programs are directed to child abuse and neglect, home and automobile safety, vaccine preventable disease and referrals to health and social services resources. Thus we wholeheartedly agree with the proponents of PAT. KDHE currently has programs in place to provide parenting education in 49 counties. We welcome the opportunity to collaborate with KSDE in furthering parenting education programs in Kansas.

Secondly, the health of adolescents and young people is of major concern to us at KDHE. Our efforts to promote access to preventive health care services for adolescents include support of a primary care project in Wichita and two health assessment projects in Kansas City and Topeka.

Primary Care Model

Wichita Adolescent Health Station

Services began in September, 1988, for the Wichita Adolescent Health Station which is operated by the Wichita-Sedgwick County Department of Community Health. The project was designed to provide comprehensive health services including athletic physical examinations, immunizations, intervention and referrals for acute and chronic health problems, health education, and reproductive health services. During the 1988-89 school year, the station provided services to 422 middle and high school students. The three major categories of service provision were focused on respiratory conditions, problems with ears and eyes, and reproductive health including

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prenatal care and treatment for sexually transmitted diseases. The project is located immediately across the street from an inter-city high school (North High) which serves many minority and low income students and which experiences a 21% high school dropout rate per year. Students from two feeder middle schools, Horace Mann and John Marshall, are also served. During the 1989-90 school year, the Horace Mann Middle School will be changed to an elementary school center so a nearby high school will be added. The project will then serve two high schools and one middle school. The support for the project and a good working relationship exists between clinic staff and school personnel. The success of this health station has inspired the community to seek private funding to support a second adolescent health station to provide access to other high school students in the city.

Health Assessment Models

Topeka-Shawnee County Get Fit Program

This school health assessment program targets students in grades 8, 9, and 10 in four rural school districts that surround the City of Topeka. The program is designed to assist adolescents to maintain health and fitness levels through the provision of fitness screening, education, and counseling services. A health risk appraisal is performed along with screening on body composition, blood pressure, body strength and endurance, flexibility, and laboratory screening tests which include cholesterol, a complete blood count, and glucose. The program is directed by the health department and is implemented by public health nurses who provide the health services to the school districts involved. Good administrative support from all four school districts has been provided and a good collaborative relationship has existed between the agencies for many years. The project officially got underway in January, 1989, and has screened approximately sixty students. Some different marketing strategies will be employed during the 1989-90 school year to elicit much higher student participation. Two of the high schools are incorporating the "Get Fit" program into their school curriculum during the 1989-90 school year. Over 500 brochures have been distributed to students.

Project Health Track - Kansas City, Kansas

This health assessment project was established to encourage high school students in grades 9-12 to establish health lifestyles aimed at preventing such problems as high blood pressure, nutritional problems, stress management problems, and inadequate strength and endurance. A fitness screening protocol was established whereby all students in five high school physical education classes were screened for height and weight, blood pressure, vision, body composition, endurance, strength, and flexibility. A total of 1,205 students were screened and about 33% of those screened were found to have high cholesterol levels at the initial screening. A health risk appraisal was also solicited from students screened with several high risk behaviors identified in all five schools including very low use of seatbelts in vehicles, high alcohol consumption, and many who had concerns about getting AIDS. The project is located in the Kansas

City-Wyandotte County Health Department and serves the low income, inner-city students with a high concentration of minorities. The health department has received good support from the USD 500 school administration.

The FY90 budget for adolescent health initiatives is $127,783. An additional $100,000 is budgeted for expansion in FY91.

The third program area that I will address is:

SERVICES FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS SECTION OF THE BUREAU OF FAMILY HEALTH

Special Health Services (SHS) is a health service program that offers screening, diagnosis, and treatment to children under 21 years old with severely handicapping conditions. The purpose of the program is to promote the functional skills of young persons in Kansas. SHS is supported by federal and state funds and assists families in obtaining high quality medical and health services. Diagnostic services are available to all youth zero to 21 years of age, regardless of income, who are suspected of having a handicapping condition. Ongoing treatment services are provided to youth who meet financial and medical eligibility criteria.

Application for service is made through county health departments across the state, the Topeka administrative office, or one of the field offices in Kansas City or Wichita. Quality is assured through the use of board certified medical specialists, credentialed support service providers, and approved hospitals.

During FY 1988, there were 6,869 children served by SHS and 1,657 claims were paid for treatment services. All 6,869 children received the case management services which include counseling concerning current and long-term treatment needs, care monitoring, review of treatment plans, information, and referral for other needed services.

A cooperative outreach project with the Department of Education provides "Special Child Clinics." Other outreach services are provided for orthopedic conditions, neurological impairments, genetics, and cardiac diseases. In FY 1988, there were 73 outreach clinic days at ten sites across Kansas. SHS also actively collaborates with the Department of Education (Special Education Administration Section), the Department of Social and Rehabilitation Services (Medical Services, Vocational Rehabilitation), and the University of Kansas Medical School Programs in cooperative efforts to improve services to Kansas youth with handicaps, crippling conditions, disabilities, and chronic diseases.

Some specific program services administered by SHS include:

- Case management services to disabled and blind children under age 16 who receive Supplemental Security Income benefits, as determined and referred by the Social Security Administration.

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- Phenylketonuria, Congenital Hypothyroid, and Galactosemia: This program provides follow-up on abnormal newborn screening tests by notifying the physician, providing consultants to conduct diagnostic and follow-up clinics, providing the necessary treatment product as long as medically necessary. A registry of those individuals with a confirmed diagnosis for use in follow-up activities is maintained.

- Hemophilia: This program supports an annual comprehensive evaluation for children with hemophilia and provides the blood factor (blood coagulant) used in a home therapy program supervised by the Regional Comprehensive Hemophilia Program staff. These services are available to individuals of all ages who meet the SHS financial guidelines and who participate in the Regional Comprehensive Hemophilia Program (K.S.A. 65-1131 through 65-1134).

- Sickle Cell Trait and Anemia: This program provides statewide voluntary screening for sickle cell trait and anemia and counseling at no cost to the individual. The program provides medical specialty services to those individuals with diagnosis of sickle cell anemia who meet the SHS financial guidelines without respect to age. There were 3,586 individuals screened in FY 1988 with approximately 280 persons identified with abnormal hemoglobin. KDHE recently received a federal grant to develop a program to screen newborns for sickle cell disease.

- Infant and Toddler: In FY 1987, KDHE was designated as the lead agency in the development of a statewide comprehensive, interagency, multidisciplinary services program for children zero through two years of age who have handicaps or are at risk for developmental delay. Funding of this program is provided through (federal) Public Law 99-457.

- Respite Care: In September, 1988, KDHE received a grant to develop respite care services for families with children having special needs. Kansas Children's Service League was contracted to conduct respite care program in Topeka, Manhattan, and Garden City focusing on hourly, one-night, and week-end respite service.

The total funding for this program for FY89 was $3,236,089 and for FY90 it is estimated to be $3,561,553. Of the FY 90 total, $1,239,739 is SGF.

CHILD CARE

The need for child day care which meets the requirements of working parents and which also protects the health and safety of children continues to increase, not only because of more and more women entering the work force, but also as a result of the KANWork Act in Kansas and the Welfare Reform Act nationally.

Although KDHE is not a recruitment agency, the child care regulatory program does contribute to the availability of day care by endeavoring to make a timely response to applications for licenses and certificates of

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registration, and keeping the licenses and certificates current. In addition, regulations are amended to reflect changing child care needs.

The FY91 budget includes a total of $552,053 for the Child Care program. This amount reflects a 25% ($48,125) increase in funds for county health departments to conduct inspections and investigate complaints.

Conclusion:

KDHE is one of the agencies in Kansas directed to address health promotion and disease prevention as well as the quality of life for Kansas children and families. We are committed to the well being of our state's children. We have a range of programs in place to address basic health concerns and the record reflects steady improvements in the number of children and families served. The Department is committed to making the best use of available resources to continue this trend.

Thank you and I appreciate the opportunity to share some of our Department's efforts in caring for our state's children.

Presented by: Richard Morrissey
Deputy Director, Division of Health
Kansas Department of Health and Environment

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If you have
any questions . . .

Please call your healthy start home visitor, your local health department, or the Kansas Department of Health and Environment.

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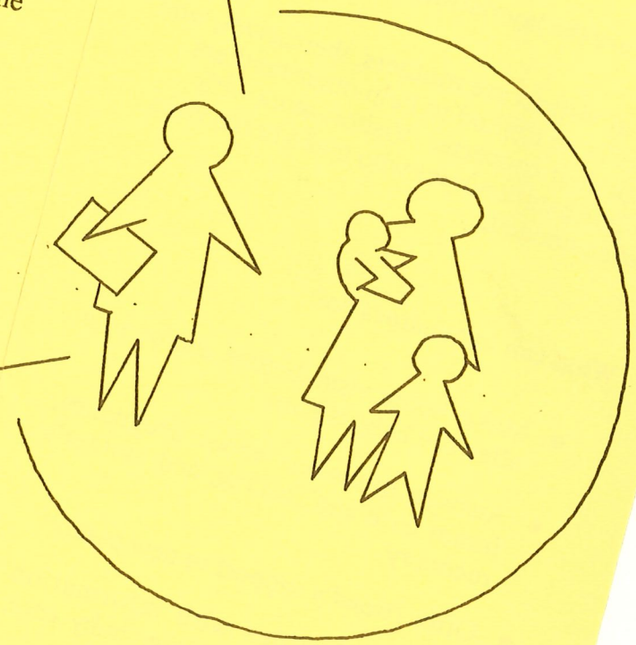
Healthy Start



Home Visitor Program

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