Approved: February 28, 2007
Date

MINUTES OF THE SENATE WAYS AND MEANS COMMITTEE

The meeting was called to order by Chairman Dwayne Umbarger at 10:40 A.M. on January 29, 2007, in Room 123-S of the Capitol.

All members were present.

Committee staff present:
Jill Wolters, Senior Assistant, Revisor of Statutes
Alan Conroy, Director, Kansas Legislative Research Department
J. G. Scott, Kansas Legislative Research Department
Audrey Dunkel, Kansas Legislative Research Department
Susan Kannarr, Kansas Legislative Research Department
Becky Krahl, Kansas Legislative Research Department
Michael Steiner, Kansas Legislative Research Department
Melinda Gaul, Chief of Staff, Senate Ways & Means
Mary Shaw, Committee Assistant

Conferees appearing before the committee:
Paul Morrison, Kansas Attorney General
Dr. Howard Rodenberg, Kansas Department of Health and Environment
Jim Redmon, Executive Director, Children's Cabinet
Melissa Ness, Chair, Children's Cabinet
Mary Jayne Hellebust, Director, Tobacco Free Kansas Coalition

Others attending:
See attached list.

Chairman Umbarger made the following referrals:

SB 24--Medical student loan program; monthly stipend, increase; inflation factor

Referred to the Higher Education Subcommittee

SB 25--Nurse educator service scholarship

Referred to the Higher Education Subcommittee

SB 167--Postretirement benefit adjustment of 3% for retirants from school employment of the Kansas Public Employees Retirement System

Referred to the KPERS Issues Subcommittee

SB 193--State debt limitations and procedures

Referred to Capital Improvements Subcommittee

The Chairman welcomed Kansas Attorney General Paul Morrison who presented an update on the on-going water litigation and the tobacco master settlement agreement (Attachment 1). General Morrison explained that all of the lawsuits are very complex and have an extensive history. In regard to the Kansas v. Colorado, Kansas filed this suit in 1985 with the U. S. Supreme Court to enforce the terms of theArkansas River compact. The court found that well-pumping in Colorado was in violation of the Compact. The Special Master in this case has filed four reports (1994, 1997, 2000 and 2003) and the Court has issued three opinions (1995, 2001, and 2004). Since March, 2005, the states have been updating the current measurement model and drafting the final decree. At the present time the states are awaiting the final decree from the Special Master. It was noted that if Kansas and Colorado disagree as to whether compliance has been achieved, further litigation or arbitration may become necessary.

MINUTES OF THE Senate Ways and Means Committee at 10:30 A.M. on January 29, 2007, in Room 123-S of the Capitol.

In regard to the Tobacco Master Settlement Agreement (MSA), General Morrison provided history on the settlement. He provided current status in his written testimony. General Morrison explained that the Master Settlement Agreement developed a Strategic Contribution Fund that required the manufacturers to pay an increased amount from 2008-2017. Based on a percentage of how much each state contributed to the original MSA effort (time, money, people, etc.), states were allocated a share of this strategic fund. Kansas gets 1.85 percent of the total amount, which translates into an estimated $15.4 million in April of 2008. He noted that this amount is expected to remain relatively flat until 2017 when the Strategic Contribution Fund would be depleted. Committee questions and discussion followed.

Staff provided an update of the Children's Initiatives Fund, FY 2006 - FY 2008 (Attachment 2) and State Water Plan Fund Expenditures, FY 2006 - FY 2008 (Attachment 3).

There was a continued discussion on the Master Settlement Agreement (MSA) Bonus Funds. The Chairman welcomed Dr. Howard Rodenberg, MD, Kansas Department of Health and Environment (Attachment 4). Dr. Rodenberg explained how tobacco settlement funds have helped to prevent the leading causes of death in Kansas, and how the investment of additional funds can accelerate the Agency's current efforts to achieve state goals for prevention of primary threats to health. He also provided history of MSA funds invested in tobacco use prevention in Kansas, accomplishments to date, additional funding opportunities and the need for support in preventing chronic disease. Committee questions and discussion followed.

Chairman Umbarger welcomed Melissa Ness, Chair, and Jim Redmon, Executive Director, Kansas Children's Cabinet and Trust Fund, who presented an overview and additional detailed information in their Briefing Binder (Attachment 5). The information contained in the attachment was compiled based on the requests of the Kansas Children's Cabinet and Trust Fund to develop an accountability framework for the Children's Initiative Funds (CIF). Data was gathered from a variety of sources including written program materials, public records and face to face interviews with program staff. It was noted that newly funded 2007 programs were not assessed. This is an ongoing process to strengthen the quality of not only the CIF recommendation process, but more importantly, to improve the quality of services to children and families in Kansas. Committee questions and discussion followed.

The Chairman welcomed Mary Jayne Hellebust, Executive Director, Tobacco Free Kansas Coalition, who presented information about the health benefits and savings that will come from adopting a comprehensive statewide tobacco prevention program (Attachment 6). Ms. Hellebust addressed and detailed funding tobacco prevention programs adequately, costs of treating tobacco illnesses, tobacco prevention needing to begin in childhood, some successes in Kansas, inadequate tobacco control funding and components and funding levels for a comprehensive statewide tobacco prevention program. Committee questions and discussion followed.

The meeting adjourned at 12:15 p.m. The next meeting is scheduled for January 30, 2007.

SENATE WAYS AND MEANS COMMITTEE
GUEST LIST

Date January 29, 2007

Name	Representing
Cheri Froetschner	DOB
Julia Thomas	DOB
Joe Turnbull	KWO
LISA BENLON	AMER. CANCER SOC.
Mary Jeanne Kelly-Reed	TFKC
Linda L. McCarville	American Heart Assn.
Jackie Counts	KU
Jim Wellington	Kansas Children's Cabinet
Lee Ralph	KDA
David L. Pope	KDA
Sunee Mickle	Kansas Health Institute
Sarah Green	KHI News Service
Alice Womack	SRS
Paula Marmet	KDHE
[illegible]	ICOTS
[illegible]	LCR
Ron Seeber	Hein Law Firm
MARK P. MATTE	VIA CHRISTI HEALTH SYSTEM
Ginger Park	KDHE
PHILIP A. HURLEY	PAT HURLEY & CO.
Doug Bowman	CCECDS
Duane Goossen	DofA
Mike Beezley	Healthwest Inc.

SENATE WAYS AND MEANS COMMITTEE
GUEST LIST

Date 1-29-07

Name	Representing
Sheila Frahm	KACCT
Jenna Rae	KCSL
Leslie Kaufman	Ks Co-op Council
Mary Jane Stankiewicz	KGFA / KARA
Jarod Forbes	Onion Ethanol
Dan Gibb	KSAG
Carolyn Dodderidge	Ks St Ds Assn
Stuart Little	Little Govt. Relations
Michael Hooper	Kearney & Assoc.
Lynette Bakker	AG's Office
Charles Nerlis	Legislative Intern
Doug Bahnen	AG's office

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Senate Ways & Means Committee
Status of Water and Tobacco Litigation
Attorney General Paul Morrison
January 29, 2007

Mr. Chairman and members of the committee, I am here today to provide an overview of on-going water litigation and the tobacco master settlement agreement.

Water Litigation

Kansas V. Nebraska & Colorado

In 1998 Kansas filed suit against the state of Nebraska over a dispute regarding use of water in the Republican River basin. In 2002 the states reached a comprehensive settlement, which was approved by the court in 2003. As part of the settlement, Kansas, Colorado and Nebraska agreed upon the use of the Republican River Compact Administration Groundwater Model, which is used to account for each state's consumptive use of Republican River basin waters.

The primary obligation of each state under the settlement is to limit its use of the basin's water supply to an agreed upon share. Compliance with the settlement is to be measured for the period of 2003-2007 and every five years thereafter. Both Nebraska and Colorado have significantly overused their allocations in each year since the accounting began in 2003. Since the water supply of the basin is 100% allocated, this means that Kansas has not received its full allocation. In 2008, the official accounting for the first five-year period will likely show that Nebraska and Colorado are out of compliance with the settlement.

The settlement includes dispute resolution procedures, and it seems likely that Kansas will begin to use these procedures as the situation dictates. The Attorney General will work in partnership with the Kansas Department of Agriculture, Division of Water Resources to take any action that may be required as a result of negotiations. Any proposed action will be brought before the legislature in advance.

Kansas V. Colorado

Kansas filed this suit in 1985 with the U.S. Supreme Court to enforce the terms of the Arkansas River Compact. The court found that well pumping in Colorado was in violation of the Compact. The Special Master in this case has filed four reports (1994, 1997, 2000, and 2003) and the court has issued three opinions (1995, 2001, and 2004). In

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its last opinion, the Court ordered the Special Master to resolve all pending issues, and prepare the final decree.

Since March, 2005 the states have been updating the current measurement model and drafting the final decree. In April, 2005 Colorado paid Kansas more than $34 million in damages and pre-settlement interest for violations that occurred between 1950 and 1999. In June, 2006 Colorado paid $1.1 million in costs.

At present, the states are awaiting the final decree from the Special Master. The Special Master has recommended that the court maintain jurisdiction for a limited period of time to determine if Colorado has been in compliance for the first ten year accounting period (1997-2006). If Kansas and Colorado disagree as to whether compliance has been achieved, further litigation or arbitration may become necessary.

Tobacco Master Settlement Agreement

Background

The tobacco Master Settlement Agreement (MSA) resulted from a lawsuit filed in 1996, and was finalized in 1998. The agreement was reached between 46 states and territories (including Kansas) and the four original participating manufacturers: Philip Morris; RJ Reynolds; Brown & Williamson; and Lorillard.

The major requirements of the MSA are restrictions on marketing practices and annual payments to the states for damages incurred through their Medicaid programs caring for those suffering from smoking-related illnesses. All known tobacco manufacturers that were not a party to the litigation were offered participation in the MSA. To date 45 manufacturers have taken the opportunity to join. The first group of manufacturers that chose to join the settlement were not required to make payments if their market share did not grow from the time of entry into the MSA. However, all manufacturers that entered the agreement following that first group are required to make payments into the settlement based on annual cigarette sales. Any manufacturer not engaged in the MSA is subject to Kansas escrow statutes, and could be subject to future lawsuits.

Escrow account laws were passed in all of the MSA states. Kansas law requires that all non-MSA manufacturers keep in escrow an amount similar to that paid by the participating manufacturers. The idea of requiring escrow accounts is to address any future lawsuits that may be brought on behalf of consumers. The Escrow Accounts were also an attempt to level the playing field in the tobacco industry so that MSA companies did not suffer an "unfair disadvantage" relative to the rest of the market. The funding stays in Escrow Accounts for 20 years, and is returned after that point if no litigation is pending.

Monies Received

Through the MSA, each state was assigned an "allocable share" or percentage of national cigarette sales. These receipts are paid to an MSA account, and Kansas receives 0.834% of the total. The funds received by Kansas are distributed in accordance with K.S.A. 38-201, *et. Seq.* The first $1.0 million received is earmarked for tobacco control efforts. The remainder of the funds are deposited into the Kansas Endowment for Youth

(KEY) Fund and the Children's Initiatives Fund. For sales year 2004, Kansas received $49,463,355 including interest. For sales year 2005, Kansas received $48,774,918. In December, 2006 Kansas also received a payment of $447,382 from a non-litigant participant of the MSA. House of Prince increased its market share of sales during sales year 2005, and as a result was required to pay into the MSA.

Current Status

Under the original terms of the MSA, the state's 2005 total receipts should be significantly higher than they were. Two MSA companies withheld a portion of their payment to all states in the MSA while they are disputing the basis of the payments. The two companies, R.J. Reynolds and Lorillard, are arguing that the states have not proven that they are diligently enforcing their escrow statutes.

All of the original participating manufacturers have filed motions to compel arbitration of this matter in every state that is a party to the MSA. Kansas has obtained outside counsel to represent the state's interests in this matter, and Kansas' response was filed in Shawnee County District Court on December 11th. No hearing date has been set at this time. Of the states arguing against court-ordered arbitration, 28 states have lost their cases and been ordered to arbitration; 8 states have final orders of arbitration (no potential for appeal); and all others are on appeal.

The participating manufacturers have submitted a proposal to the MSA states to settle this matter. The states' Attorneys General are in the midst of negotiating various potential counterproposals. Following approval by all of the MSA states, a counterproposal will be sent to the manufacturers. I have been told that the counter proposal should be sent to the manufacturers by February. The response of the manufacturers will determine how long a final agreement would take, if a compromise can be reached.

Future Receipts

The MSA developed a Strategic Contribution Fund that required the manufacturers to pay an increased amount from 2008-2017. Based upon a percentage of how much each state contributed to the original MSA effort (time, money, people, etc.), states were allocated a share of this strategic fund. Kansas gets 1.85% of the total amount, which translates into an estimated $15.4 million in April, 2008. This amount is expected to remain relatively flat until 2017, when the Strategic Contribution Fund would be depleted.

Thank you for the opportunity to present to the Committee. I would be happy to stand for questions.

Children's Initiatives Fund
FY 2006 - FY 2008

	Actual FY 2006	Legislative Approved FY 2007	Gov. Rec. FY 2007	Gov. Rec. FY 2008
Department of Health and Environment				
Healthy Start/Home Visitor	$ 250,000	$ 250,000	$ 250,000	$ 250,000
Infants and Toddlers Program (Tiny K)	800,000	1,200,000	1,200,000	1,200,000
Smoking Cessation/Prevention Program Grants	1,000,000	1,000,000	1,000,000	1,000,000
PKU/Hemophilia	-	208,000	208,000	208,000
Subtotal - KDHE	$ 2,050,000	$ 2,658,000	$ 2,658,000	$ 2,658,000
Juvenile Justice Authority				
Juvenile Prevention Program Grants	$ 5,413,777	$ 5,414,487	$ 5,414,487	$ 5,414,487
Juvenile Graduated Sanctions Grants	3,585,513	3,585,513	3,585,513	3,585,513
Subtotal - JJA	$ 8,999,290	$ 9,000,000	$ 9,000,000	$ 9,000,000
Department of Social and Rehabilitation				
Children's Cabinet Accountability Fund	$ 654,298	$ 546,126	$ 546,126	$ 541,802
Children's Mental Health Initiative	4,000,000	3,800,000	3,800,000	3,800,000
Family Centered System of Care	5,000,000	5,000,000	5,000,000	5,000,000
Therapeutic Preschool	1,000,000	1,000,000	1,000,000	1,000,000
Child Care Services	1,400,000	1,400,000	1,400,000	1,400,000
Community Services - Child Welfare	3,492,101	3,492,101	3,492,101	3,492,101
Smart Start Kansas - Children's Cabinet	8,726,198	9,273,019	9,273,019	8,443,279
Family Preservation	2,957,899	2,957,899	2,957,899	2,957,899
School Violence Prevention	114,000	228,000	228,000	228,000
Attendant Care for Independent Living (ACIL)	50,000	50,000	50,000	50,000
Pre-K Pilot	-	2,000,000	2,000,000	5,500,000
Early Head Start	-	-	-	1,600,000
Child Care Quality Initiative	-	-	-	1,000,000
Subtotal - SRS	$ 27,394,496	$ 29,747,145	$ 29,747,145	$ 35,013,081
Division of Health Policy and Finance		-	-	
HealthWave	$ 2,000,000	$ -	$ -	$ -
Medical Assistance	3,000,000	-	-	-
Immunization Outreach	499,700	-	-	-
Subtotal - DHPF	$ 5,499,700	$ -	$ -	$ -
Kansas Health Policy Authority				
HealthWave	$ -	$ 2,000,000	$ 2,000,000	$ -
Medical Assistance	-	3,000,000	3,000,000	-
Immunization Outreach	-	500,000	500,000	500,000
Subtotal - KHPA	$ -	$ 5,500,000	$ 5,500,000	$ 500,000
Department of Education				
Reading and Vision Research	$ 300,000	$ 300,000	$ 300,000	$ 300,000
Parent Education	2,499,990	-	-	-
Four-Year -Old At-Risk Programs	1,504,045	-	-	-
Special Education	890,190	-	-	-
Subtotal - Dept. of Ed.	$ 5,194,225	$ 300,000	$ 300,000	$ 300,000
University of Kansas Medical Center				
Tele-Kid Health Care Link	$ 236,498	$ 268,509	$ 268,509	$ 250,000
TOTAL	**$ 49,374,209**	**$ 47,473,654**	**$ 47,473,654**	**$ 47,721,081**

	Actual FY 2006	Legislative Approved FY 2007	Gov. Rec. FY 2007	Gov. Rec. FY 2008
Beginning Balance	$ 3,147,150	$ 3,708,488	$ 3,708,488	$ -
Plus: Other Income*	348,546	114,000	114,000	-
State General Fund Transfer	375,000	-	-	-
KEY Fund Transfer In	49,514,213	43,651,166	43,651,166	47,721,081
Total Available	$ 53,384,909	$ 47,473,654	$ 47,473,654	$ 47,721,081
Less: Expenditures	(49,374,209)	(47,473,654)	(47,473,654)	(47,721,081)
Transfer Out to KEY Fund	(300,000)	-	-	-
Transfer Out to State General Fund	(2,212)	-	-	-
ENDING BALANCE	**$ 3,708,488**	**$ -**	**$ -**	**$ -**

* Other Income includes released encumbrances, recoveries and reimbursements.

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Use of Children's Initiatives Fund Money

KSA 38-2102(b) directs the use of the Children's Initiatives Fund (CIF) as follows:

- CIF funds ".... shall be used for the purposes of providing additional funding for programs, projects, improvements, services and other purposes directly or indirectly beneficial to the physical and mental health, welfare, safety and overall well-being of children in Kansas..."

- In allocating funding, the Legislature "...shall emphasize programs and services that are data-driven and outcomes-based and may emphasize programs and services that are generally directed toward improving the lives of children and youth by combating community-identified risk factors associated with children and youth becoming involved in tobacco, alcohol, drugs or juvenile delinquency."

- All programs must have a clearly articulated objective, be supported by credible research, constitute best practices in the field, have data available to benchmark the program's desired outcomes, have an evaluation and assessment component as part of the program design.

- CIF dollars "...shall not be used to replace or substitute for moneys appropriated from the state general fund in the immediately preceding fiscal year."

State Water Plan Fund Expenditures

Expenditures	Actual FY 2006	Agency Est. FY 2007	Gov. Rec. FY 2007	KWA Rec. FY 2008	Agency Req. FY 2008	Gov. Rec. FY 2008
Agency/Program						
Department of Health and Environment						
Contamination Remediation	$ 1,183,815	$ 954,525	$ 954,525	$ 0	$ 0	$ 0
TMDL Initiatives	316,744	299,277	299,274	298,741	299,277	299,928
Local Environmental Protection Prog.	1,502,735	1,502,837	1,502,852	0	0	0
Nonpoint Source Program	324,885	290,677	290,665	284,654	290,675	301,821
WRAPS	774,240	800,000	800,000	800,000	800,000	800,000
Use Attainability Analysis	130,880	169,120	169,120	0	0	0
Total—Health & Environment	$ 4,233,299	$ 4,016,436	$ 4,016,436	$ 1,383,395	$ 1,389,952	$ 1,401,749
Univer. of Kansas–Geological Survey	$ 40,856	$ 40,000	$ 40,000	$ 40,000	$ 40,000	$ 40,000
Department of Agriculture						
Floodplain Management	$ 68,245	$ 0	$ 0	$ 0	$ 0	$ 0
Interstate Water Issues	251,059	0	0	0	0	584,217
Subbasin Water Resources Mgt.	548,048	687,586	687,586	667,474	678,595	678,595
Water Appropriations Subprogram	187,925	0	0	0	0	0
Water Use	60,000	60,000	60,018	71,121	60,000	60,000
Kansas v. Colorado Compliance	0	1,271,017	1,271,017	0	0	0
Total—Dept. of Agriculture	$ 1,115,277	$ 2,018,603	$ 2,018,621	$ 738,595	$ 738,595	$ 1,322,812
State Conservation Commission						
Water Resources Cost Share	$ 3,371,761	$ 4,360,951	$ 3,414,359	$ 3,412,218	$ 3,412,218	$ 3,418,063
Nonpoint Source Pollution Asst.	2,601,213	3,237,626	2,757,520	3,699,009	3,699,009	3,683,854
Aid to Conservation Districts	1,043,966	1,048,000	1,048,000	0	0	1,050,000
Watershed Dam Construction	352,499	1,351,499	1,351,499	1,055,000	1,055,000	1,055,000
Water Quality Buffer Initiative	247,600	586,669	307,157	350,000	350,000	350,000
Riparian and Wetland Program	244,310	200,709	251,782	446,782	251,782	251,782
Multipurpose Small Lakes	536,333	1,100,000	1,100,000	1,250,000	1,250,000	1,250,000
Water Transition Assistance Program	0	1,184,388	1,184,388	1,500,000	1,420,885	1,414,416
Salt Cedar Control Demonstrations	0	65,000	65,000	0	195,000	195,000
Conservation Reserve Enhancement	0	5,000,000	5,000,000	0	0	0
Lake Restoration/Management	0	335,000	335,000	2,719,713	2,719,713	2,719,713
Total—Conservation Commission	$ 8,397,682	$ 18,469,842	$ 16,814,705	$ 14,432,722	$ 14,353,607	$ 15,387,828
Kansas Water Office						
Assessment and Evaluation	$ 545,055	$ 1,083,660	$ 1,083,660	$ 857,605	$ 857,605	$ 857,605
GIS Database Development	247,405	247,405	247,405	250,000	250,000	250,000
MOU - Storage Oper. and Maint.	364,954	409,132	455,890	733,384	733,384	733,384
PMIB Loan Payment for Storage	234,150	237,353	237,945	0	0	0
Stream Gauging Program	412,668	0	0	0	0	0
Technical Assistance to Water Users	210,004	266,150	266,150	624,949	624,949	624,949
Weather Stations	0	60,000	60,000	100,000	100,000	100,000
Water Planning Process	276,464	0	0	0	0	0
Water Resource Education	54,000	84,000	84,000	84,000	84,000	84,000
Weather Modification	120,000	120,000	120,000	240,000	240,000	240,000
Kansas Water Authority	40,374	0	0	0	0	0
Neosho River Basin Issues	0	0	0	500,000	500,000	500,000
Total—Kansas Water Office	$ 2,505,074	$ 2,507,700	$ 2,555,050	$ 3,389,938	$ 3,389,938	$ 3,389,938
Department of Wildlife and Parks						
Almena Irrigation District	$ 0	$ 120,000	$ 120,000	$ 1,000,000	$ 1,000,000	$ 1,000,000
Stream (Biological) Monitoring	40,000	40,000	40,000	40,000	40,000	40,000
Total—Wildlife and Parks	$ 40,000	$ 160,000	$ 160,000	$ 1,040,000	$ 1,040,000	$ 1,040,000
Total Water Plan Expenditures	**$ 16,332,188**	**$ 27,212,581**	**$ 25,604,812**	**$ 21,024,650**	**$ 20,952,092**	**$ 22,582,327**

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State Water Plan Resources

	Actual FY 2006	Gov. Rec. FY 2007	Gov. Rec. FY 2008
Beginning Balance	$ 7,682,094	$ 9,591,892	$ 2,866,702
Adjustments:			
Released Encumbrances	$ 1,333,653	$ 2,173,022	$ 0
Transfer to Kansas Corporation Commission	(400,000)	(400,000)	(400,000)
Add Receipts:			
State General Fund Transfer	$ 6,000,000	$ 6,000,000	$ 6,000,000
Economic Development Fund Transfer	2,000,000	2,000,000	2,000,000
Municipal Water Fees	3,454,401	3,520,000	3,485,184
Industrial Water Fees	1,104,837	1,051,000	1,129,437
Stock Water Fees	359,112	399,000	366,454
Pesticide Registration Fees	989,800	950,000	965,000
Fertilizer Registration Fees	3,034,328	2,917,600	2,940,000
Pollution Fines and Penalties	140,395	70,000	70,000
Clean Drinking Water Fee Fund	0	0	3,199,662
Sand Royalty Receipts	225,460	199,000	192,867
Subtotal—Receipts	$ 17,308,333	$ 17,106,600	$ 20,348,604
TOTAL AVAILABLE	**$ 25,924,080**	**$ 28,471,514**	**$ 22,815,306**
Less: Expenditures	$ (16,332,188)	$ (25,604,812)	$ (22,582,327)
ENDING BALANCE	**$ 9,591,892**	**$ 2,866,702**	**$ 232,979**

KANSAS

DEPARTMENT OF HEALTH
AND ENVIRONMENT

Division of Health

Kathleen Sebelius, Governor
Roderick L. Bremby, Secretary

www.kdheks.gov

Testimony Regarding MSA Bonus Funds

To
Senate Ways and Means Committee
123-South

Presented by
Howard Rodenberg, MD, MPH
Kansas Department of Health and Environment

January 29, 2007

Chairman Umbarger and members of the Senate Ways and Means Committee, my name is Dr. Howard Rodenberg. I serve as the Director of the Division of Health for the Kansas Department of Health and Environment and as Kansas State Health Officer. Thank you for the opportunity to talk with you about how tobacco settlement funds help us to prevent the leading causes of death in Kansas, and how the investment of additional funds can accelerate our current efforts to achieve state goals for prevention of these primary threats to health.

History of MSA funds invested in tobacco use prevention in Kansas

Kansas was a participant in the Master Settlement Agreement (MSA) in November 1998, which ruled the State was to receive more than $50 million per year for 25 years to compensate for the cost of tobacco use. The Kansas Legislature established a Kansas Endowment for Youth (KEY) fund to deposit the revenues received as a result of the MSA. A Children's Initiative Fund (CIF) was established to enable transfer of a portion of the KEY fund for the legislature to appropriate for programs to benefit children. In 1999, the state Tobacco Use Prevention Program (TUPP) was allocated $500,000 from the CIF to conduct a local comprehensive tobacco use prevention community program. Saline County was selected through a competitive bid process to conduct the comprehensive program and has been supported at this level since 2000.

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The CIF appropriation for Tobacco use prevention was increased to $1,000,000 beginning in SFY2005. In addition to the $1 million from the CIF, KDHE receives about $1,350,000 in federal funds through a cooperative agreement for tobacco use prevention from the Centers for Disease Control and Prevention (CDC). KDHE has responded by expanding the number of comprehensively funded communities who can implement best-practice, evidence-based programs in tobacco use prevention and cessation to five. (The five communities that were funded at this level beginning in SFY06 are noted with a star figure on the map accompanying this testimony.)

Accomplishments to date

By effectively leveraging state and local resources, the state has achieved impressive results despite total funding being less than 20% of the minimum amount recommended for a statewide comprehensive tobacco use program by the CDC . Extensive research forms the basis for the CDC recommendations, which describe the essential components for achieving success in reducing the disease burden of tobacco use. These components include:

- **Community programs to reduce tobacco use.** This component focuses on building capacity and engaging the whole community to change the way tobacco is promoted, sold and used.
- **Chronic disease programs** to reduce the burden of tobacco-related disease. This component focuses on integrating tobacco use prevention and cessation into chronic disease prevention, detection and early intervention activities.
- **School Programs.** This component goes far beyond educating students about the harms of tobacco to focus on the social influences that promote tobacco use among youth and teach skills to resist those influences that promote initiation of tobacco use.
- **Enforcement.** This component addresses both the sale of tobacco to youth as well as availability of tobacco to the 64% of youth who report that they get their tobacco through social sources.
- **Statewide programs.** To achieve progress in eliminating disparities related to tobacco use, this component focuses on supporting statewide initiatives and organizations that have access to diverse communities.
- **Countermarketing.** This component focuses on use of mass media and other means to promote available resources dedicated to tobacco use and dependence, inform Kansans on the harmful, long-term effects of tobacco use and set a supportive climate for community and in-school efforts to address tobacco control policies and education.
- **Cessation Programs.** This component focus is to provide resources to those who want to quit, incorporating tobacco curricula into all health related degree programs, training health care providers on evidence-based strategies for cessation and ensuring access to cessation programs that address needs of special populations, such as pregnant women, minorities, persons residing in rural areas and youth.

- **Surveillance and Evaluation.** This component outlines a surveillance plan to monitor attitudes, beliefs and behaviors related to tobacco use; prevalence of pro-tobacco influences, including advertising, promotions and events that glamorize tobacco; worksite policies; and youth behaviors related to tobacco use.

Examples of accomplishments that have been achieved in Kansas by utilizing these evidence-based practices include:

- A drop in adult smoking rates from 22.1% in 2002 to 20.4% in 2005. (In real terms, this represents potentially 84,000 fewer Kansans are smokers since 2002.
- More than 17 communities to date have adopted smoke-free ordinances
- Children in more than 31 schools and/or districts (approximately 4% of the state's school aged children) now attend schools that have adopted tobacco fee school grounds policies.
- 14% of middle school and 15% of high school students participated in an anti-smoking event. This potentially represents up to 38,000 students in grades 6-12.
- Fewer vendors selling tobacco to youth (80% compliance)
- More than 200 health care providers who systematically refer pregnant women who smoke to the Kansas Tobacco Quitline
- More than 2,300 Kansans contacting the Kansas Tobacco Quitline for assistance, over half of whom have taken action to quit
- Compiling data for delivery to the legislature and the state each year as the "Kansas Tobacco Use Report."

To achieve these results, KDHE and its partners in tobacco use prevention have employed a number of interventions, albeit at less than recommended funding levels. Some examples of strategies that have led to the above results include:

- State staff answered over 1,800 calls for assistance and provided technical assistance to communities regarding school programs, and community interventions,
- Local grantee actions generated over 1,300 newspaper articles totaling over 23,000 column inches with a readership of over 5 million each month. An analysis of content revealed the strong public sentiment in favor of clean indoor air policies.
- A 24-hour Quitline was established. The service is available to any Kansan at no cost. Nearly 3,000 Kansans contacted the quit line between June 2005 and November 2006 at no cost; 40% of callers reported their annual household income as less than $15,000.
- Provider training initiative to increase tobacco cessation among pregnant women. The number of pregnant women calling the quit line increased from 2/month to 30 per month pre and post intervention.
- By the end of 2005, 103 TASK (youth "companies") were actively operating to influence their peers to take a stand against tobacco.

- A Synar Advisory Group was formed as a collaborative effort between multiple state agencies and organizations to improve retailer compliance with state law regarding sales to youth.
- Excise tax on cigarettes was raised $0.79/pack in 2003. This contributed to reductions in use, but is no longer a significant factor, as Kansas has fallen to 29th (bottom half) of states in amount of excise tax.
- State staff conducted 16 statewide training workshops to community coalition members in implementing one or more components of a community based tobacco use prevention program.
- State staff provided on-site technical assistance to over 59 school districts representing over 66,000 students to promote the development of tobacco prevention, physical activity nutrition and policy developed at the school level in a manner that links school-based activities to their respective community's broader health promotion agenda.

Additional funding opportunities

Beginning in 2008, the states that were part of the 1998 MSA (Kansas included) are scheduled to begin receiving annual bonus settlement payments. The bonus payments are a result of additional penalties applied to the tobacco industry for violating terms of the1998 agreement and are projected to continue for at least 10 years. Kansas' share of the bonus payments is projected to be approximately $16 million per year and offers an ongoing source for funding further statewide health programming. It should be noted that while these funds are anticipated, they are by no means guaranteed. Legal action continues as tobacco companies dispute the additional payments. Nonetheless, foresight demands that such allocation strategies be considered for the expected arrival of the funds in the future.

Preventing Chronic Disease: The need for support

Increasing health care costs are projected to provide ongoing challenges to the state's budget. Data shows that the cost of treating the complications of chronic diseases have the potential of eliminating all surplus operating funds of even the most solvent of states. More than 75% of all health care costs in 2006 are a result of chronic diseases, amounting to over $14 billion in Kansas each year. Poor nutrition, lack of physical activity and the use of and exposure to tobacco products are the driving forces behind these preventable diseases. In terms of disease, tobacco use alone costs the state more than $927 million in medical costs each year (approximately $582 per household) and obesity adds another $657 million to medical costs paid by Kansans. In terms of costs borne directly by state government, Kansas spends over $196 million per year in Medicaid expenditures for tobacco related disease and another $143 million per year in Medicaid expenditures for obesity related costs. Not included in these totals are the indirect costs of lost productivity due to tobacco related disease, approximately $863 million per year.

In response to these issues, KDHE staff has been instrumental in the development of a Comprehensive Cancer Control Plan, a Heart Disease and Stroke State Plan and a Tobacco Use Prevention state plan. All these planning processes engaged a broadly representative group of agencies and organizations that share a common interest in reducing the personal and medical burden of chronic disease upon Kansas and its economy. A similar process to develop a state plan for diabetes in Kansas is currently underway. Each of the resultant plans identified primary prevention as key to saving lives and saving dollars for the state.

The Kansas Chronic Disease Risk Reduction Program directs resources to support community programs combating the leading causes of preventable death. It does so using a process focused on supporting local agency's responding to identified community needs. The program puts into practice the philosophy outlined in the Governor's call to action in her "Healthy Kansas" initiative by focusing directly on reducing the risk factors for chronic disease: tobacco use, physical inactivity and unhealthy eating practices. In addition to allocating resources to local health agencies, the program has implemented marketing and media initiatives, engaged health care providers, supported school based health promotion, and promoted worksite wellness programs. State staff provides technical assistance and guidance to county health departments that coordinate local activities through community coalitions and youth organizations aimed at improving Kansans' health. In 2006, 36 Chronic Disease Risk Reduction grant awards reached 42 counties, which comprise approximately 65% of the state's population for support of programs aimed at reducing tobacco use, increasing physical activity and promoting healthy eating practices. Twenty-three of those awards were for amounts less than $15,000 and 9 more were less than $30,000. The local coalitions who implemented the grants leveraged additional resources in excess of ½ million dollars. In spite of limited resources, these communities have built strong coalitions that have demonstrated effectiveness in implementing best practice interventions to reduce chronic disease risk factors. They stand ready to expand their impact as new sources of revenue become available, thus enabling them to implement more components of their respective plans. The investment of additional resources toward these efforts should be expected to yield additional benefit. The Chronic Disease Risk Reduction Program has served as the basis of local infrastructure to address the leading causes of chronic disease for 15 years in our state.

The CDRR Program has been funded predominantly with Federal resources. This local grants program directly responds to the priorities for preventing disease that are identified in the Healthy Kansans 2010 Report as well as the State Comprehensive Cancer Plan and the State Heart Disease and Stroke Plan. Additional funding for the CDRR program would enable KDHE to increase implementation funding to the 29 grantees that are currently funded at the lowest levels, as well as to provide support to the 63 counties that currently receive no financial support from KDHE for addressing prevention of risk factors for the two leading causes of death.

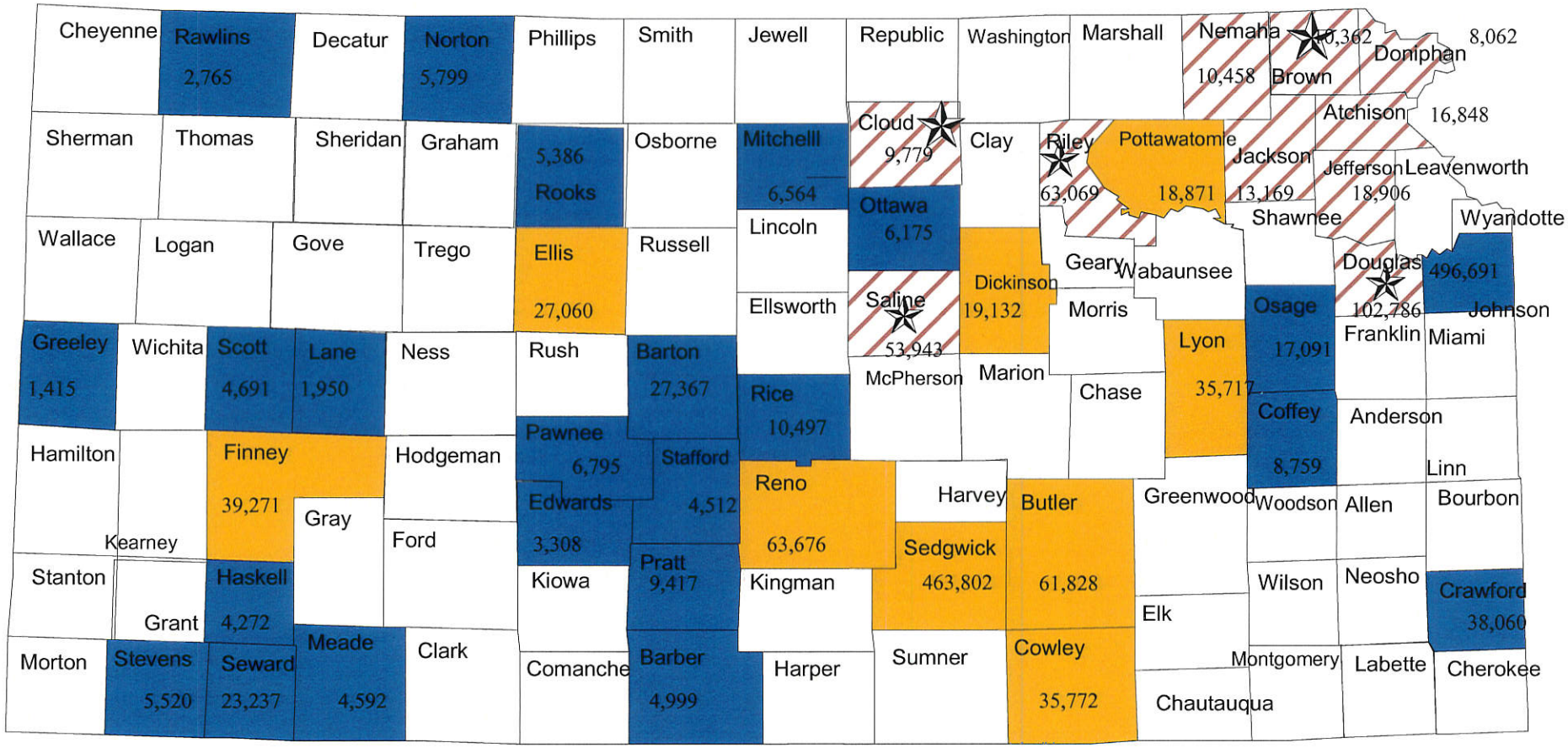
The 10 Leading Health Indicators outlined in Healthy People 2010 provide a snapshot of health status for Kansans. If Kansas is to achieve improvement in overall health status, we must invest in *preventing* chronic diseases, which dominate the list of leading causes of death and are responsible for over 75% of health care expenditures. The

science leaves little doubt that prevention of the risk factors addressed in the CDRR program plays a crucial role in assuring our success in improving the overall health of Kansans. While we can take pride in the impressive progress to date, continued investment will enable Kansas to accomplish similar achievements in all 10 of the Healthy People 2010 indicators, particularly those impacted by program activity aimed at reducing the chronic disease risk factors of tobacco use, physical inactivity and unhealthy eating practices.

Thank you, and I'll be happy to stand for any questions.

Chronic Disease Risk Reduction Grants

August 2005 Fiscal Yr'06



LEGEND

Level A Building capacity

Level B Limited intervention

Level C Comprehensive tobacco
Limited intervention for physical activity & nutrition

2004 population estimates

CHILDREN'S INITIATIVE FUND
Briefing Binder
Prepared for the Senate Ways and Means Committee Testimony
January 29, 2007

Kansas Children's Cabinet and Trust Fund
Melissa Ness, Chair
Jim Redmon, Executive Director

Prepared by
The Institute for Educational Research and Public Service,
University of Kansas

KANSAS CHILDREN'S CABINET AND TRUST FUND

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November 8, 2006

Dear Kansas Children's Cabinet and Trust Fund Members,

The contents in the Briefing Binder were compiled based on the requests of the Kansas Children's Cabinet and Trust Fund to develop an accountability framework for the Children's Initiative Funds (CIF). Data were gathered from a variety of sources including written program materials, public records, and face-to-face interviews with program staff. In total, 17 interviews were conducted. Newly funded 2007 programs were not assessed.

The accountability framework was applied to evaluate each program's alignment with Kansas Children's Cabinet and Trust Fund priorities, as well as to assess each program's results and evaluation, the use of evidence-based practices, and the inclusion of consumer voice. The data gathered for the framework provide a baseline for future comparison. It also creates opportunities for programs to engage in continuous quality improvement, identify technical assistance needs, and assess evaluation capacity.

The accountability framework provides the Kansas Children's Cabinet and Trust Fund with a dynamic and forward-looking process to make recommendations on CIF expenditures. The comprehensive profiles generated for this Briefing Binder are an in-depth look at how CIF allocations translate into services and results for Kansans.

This is an ongoing process to strengthen the quality of not only the CIF recommendation process, but more importantly, to improve the quality of services to children and families in Kansas.

Sincerely,

Jim Redmon by JC

Jim Redmon
Executive Director

CHILDREN'S INITIATIVE FUND
Briefing Binder Table of Contents

Section/Description **Page(s)**

Section Three: Program Information Sheets (Continued)

Section Four: Service Area Maps

Maps illustrating the counties that benefit from each program.

Section Five: Appendices

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Section Three: Program Information Sheets (Continued)

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Maps illustrating the counties that benefit from each program.

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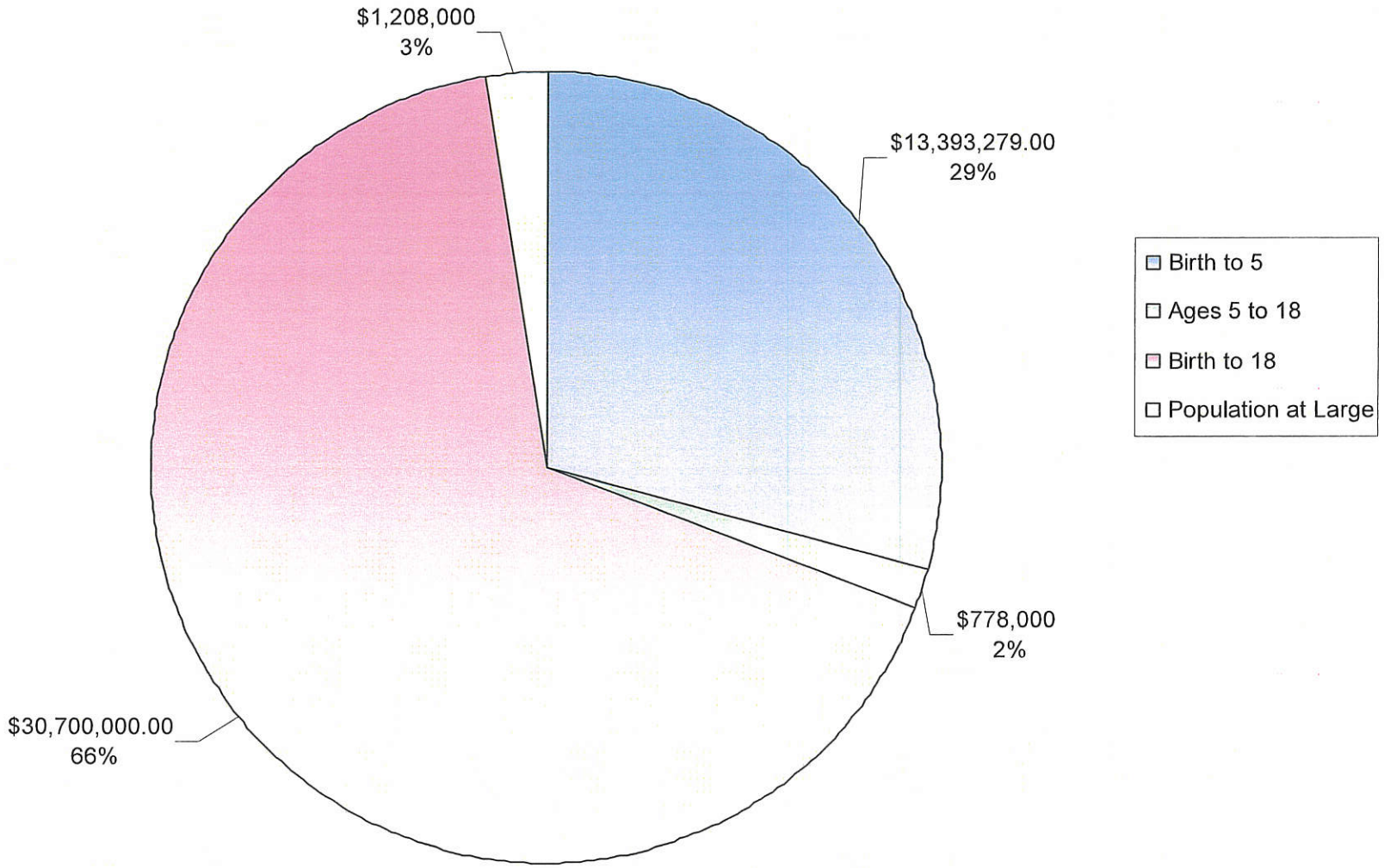
CHILDREN'S INITIATIVE FUND
Briefing Binder
November 8, 2006

Section One: Overview

FY07 Amount by Target Population



CIF Programs by Target Population

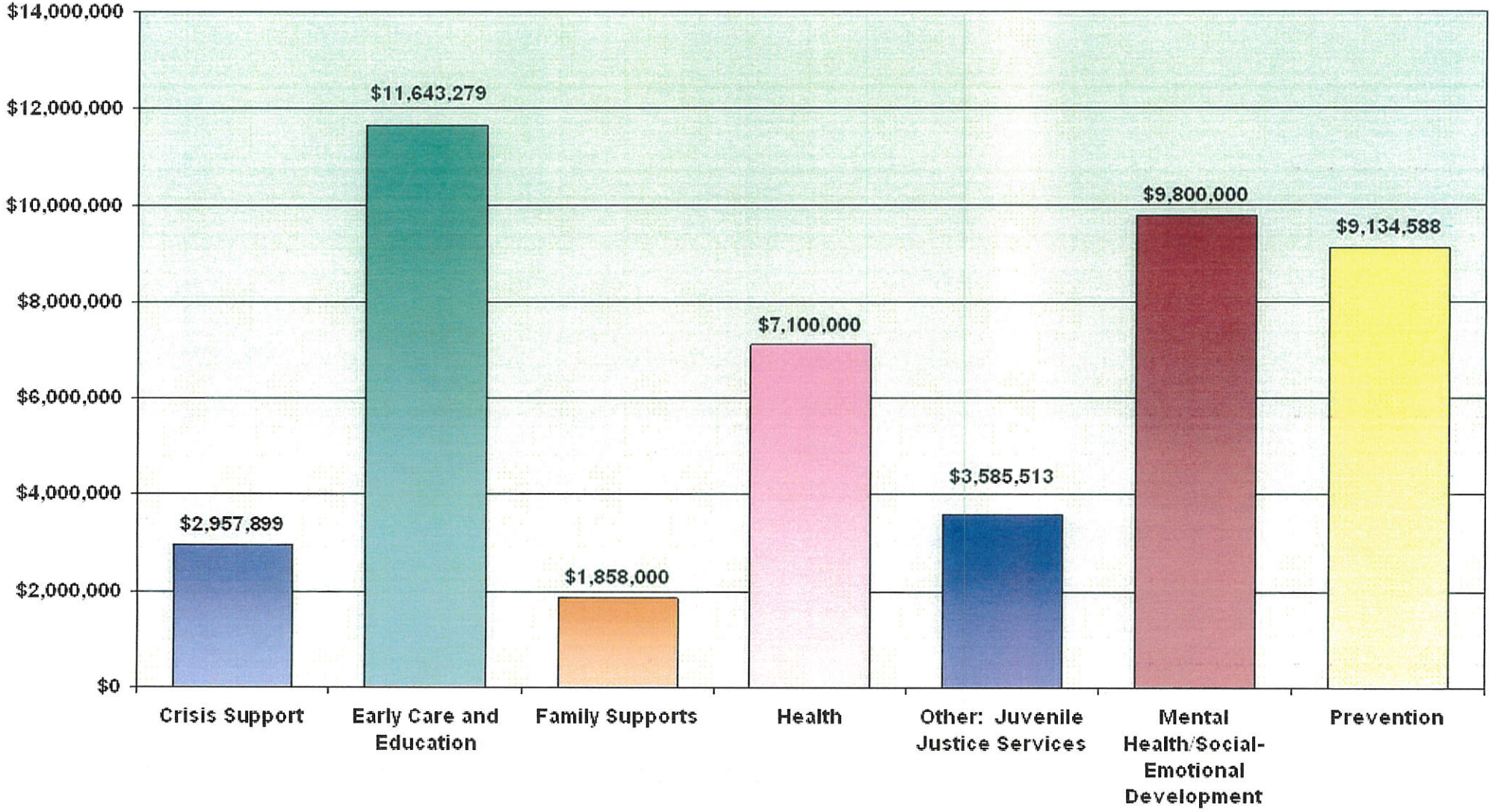
Birth to five	Five to 18	Birth to 18	Population at large
Healthy Start Home Visitors (KDHE) $250,000	School Violence Prevention (SRS) $228,000	Child Care Assistance Program (SRS) $1,400,000	PKU and Hemophilia Services (KDHE) $208,000
Immunization Outreach (KDHE) $500,000	Reading and Vision Research (KSDE) $300,000	JJA Prevention & Intervention Grants (JJA) $5,414,487	Smoking Prevention Grants (KDHE) $1,000,000
Infants & Toddlers Program (KDHE) $1,200,000	TeleKidcare Project (KU Med Center) $250,000	JJA Graduated Sanctions Grants (JJA) $3,585,513	
Smart Start (SRS/KCCTF) $8,443,279		Family Centered Systems of Care (SRS) $5,000,000	
Therapeutic Services to Preschoolers (SRS) $1,000,000		Children's Mental Health Initiative (SRS) $3,800,000	
Pre-K Pilot (SRS/KCCTF) $2,000,000		Family Preservation (SRS) $2,957,899	
		Community Services for Child Welfare (SRS) $3,492,101	
		Attendant Care for Independent Living (SRS) $50,000	
		HealthWave (KHPA) * $2,000,000	
		Medical Assistance (KHPA) * $3,000,000	

Notes:

The Children's Cabinet Accountability Fund does not apply to these categories and is not included in the table ($541,802).

* Information has not been received from these programs. Target population is based on available information.

Primary Program Focus Areas



Primary Focus Areas by Program

Crisis Support	Early Care and Education	Family Supports	Health	Other: Juvenile Justice Services	Mental Health/Social-Emotional Development	Prevention
Family Preservation (SRS) $2,957,899	Infants & Toddlers Program (KDHE) $1,200,000	Child Care Assistance Program (SRS) $1,400,000	Attendant Care for Independent Living (SRS) $50,000	JJA Graduated Sanctions Grants (JJA) $3,585,513	Children's Mental Health Initiative (SRS) $3,800,000	Community Services for Child Welfare (SRS) $3,492,101
	Pre-K Pilot (SRS/KCCTF) $2,000,000	Healthy Start Home Visitors (KDHE) $250,000	HealthWave (KHPA) $2,000,000		Family Centered Systems of Care (SRS) $5,000,000	JJA Prevention & Intervention Grants (JJA) $5,414,487
	Smart Start (SRS/KCCTF) $8,443,279	PKU and Hemophilia Services (KDHE) $208,000	Immunization Outreach (KDHE) $500,000		Therapeutic Services to Preschoolers (SRS) $1,000,000	School Violence Prevention (SRS) $228,000
			Medical Assistance (KHPA) $3,000,000			
			Reading and Vision Research (KSDE) $300,000			
			Smoking Prevention Grants (KDHE) $1,000,000			
			TeleKidcare Project (KU Med Center) $250,000			

CHILDREN'S INITIATIVE FUND
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Section Two: At-A-Glance Tables

CIF Programs: Target Population Information At-A-Glance

Program Name	Amount FY07	Target Population	Percent of services provided to Birth to Five population
Attendant Care for Independent Living	$50,000	Birth to 18	Not available **
Child Care Assistance Program	$1,400,000	Birth to 18	66%
Children's Mental Health Initiative	$3,800,000	Birth to 18	Not available **
Community Services for Child Welfare (HCBS/SED)	$3,492,101	Birth to 18	Not available **
Family Centered Systems of Care	$5,000,000	Birth to 18	27%
Family Preservation	$2,957,899	Birth to 18	35%
Healthy Start Home Visitors *	$250,000	Birth to five	75%
Immunization Outreach	$500,000	Birth to five	100%
Infants and Toddlers Program	$1,200,000	Birth to five	100%
Juvenile Graduated Sanctions Grants	$3,585,513	Birth to 18	3%
Juvenile Prevention & Intervention Program Grants	$5,414,487	Birth to 18	30% ***
PKU and Hemophilia Services	$208,000	Population at large	Not assessed
Pre-K Pilot	$2,000,000	Birth to 5	100%
Reading and Vision Research	$300,000	Five to 18	0%
School Violence Prevention	$228,000	Five to 18	0%
Smart Start Kansas	$8,443,279	Birth to five	100%
Smoking Prevention Grants	$1,000,000	Population at large	Not available **
TeleKidcare Project	$250,000	Five to 18	Not available **
Therapeutic Preschool Services	$1,000,000	Birth to five	100%

NOTES:
Information regarding Medical Assistance and HealthWave programs was not provided, therefore is not included in this table.

*The Healthy Start Home Visitors program provides pre and post-natal services. 25% of services are provided to pregnant women.
** General access to services was reported, but specific numbers of consumers served were not available.
*** Age range specified for this program is Birth to Six.

Financial Information for CIF Programs At-A-Glance

Program Name	Amount FY07	Total Budget	Budget Notes	Significance of CIF funding to total budget	Impact/Reach *
Attendant Care for Independent Living	$50,000	$18 million	Total budget: $18 million	.003%	1
Child Care Assistance Program	$1,400,000	$75 million	Every $1 generated in State funding draws down almost $3 in Federal funding.	1.8%	351
Children's Mental Health Initiative	$3,800,000	$30+ million	CIF money enhances the State match for Federal funding and allows more Federal draw down.	15%	325
Community Services for Child Welfare (HCBS/SED)	$3,492,101	$3,492,101	Regional Offices determine what programs are funded.	100%	4,086
Family Centered Systems of Care	$5,000,000	$5,000,000		100%	6,884
Family Preservation	$2,957,899	$11 million	Total budget: $11,364,083	25%	1,844
Healthy Start Home Visitors	$250,000	$1,041,000		24%	3,819
Immunization Outreach	$500,000 **	$250,000	80% of funding goes to incentives and 20% is dedicated to media and printing costs.	100%	Not available ****
Infants and Toddlers Program	$1,200,000	$8 million		15%	442
Juvenile Graduated Sanctions Grants	$3,585,513 ***	$30 million		12%	3,222
Juvenile Prevention & Intervention Program Grants	$5,414,487 ***	$7,264,598		100%	57,526
Reading and Vision Research	$300,000	$300,000	Professional services are provided in-kind.	100%	150
School Violence Prevention	$228,000	$228,000		100%	440
Smart Start Kansas	$8,443,279	$8,443,279		100%	13,979
Smoking Prevention Grants	$1,000,000	$2,631,000	CIF money is focused specifically on seven sites to provide a comprehensive tobacco prevention program.	38%	Not available ****
TeleKidcare Project	$250,000	$250,000	Recently gained approval to bill Medicaid for reimbursement of services.	100%	501
Therapeutic Preschool Services	$1,000,000	$1,000,000	Funding is Federally matched.	100%	446

NOTES:
Pre-K Pilot and PKU and Hemophilia Services were not interviewed in this first year receiving CIF funding and are not included in this table. Information regarding Medical Assistance and HealthWave programs was not provided, therefore was not included in this table.

*Estimated numbers of consumers served by CIF. Impact was calculated by multiplying the total reach of the program by the percentage of the budget comprised of CIF funds.
** Program reports receiving $250,000; half the allocated amount.
***JJA programs report that Prevention & Intervention actually receives $7,264,598 and Graduated Sanctions receives $1,735,402 of CIF money.
**** General access to services was reported, but specific numbers of consumers served were not available.

Evidence-Based Practice Levels At-A-Glance

		Level 1 Criteria: Emerging Practices & Programs					Level 2 Criteria: Promising Practices & Programs	
Program Name	**Amount FY07**	**Theory of Change**	**Outcomes**	**Anecdotal Reports**	**Quality Improvement Activities**	**Evaluation in Progress/ Completed**	**Adherence to Model Fidelity**	**Research using control group**
Attendant Care for Independent Living	$50,000			√				
Child Care Assistance Program	$1,400,000	√	√	√	√	√	√	
Children's Mental Health Initiative	$3,800,000	√	√	√	√	√	√	
Community Services for Child Welfare (HCBS/SED)	$3,492,101							
Family Centered Systems of Care	$5,000,000		√	√		√*		√*
Family Preservation	$2,975,899	√	√	√	√	√	√	
Healthy Start Home Visitors	$250,000	√	√	√	√	√	√	
Immunization Outreach	$500,000		√	√		√		
Infants and Toddlers Program	$1,200,000	√	√	√	√	√	√	
Juvenile Graduated Sanctions Grants	$3,585,513		√	√		√	√	
Juvenile Prevention & Intervention Program Grants	$5,414,487	√	√		√	√	√	
Reading and Vision Research	$300,000	√	√	√		√		√
School Violence Prevention	$228,000		√*	√				
Smart Start Kansas	$8,443,279	√	√	√	√	√		
Smoking Prevention Grants	$1,000,000	√		√	√	√	√*	
Telekidcare Project	$250,000	√		√				
Therapeutic Preschool Services	$1,000,000	√	√	√	√	√	√	

NOTES:
Pre-K Pilot and PKU and Hemophilia Services were not interviewed in this first year receiving CIF funding and are not included in this table. Information regarding Medical Assistance and HealthWave programs was not provided and are not included in this table.

Key:
√ Meets criteria
√* Some of the program components meet criteria

See Appendix C for checklist criteria.

Quality Evaluation At-A-Glance

Program Name	Amount FY07	Overall Rating	Quality Evaluation Steps				
			Describe the Program (A)	Focus the Evaluation (B)	Gather Credible Evidence (C)	Justify Conclusions (D)	Ensure Use and Lessons Learned (E)
Attendant Care for Independent Living	$50,000	√-	√+	√-	√-	√-	√-
Child Care Assistance Program	$1,400,000	√+	√+	√+	√	√+	√+
Children's Mental Health Initiative	$3,800,000	√+	√+	√+	√+	√+	√+
Community Services for Child Welfare (HCBS/SED)	$3,492,101	√-	√-	√-	√-	√-	√-
Family Centered Systems of Care	$5,000,000	√	√	√+	√	√	√
Family Preservation	$2,957,899	√+	√+	√+	√+	√+	√+
Healthy Start Home Visitors	$250,000	√+	√+	√+	√	√+	√+
Immunization Outreach	$500,000	√	√+	√	√	√	√-
Infants and Toddlers Program	$1,200,000	√+	√+	√+	√+	√+	√+
Juvenile Graduated Sanctions Grants	$3,585,513	√	√+	√-	√	√	√+
Juvenile Prevention & Intervention Program Grants	$5,414,487	√+	√+	√+	√	√	√+
Reading and Vision Research	$300,000	√	√+	√+	√	√	√-
School Violence Prevention	$228,000	√	√+	√-	√-	√-	√+
Smart Start Kansas	$8,443,279	√+	√+	√+	√	√+	√+
Smoking Prevention Grants	$1,000,000	√+	√+	√+	√	√+	√+
Telekidcare Project	$250,000	√	√+	√-	√	√	√
Therapeutic Preschool Services	$1,000,000	√+	√+	√+	√+	√+	√+

NOTES:
Pre-K Pilot and PKU and Hemophilia Services were not interviewed in this first year receiving CIF funding and are not included in this table.
Information regarding Medical Assistance and HealthWave programs was not provided, therefore is not included in this table.

Key:
√+ Exemplary (> 75% of criteria met)
√ Adequate (50-75% of criteria met)
√- Needs Improvement (< 50% of criteria met)

See Appendix E for checklist criteria.

Program Overview At-A-Glance

Program Name	CIF Amount FY07	Total Budget	Percentage of Birth to 5 consumers	CIF significance to total budget	Program Results * (Impact/Reach)	Quality Evaluation	Consumer Voice**
Attendant Care for Independent Living	$50,000	$18 million	NAV**	.003%	1	√-	NO
Child Care Assistance Program	$1,400,000	$75 million	66%	1.8%	351	√+	YES
Children's Mental Health Initiative	$3,800,000	$30+ million	NAV**	15%	325	√+	YES
Community Services for Child Welfare (HCBS/SED)	$3,492,101	$3,492,101	NAV**	100%	4,086	√-	NO
Family Centered Systems of Care	$5,000,000	$5,000,000	27%	100%	6,884	√	YES
Family Preservation	$2,957,899	$11 million	35%	25%	1,844	√+	YES
HealthWave	$2,000,000	NIF	NIF	NIF	NIF	NIF	NIF
Healthy Start Home Visitors	$250,000	$1,041,000	75%	24%	3,819	√+	YES
Immunization Outreach	$500,000	$250,000	100%	100%	NAV*	√	NO
Infants and Toddlers Program	$1,200,000	$8 million	100%	15%	442	√+	YES
Juvenile Graduated Sanctions Grants	$3,585,513	$30 million	3%	12%	3,222	√	NO
Juvenile Prevention & Intervention Program Grants	$5,414,487	$7,264,598	30%	100%	57,526	√+	NO
Medical Assistance	$3,000,000	NIF	NIF	NIF	NIF	NIF	NIF
PKU and Hemophilia Services	$208,000	NAS	NAS	NAS	NAS	NAS	NAS
Pre-K Pilot	$2,000,000	$2,000,000	100%	100%	NAS	NAS	NAS
Reading and Vision Research	$300,000	$300,000	NAV**	100%	150	√	NO
School Violence Prevention	$228,000	$228,000	NAV**	100%	440	√	YES
Smart Start Kansas	$8,443,279	$8,443,279	100%	100%	13,979	√+	YES
Smoking Prevention Grants	$1,000,000	$2,631,000	NAV**	38%	NAV*	√+	YES
TeleKidcare Project	$250,000	$250,000	NAV**	100%	501	√	YES
Therapeutic Preschool Services	$1,000,000	$1,000,000	100%	100%	446	√+	YES

NOTES:

*Estimated numbers of consumers served by CIF. Impact was calculated by multiplying the total reach of the program by the percentage of the budget comprised of CIF funds.

**Based on whether or not the program includes consumer voice as a part of their review process.

NIF = Information regarding these programs was not provided, therefore the programs could not be assessed.

NAS = These programs were newly funded by CIF and were not assessed.

NAV* = Specific numbers regarding consumers age Birth to 5 were not available.

NAV** = Program is available to the public. Specific numbers of consumers served were not available.

CHILDREN'S INITIATIVE FUND
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November 8, 2006

Section Three: CIF Program Information Sheets

Please refer to the appendices for clarification regarding data collection stage, quality evaluation, and evidence-based practices.

CHILDREN'S INITIATIVE FUND
Program Information Sheet

Program: Attendant Care for Independent Living

Description: Program for KanBeHealthy participants under age 21 who are chronically ill and technologically dependent, requiring daily ongoing medical care and monitoring by medical personnel. Diverts people from institutional settings.

Goals: Short term: meet the medical needs of medically fragile, technologically-dependent children by providing skilled level nursing services to keep them in the home. Long term: prevent hospitalization/institutionalization by empowering independence through education and skills development allowing the consumer to function and maintain self sufficiency so that they may participate as members of society.

Financial Information: FY07 Allotment: $50,000
CIF funding percentage of total budget: .003%

Primary Target Population: Birth to 18

Primary Program Focus Area: Health

Results: Data Collection Stage: 3 (Outputs)
Consumers served by CIF dollars: 1

Evidence Based Practices: The program staff report that trained staff adhere to licensure requirements; decisions are made based on the medical needs of the consumer. The staff did not identify a theory of change that guides the program, nor did they articulate measurable outcomes. Materials did not address whether the program has a manual, book, or other training materials that describe program components and administration. Anecdotal reports were provided regarding program effects on individual participants. Discussions regarding implementation of quality improvement and evaluation activities are in process.

Attendant Care for Independent Living, page 2

Quality Evaluation: This evaluation is conducted at the state level by program staff. Details regarding the program purpose, context, and services are provided in the evaluation materials. The evaluation consists of a tracking system to monitor hospitalization and death rates of consumers. Staff are currently in the process of developing an evaluation plan and an assessment tool to better assess program impact.

Programmatic Suitability: Consumer satisfaction was not identified as a part of this program evaluation.

CHILDREN'S INITIATIVE FUND
Program Information Sheet

Program: Child Care Assistance Program

Description: Provides financial assistance to low income families meeting criteria for child care services. Families choose their provider. Providers must be enrolled with SRS.

Goals: Provide child care support service to low-income families to support employment and lead to financial self sufficiency.

Financial Information: FY07 Allotment: $1,400,000
CIF funding percentage of total budget: 1.8%
Total budget: $75 million. Every $1 generated in State funding draws down almost $3 in Federal funding.

Primary Target Population: Birth to 18

Primary Program Focus Area: Family Supports

Results: Data Collection Stage: 4 (Outputs)
Consumers served by CIF dollars: 351

Evidence Based Practices: The information gathered describes the theory that guides the program, as well as measurable outcomes. Materials did not address whether the program has a manual, book, or other training materials that describe program components and administration. Anecdotal reports of how the program affects individual participants were provided. Staff are engaged in quality control reviews, and their evaluation consists of a performance monitoring system to meet Federal mandates.

Child Care Assistance Program, page 2

Quality Evaluation:

This evaluation is conducted at the local and state level by program staff. Details regarding the program purpose, services, and program partners are provided in the evaluation materials. Because CCAP receives significant state and Federal funding, the evaluation plan consists of the state mandated data collection and reporting plan. Program impact is assessed using a performance monitoring system. Benchmarks are set by the state to assess progress toward established goals. Specific areas addressed by the evaluation include child care accessibility, affordability, and licensure. Results are communicated regularly through reports to the Federal government.

Programmatic Suitability:

Consumer satisfaction is a part of this program evaluation. Focus groups with parents and providers are conducted.

CHILDREN'S INITIATIVE FUND
Program Information Sheet

Program: Children's Mental Health Initiative

Description: This program waives traditional Medicaid rules to allow children to receive a Medical Card based upon the child's income rather than that of the family. This allows access to services intended to prevent out-of-home placement and is a diversion program for psychiatric hospitalization regardless of parental income.

Goals: To provide intensive community-based services in an effort to maintain children and youth with severe emotional disturbances in the home and community and prevent hospitalization.

Financial Information: FY07 Allotment: $3,800,000
CIF funding percentage of total budget: 15%
CIF money enhances the State match for Federal funding and allows more Federal draw down.

Primary Target Population: Birth to 18

Primary Program Focus Area: Mental Health/Social-Emotional Development

Results: Data Collection Stage: 7 (Outcomes)
Consumers served by CIF dollars: 2,061

Evidence Based Practices: The information gathered describes the theory that guides the program. Staff provided a summary of peer-reviewed literature focused on attendant care for children and youth with severe emotional disorders. Materials did not address whether the program has a manual, book, or other training materials that describe program components and administration. Staff monitor fidelity of the wraparound services. The research evaluation was completed by external evaluators.

Children's Mental Health Initiative, page 2

Quality Evaluation:

This evaluation is conducted at the local and state level by program staff and external evaluators. Details regarding the program purpose, context, and services are provided in the evaluation materials. The evaluation plan includes a thorough description of the method for gathering and analyzing the data. Results are communicated regularly through agency reports to the Federal government. Program impact is assessed using a performance monitoring system. Benchmarks are set at the local level to assess progress toward intended outcomes. In addition, trends over time are evaluated at the state level. Specific child outcomes tracked by CMHI include out-of-home placement, law enforcement contacts, school attendance, and school functioning.

Programmatic Suitability:

Consumer satisfaction is a part of this program evaluation. Focus groups and a consumer satisfaction survey are conducted and field staff complete site visits.

CHILDREN'S INITIATIVE FUND
Program Information Sheet

Program: Community Services for Child Welfare (HCBS/SED)

Description: Funding distributed by SRS Regional Offices to subgrantees for prevention programs.

Goals: Provide prevention programs to reduce the number of children entering out of home placement.

Financial Information: FY07 Allotment: $3,492,101
CIF funding percentage of total budget: 100%

Primary Target Population: Birth to 18

Primary Program Focus Area: Prevention

Results: Data Collection Stage: 3 (Outputs)
Consumers served by CIF dollars: 4,086

Evidence Based Practices: The information gathered did not address whether the programs were guided by a specific theory(s), nor did it address whether the program has a manual, book, or other training materials that describe program components and administration. Measurable outcomes were not articulated. Anecdotal reports of how the program affects individual participants were not provided. The staff noted that they are moving in the direction of quality improvement and are planning to develop projects grounded in evidence-based programs. Evaluation of the program is in the planning stages.

Community Services for Child Welfare (HCBS/SED), page 2

Quality Evaluation: This evaluation is conducted at the local level by program staff. The evaluation consists of grantee reports outlining program goals, services, and expenditures. Staff are currently in the process of developing a standardized grantee application process and an evaluation plan to assess program impact.

Programmatic Suitability: Consumer satisfaction was not identified as a part of this program evaluation.

CHILDREN'S INITIATIVE FUND
Program Information Sheet

Program: Family Centered Systems of Care

Description: Community Mental Health Centers use this funding to build community collaboration on behalf of service delivery, provide parent support services to families of children with SED, and expand the array of mental health sevices for these children/families.

Goals: To identify gaps in services and build programs to meet the needs of children with SED and their families.

Financial Information: FY07 Allotment: $5,000,000
CIF funding percentage of total budget: 100%

Primary Target Population: Birth to 18

Primary Program Focus Area: Mental Health/Social-Emotional Development

Results: Data Collection Stage: 4 (Outputs)
Consumers served by CIF dollars: 6,884

Evidence Based Practices: The information gathered describes several activities and services funded under this program. One of these services is the parent support services. The following evidenced-based practice review is limited to the parent support services (PSS) program. The materials did not address a specific theory of change that guides the program. Outcomes have been identified. Materials did not address whether the program has a manual, book, or other training materials that describe the program components and administration. Staff provided anecdotal reports of how the program affects families. On-site visits to community mental health centers for quality improvement are in the planning stages. An evaluation has been conducted for the PSS program.

Family Centered Systems of Care, page 2

Quality Evaluation:

This evaluation is conducted at the local and state level by program staff and external evaluators. Details regarding the activities, services, and interagency partnerships are provided in the evaluation materials. The state evaluation is a broad examination of children receiving case management services through the Community-Based Services Program for youth with SED. The evaluation includes a thorough description of the data collection plan and a summary of results. Child outcomes tracked include out-of-home placement, law enforcement contacts, school attendance, and school function. Progress toward specific FCSC goals is not currently being assessed.

Programmatic Suitability:

Consumer satisfaction is a part of this program evaluation. Consumer satisfaction surveys, focus groups, on-site visits, parent surveys and provider surveys are conducted.

CHILDREN'S INITIATIVE FUND
Program Information Sheet

Program:	Family Preservation Services
Description:	Services provided to families in crisis who are at risk of having a child removed from the home. Family Preservation Services are provided by contracted agencies.
Goals:	To provide a full range of services to families by utilizing the strengths of the family and building upon those strengths and capabilities to resolve issues and maintain the family as a whole.
Financial Information:	FY07 Allotment: $2,957,899 CIF funding percentage of total budget: ~25%
Primary Target Population:	Birth to 18
Primary Program Focus Area:	Crisis Support
Results:	Data Collection Stage: 6 (Outcomes) Consumers served by CIF dollars: 1,844
Evidence Based Practices:	The information gathered describes the theory that guides the program. Outcomes have been identified. Materials did not address whether the program has a manual, book, or other training materials that describe program components and administration. Staff provided anecdotal reports of how the program affects the individual participants. Adherence to model fidelity using the "In Home Case Readers' Manual" and quality improvement is ongoing. Staff provided a literature review of research findings gathered from other states. An evaluation has been conducted for this program.

Family Preservation Services, page 2

Quality Evaluation:

This evaluation is conducted at the state level by program staff. Details regarding the program purpose, context, and services are provided in the evaluation materials. The evaluation plan includes a detailed description of the Federally-mandated data collection system and reporting requirements. Program impact is assessed using a performance monitoring system. Contracted service providers must provide evidence that state benchmarks have been met or exceeded. Specific outcomes tracked by Family Preservation include engagement in services, child maltreatment, customer satisfaction with services, and prevention of foster care placements. Results are reviewed regularly by the advisory group and reported annually to SRS.

Programmatic Suitability:

Consumer satisfaction is a part of this program evaluation. Satisfaction surveys are conducted every 90 days.

CHILDREN'S INITIATIVE FUND
Program Information Sheet

Program: Healthwave

Description:

Goals: To make affordable health insurance available to uninsured children and adolescents in Kansas.

Financial Information: FY07 Allotment: $2,000,000
CIF funding percentage of total budget:

Primary Target Population: Birth to 18

Primary Program Focus Area: Health

Results: Data Collection Stage:
Consumers served by CIF dollars:

Evidence Based Practices:

Quality Evaluation:

Programmatic Suitability:

CHILDREN'S INITIATIVE FUND

Program Information Sheet

Program:	Healthy Start Home Visitors
Description:	Provides home visits to expectant and parenting families with newborns and young children. Visitors link families with health departments, medical homes, and community resources. Parenting education is provided, i.e., home safety, breastfeeding concerns, and immunizations.
Goals:	To enable at-risk families to become healthier and more self-sufficient by improving their access to early intervention services.
Financial Information:	FY07 Allotment: $250,000 CIF funding percentage of total budget: 24%
Primary Target Population:	Birth to five
Primary Program Focus Area:	Family Supports
Results:	Data Collection Stage: 4 (Outputs) Consumers served by CIF dollars: 3, 819
Evidence Based Practices:	The information gathered describes the theory that guides the program. Outcomes have been identified. The program has a manual that describes the components and administration of the program. Staff provided anecdotal reports of how the program affects the individual participants. Staff are engaged in quality improvement activities and are monitoring adherence to model fidelity. An evaluation of the program has been conducted.

Healthy Start Home Visitors, page 2

Quality Evaluation:

This evaluation is conducted at the local and state level by program staff and external evaluators. Details regarding the program purpose, history, target population, and services are provided in the evaluation materials. The evaluation plan includes a description of the data collection system and the plan for communicating results. Program impact is assessed using a performance monitoring system. Data collected by the home visitors and collaborating agencies are used to track progress toward specific performance goals set by the state Maternal Child Health program. Data routinely tracked include prenatal visits, prenatal referrals, and consumer satisfaction with services. This information is reviewed on a monthly basis by the Kansas Department of Health and Environment and the Maternal and Child Health staff for continuous improvement purposes. The HSHV program is currently in the process of developing an electronic data collection system to link HSHV services with child and family outcomes.

Programmatic Suitability:

Consumer satisfaction is a part of this program evaluation. Client surveys and site visits (through an external evaluator) are conducted.

CHILDREN'S INITIATIVE FUND
Program Information Sheet

Program: Immunization Outreach

Description: This program uses incentives to increase participation rates in immunization programs across the State.

Goals: This program is aimed at increasing immunization rates for children age two and younger.

Financial Information: FY07 Allotment: $500,000
CIF funding percentage of total budget: 100%
80% of funding goes to incentives and 20% is dedicated to media and printing costs.

Primary Target Population: Birth to five

Primary Program Focus Area: Health

Results: Data Collection Stage: 6 (Outcomes)
Consumers served by CIF dollars: Not available.

Evidence Based Practices: No theory was articulated that guides this program. Outcomes have been identified. The staff did not have a manual or other writings that would serve as a guide to implement the program, however they have been asked to speak at conferences regarding the implementation of such a program. Staff provided anecdotal reports of how the program affects the individual participants. An evaluation has been conducted for this program.

Immunization Outreach, page 2

Quality Evaluation:

This evaluation is conducted at the county and state level by external evaluators and program staff. Details regarding the program purpose, context, and services are provided in the evaluation materials. The evaluation plan includes a description of the method for gathering and analyzing the data. Program impact is assessed using a performance monitoring system. Progress toward the 90% coverage goal, set by Healthy People 2010, is evaluated for all participating health departments. At the state level, the evaluation focuses on trends over time and comparisons of immunization rates by population density. Results are communicated through reports to the Federal government.

Programmatic Suitability:

Consumer satisfaction was not identified as a part of this program evaluation.

CHILDREN'S INITIATIVE FUND
Program Information Sheet

Program:	Infants and Toddlers Program
Description:	Statewide system of community-based, family-centered early intervention developmental services for children birth to three with delays or disabilities. These services are individualized to meet the needs of the child being served and occur in natural settings.
Goals:	To ensure the availability of a collaborative, comprehensive, and family-centered service delivery system that meets the developmental needs of infants and toddlers who have delays or disabilities.
Financial Information:	FY07 Allotment: $1,200,000 CIF funding percentage of total budget: 15%
Primary Target Population:	Birth to five
Primary Program Focus Area:	Early Education
Results:	Data Collection Stage: 5 (Outcomes) Consumers served by CIF dollars: 442
Evidence Based Practices:	The information gathered describes the theory that guides the program. Outcomes have been identified. Staff use implementation standards from evidence-based models and provided anecdotal reports of how the program affects the individual participants. Staff are engaged in ongoing fidelity monitoring and quality improvement activities. An evaluation of the program was provided.

Infants and Toddlers Program, page 2

Quality Evaluation:

This evaluation is conducted at the local and state level by program staff. Details regarding the program structure and services are provided in the evaluation materials. The evaluation includes a detailed description of the data collection plan and the plan for disseminating results to stakeholders. Program impact is assessed using a comprehensive performance monitoring system. Three priority areas are monitored: 1) Early Intervention Services in Natural Environments, 2) Effective General Supervision Part C/Child Find, and 3) Effective General Supervision Part C/ Effective Transition. For each monitoring priority, specific indicators, baseline data, and six-year targets are provided. Progress toward the program's objectives is reviewed by stakeholders on a regular basis. Statewide results, including longitudinal trends, are reported annually to Kansas Department of Health and Environment and the Kansas Legislature through a formal reporting process.

Programmatic Suitability:

Consumer satisfaction is a part of this program evaluation. Parent surveys (at entrance and exit) and provider surveys are conducted.

CHILDREN'S INITIATIVE FUND
Program Information Sheet

Program:	Juvenile Graduated Sanctions Grants
Description:	Funds Juvenile Intake/Assessment (JIAS), Juvenile Intensive Supervised Probation (JISP), and Community Case Management Agency (CCMA).
Goals:	To provide crisis intervention and connect youth and families to other community-based programs as an effort to prevent the need for future and/or more serious family interventions by the court as either a CINC or Juvenile Offender.
Financial Information:	FY07 Allotment: $3,585,513 CIF funding percentage of total budget: 12%
Primary Target Population:	Birth to 18
Primary Program Focus Area:	Other: Juvenile Justice Services
Results:	Data Collection Stage: 4 (Outputs) Consumers served by CIF dollars: 3,222
Evidence Based Practices:	A theory guiding the program was not articulated. Outcomes have been identified. The program has standards describing program implementation. The staff provided anecdotal reports of how the program affects individual participants. The materials did not address ongoing quality improvement activities. Staff have been engaged in monitoring adherence to model fidelity and have conducted ongoing evaluation research.

CHILDREN'S INITIATIVE FUND
Program Information Sheet

Juvenile Graduated Sanctions Grants, page 2

Quality Evaluation:

This evaluation is conducted at the local level by program staff. Details regarding the program services and target population are provided in the proposal submission materials. As a condition of funding, grantees must submit a list of process and behavioral outcomes for tracking purposes. Program impact is assessed using a performance monitoring system. All grantees are required to collect population data and evaluate progress toward the standardized outcomes for JIAS, JISP, and CCMA. These outcomes include repeat intakes (JIAS), number of intake families who receive community-based referrals (JIAS), court substantiated probation violations (JISP), state custody placement (JISP), commitment to juvenile correction facility (JISP), new adjudications (CCMA), and out-of-home placement (CCMA). Each program is reviewed annually by state administrators through the grant process. Program staff are currently in the process of developing a statewide reporting system.

Programmatic Suitability:

Consumer satisfaction was not identified as a part of this program evaluation.

CHILDREN'S INITIATIVE FUND
Program Information Sheet

Program:	Juvenile Prevention & Intervention Program Grants
Description:	Provides funding for prevention services statewide. Four general categories of programming include: Truancy Prevention, Mentoring, After School, and Parent Training/Family Support Services.
Goals:	To provide funding for prevention and intervention services to youth in Kansas.
Financial Information:	FY07 Allotment: $5,414,487 CIF funding percentage of total budget: 100%
Primary Target Population:	Birth to 18
Primary Program Focus Area:	Prevention
Results:	Data Collection Stage: 6 (Outcomes) Consumers served by CIF dollars: 57,526
Evidence Based Practices:	The information gathered describes the theory guiding the program. Outcomes have been identified. The program has standards that describe the implementation of the program. Materials gathered did not address anecdotal reports of how the program affects individual participants. Staff are engaged in quality improvement activities and have been conducting ongoing evaluation research.

Juvenile Prevention & Intervention Program Grants, page 2

Quality Evaluation:

This evaluation is conducted at the local level by program staff. Details regarding the program purpose, services, and target population are provided in the proposal submission materials. As a condition of funding, each grantee must submit an evaluation plan which includes a description of the method for gathering the data and a plan for utilizing the results for future programming. Program impact is assessed using a performance monitoring system. As part of the evaluation process, all programs must develop individual benchmarks and report progress toward these benchmarks on an annual basis. Benchmarks must be related to the risk and/or protective factors identified in their proposal. Results are shared annually through a narrative reporting process in which achievements and areas in need of modification are identified by program staff. State administrators review the reports and provide feedback to grantees.

Programmatic Suitability:

Consumer satisfaction was not identified as a part of this program evaluation.

CHILDREN'S INITIATIVE FUND
Program Information Sheet

Program: Medical Assistance

Description:

Goals:

Financial Information: FY07 Allotment: $3,000,000
CIF funding percentage of total budget:

Primary Target Population: Birth to 18

Primary Program Focus Area: Health

Results: Data Collection Stage:
Consumers served by CIF dollars:

Evidence Based Practices:

Quality Evaluation:

Programmatic Suitability:

CHILDREN'S INITIATIVE FUND
Program Information Sheet

Program: PKU and Hemophilia Services

Description: Services provided to Kansas patients diagnosed with PKU through the purchase of treatment products, medically necessary food treatment products, and consultative services.

Goals: To promote the functional skills of young persons in Kansas who have a disability or chronic disease.

Financial Information: FY07 Allotment: $208,000
CIF funding percentage of total budget:

Primary Target Population: Population at large

Primary Program Focus Area: Family Supports

Results: Data Collection Stage:
Consumers served by CIF dollars:

Evidence Based Practices:

Quality Evaluation:

Programmatic Suitability:

CHILDREN'S INITIATIVE FUND
Program Information Sheet

Program: Pre-K Pilot

Description: Pilot project to prepare children to enter school ready to succeed. The pilot includes 27 classrooms with documented standards of evidence-based educational programs (receiving at least three stars on Kansas Quality Rating System).

Goals: Children will enter school ready to succeed.

Financial Information: FY07 Allotment: $2,000,000
CIF funding percentage of total budget: 100%

Primary Target Population: Birth to five

Primary Program Focus Area: Early Education

Results: Data Collection Stage:
Consumers served by CIF dollars:

Evidence Based Practices:

Quality Evaluation:

Programmatic Suitability:

CHILDREN'S INITIATIVE FUND
Program Information Sheet

Program: Reading and Vision Research

Description: This project provides vision therapy treatment to school-aged children with vision problems. Research examining the link between treatment and school performance is conducted as part of the project.

Goals: Ensure that children have the vision skills they need to succeed in life.

Financial Information: FY07 Allotment: $300,000
CIF funding percentage of total budget: 100%
Optometrists provide in-kind services.

Primary Target Population: School-aged children (5-18)

Primary Program Focus Area: Health

Results: Data Collection Stage: 6 (Outcomes)
Consumers served by CIF dollars: 150

Evidence Based Practices: Materials describe the theory guiding the program. Outcomes have been identified. The program has standards that describe the implementation of the program. The staff provided anecdotal reports of how the program affects individual participants. The materials did not address quality improvement activities. Staff have been engaged in ongoing evaluation research.

Reading and Vision Research, page 2

Quality Evaluation:

This evaluation of the Reading and Vision Research Initiative is conducted at the state level by external evaluators. Details regarding the treatment services and collaborating partners are provided in the evaluation materials. The evaluation plan includes a thorough description of the instruments and the method for collecting and analyzing the data. Program impact is assessed using a rigorous pretest -posttest comparison group design. Differences between the treatment group (students who completed vision therapy) and the control group (students who elected not to participate in vision therapy) are examined to assess the overall effectiveness of the program. The evaluation looks at several indicators of vision and reading performance including vision scores, reading scores, and standardized test performance. Both short-term and long-term effects are studied. Results are communicated through formal evaluation reports to program staff.

Programmatic Suitability:

Consumer satisfaction was not identified as a part of this program evaluation.

CHILDREN'S INITIATIVE FUND
Program Information Sheet

Program: School Violence Prevention

Description: Provides children with mental health support and services in a school setting with a focus on issues related to violence prevention. Uses a wraparound approach with other community providers.

Goals: Children will receive prevention services to enable them to choose healthy behaviors and succeed in school.

Financial Information: FY07 Allotment: $228,000
CIF funding percentage of total budget: 100%

Primary Target Population: School-aged children (5-18)

Primary Program Focus Area: Prevention

Results: Data Collection Stage: 6 (Outcomes)
Consumers served by CIF dollars: 440

Evidence Based Practices: Materials describe the theory guiding some of the prevention programs. Outcomes have been identified. The materials did not address whether the program has a manual, book, or other training materials that describe the program components and administration. Staff provided anecdotal reports of how the program affects individual participants. The materials did not address ongoing quality improvement activities. Staff are currently collecting utilization data and plan to move in the direction of establishing program evaluation procedures.

School Violence Prevention, page 2

Quality Evaluation:

This evaluation of the School Violence Prevention program is conducted at the local level by program staff or contracted evaluators. Details regarding the program purpose, services, and target population are provided by grantees in the proposal submission materials. As a condition of funding, each grantee must submit an evaluation plan which includes a logic model, a list of indicators, and a plan for gathering the data. Program impact is assessed using a performance monitoring system. As part of the evaluation process, all programs must develop individual benchmarks and report progress toward these goals on a regular basis. Benchmarks must be related to the Connect Kansas goals identified in their proposal. Results are shared with SRS on a quarterly basis through a narrative reporting process in which program staff discuss program reach, goal achievement and areas in need of improvement.

Programmatic Suitability:

Consumer satisfaction is a part of this program evaluation. Site visits are conducted annually.

CHILDREN'S INITIATIVE FUND

Program Information Sheet

Program:	Smart Start Kansas
Description:	Early childhood initiative serving children and families with the goal of ensuring that all children enter school ready to learn. Smart Start awards grants to community collaboratives to address gaps in early childhood learning across the State.
Goals:	Intermediate Goals: 1) Improved quality of early child care and education, 2) increased availability of early child care and education, 3) Increased affordability of early child care and education, 4) Improved child health,5) Increased family support. Long-term Goals: 1) Increased number of children experiencing high-quality, healthy living and learning environments, 2) Increased number of children entering school ready to learn.
Financial Information:	FY07 Allotment: $8,443,279 CIF funding percentage of total budget: 100%
Primary Target Population:	Birth to five
Primary Program Focus Area:	Early Education
Results:	Data Collection Stage: 7 (Outcomes) Consumers served by CIF dollars: 13,979
Evidence Based Practices:	Materials describe the theory of change that guides the overall Smart Start program. Outcomes have been identified. The evaluation materials did not address whether the program has a manual, book, or other training materials that describe program components and administration. The Smart Start program requires that individual grantees implement research-based programs and activities that have shown evidence of positive outcomes for children aged 0-5. The materials indicate that the program is engaged in ongoing evaluation research, as well as quality improvement activities at the local level.

Smart Start Kansas, page 2

Quality Evaluation:

This evaluation is conducted at the state level by external evaluators. Details regarding the program purpose, history, target population, and services are provided in the evaluation materials. The evaluation plan includes a thorough description of the method for gathering and analyzing the data. A comprehensive logic model guides the evaluation. Program impact is assessed using a rigorous comparison group design. Differences between Smart Start communities and non-Smart Start communities are examined to determine the effectiveness of the program in meeting its goals. The evaluation is driven by a logic model that outlines immediate outcomes (number of children/families served, program activity counts), intermediate (improvements in the five Core Service Areas), and long-term outcomes (increases in school readiness). Evaluation results are communicated regularly to stakeholders through formal reports and presentations. Child-level outcomes are expected in future evaluations.

Programmatic Suitability:

Consumer satisfaction is a part of this program evaluation. Site visits, provider surveys and parent surveys are conducted.

CHILDREN'S INITIATIVE FUND
Program Information Sheet

Program: Smoking Prevention Grants

Description: Statewide program providing resources and assistance to community coalitions for development, enhancement and evaluation of state and local initiatives to prevent death and disease from tobacco use and addiction. This program focuses on four areas:1) Prevent youth from starting to use tobacco, 2) Help tobacco users quit, 3) Eliminate nonsmokers' exposure to secondhand smoke, and 4) Eliminate tobacco-related disparities.

Goals: To reduce disease, disability, death, and disparities related to tobacco.

Financial Information: FY07 Allotment: $1,000,000
CIF funding percentage of total budget: 38%
CIF money is focused on seven sites to provide a comprehensive tobacco prevention program.

Primary Target Population: Population at large

Primary Program Focus Area: Health

Results: Data Collection Stage: 7 (Outcomes)
Consumers served by CIF dollars: Not available.

Evidence Based Practices: The information gathered describes the theory that guides the program. The program is based on tobacco prevention models from the Centers for Disease Control's Best Practices for Comprehensive Tobacco Control Programs. Program implementation materials were provided. Staff gathered clinical literature, as well as anecdotal reports of how the program affects individual participants. An evaluation of the program was provided. Quality improvement is ongoing and is based on the evaluation results. Adherence to model fidelity is in-process (baseline data is being collected) for the 5 A's program which assists pregnant women in their tobacco cessation efforts.

Smoking Prevention Grants, page 2

Quality Evaluation:

This evaluation is conducted at the local and state level by external evaluators. Details regarding the prevention services, target population, and community partners are provided in the evaluation materials. The evaluation plan includes a thorough description of the method for gathering and analyzing the data. At the state level, program impact is assessed using a performance monitoring system. The evaluation is guided by a logic model that outlines specific short-term, intermediate, and long- term outcomes for the program. Benchmarks are set for each outcome to evaluate progress toward goals. Results are disseminated widely to stakeholders through articles, formal reports, and presentations. At the local level, program impact is evaluated using an electronic media tracking system. The tracking system monitors activity utilization and scope of prevention activities. This information is disseminated on a quarterly basis to local communities for continuous improvement purposes.

Programmatic Suitability:

Consumer satisfaction is a part of this program evaluation. A coalition survey is conducted to address organizational capacity, barriers to implementation, and technical support. A cessation implementation evaluation is also conducted.

CHILDREN'S INITIATIVE FUND
Program Information Sheet

Program: TeleKidcare Project

Description: This program "brings the doctor to the school" via health information technologies. Children can receive acute pediatric care, chronic mental health care, pediatric specialty services and educational programming at their school.

Goals: Goals: 1) Reduce the time that a child spends out of the classroom recuperating from an acute illness, 2) Reduce ER visits, and 3) Provide access to care.

Financial Information: FY07 Allotment: $250,000
CIF funding percentage of total budget: 100%
This program just gained approval to bill Medicaid for reimbursement of services.

Primary Target Population: School-aged children

Primary Program Focus Area: Health

Results: Data Collection Stage: 4 (Outputs)
Consumers served by CIF dollars: 501

Evidence Based Practices: The information gathered describes the theory guiding the ambulatory visits, but does not address the theory(s) that the mental health visits are based upon. Staff are in the process of identifying measurable outcomes. The program has a manual that describes the program components and administration. The staff provided anecdotal reports of how the program affects individual participants and are currently collecting parent satisfaction data and counts of usage. They are also in the process of establishing program evaluation procedures.

TeleKidcare Project, page 2

Quality Evaluation:

This evaluation is conducted at the state level by program staff. Details regarding the program purpose, services, and community partners are provided in the evaluation materials. The evaluation is based on consultation records and a parent survey designed to assess satisfaction with services and perceived benefits. Program staff examine the parent responses to assess program effectiveness. Evaluation results are used primarily by the affiliated Kansas University Medical Center departments for continuous improvement purposes.

Programmatic Suitability:

Consumer satisfaction is a part of this program evaluation. A parent satisfaction survey is conducted.

CHILDREN'S INITIATIVE FUND
Program Information Sheet

Program: Therapeutic Preschool Services

Description: This program prevents/minimizes social-emotional/mental health deficits in young children. It identifies children who have or are at risk for severe emotional disturbances, preserves families/prevents out of home placements, and prepares children to enter school ready to learn.

Goals: Early identification of children who experience/are at risk for severe emotional disturbances, preserve families and prevent out-of-home placements, prepare children to enter school with the emotional, social, and other school readiness skills necessary to be successful learners.

Financial Information: FY07 Allotment: $1,000,000
CIF funding percentage of total budget: 100%
Funding is Federally matched.

Primary Target Population: Birth to five

Primary Program Focus Area: Mental Health/Social-Emotional Development

Results: Data Collection Stage: 6 (Outcomes)
Consumers served by CIF dollars: 446

Evidence Based Practices: The information gathered describes the theory guiding the program. Outcomes have been identified. The program has standards that describe the implementation of the program. The staff provided anecdotal reports of how the program affects individual participants. Staff are engaged in monitoring adherence to model fidelity and quality improvement activities and conduct ongoing evaluation research.

Therapeutic Preschool Services, page 2

Quality Evaluation:

This evaluation is conducted at the local and state level by program staff and external evaluators. Details regarding the goals, services, and community collaborations are provided by grantees in the proposal materials. As a condition of funding, each grantee must submit an evaluation plan with a logic model and a plan for gathering the data. Program impact is assessed using a performance monitoring system. For the local evaluation, programs must develop individual benchmarks and report progress toward these benchmarks on a quarterly basis. Benchmarks must be related to the Connect Kansas goals identified in their proposal. Results are shared with SRS through a narrative reporting process in which program staff discuss goal achievement and areas in need of improvement. The state evaluation of the TPS focuses on parent satisfaction with services and outcomes of children in the program. Specific child outcomes tracked by TPS include environmental risk factors of children in the program and the readiness of children exiting the program to enter regular classrooms. Results of the state evaluation are shared with stakeholders on a quarterly basis.

Programmatic Suitability:

Consumer satisfaction is a part of this program evaluation. Parent evaluations and parent exit surveys are conducted.

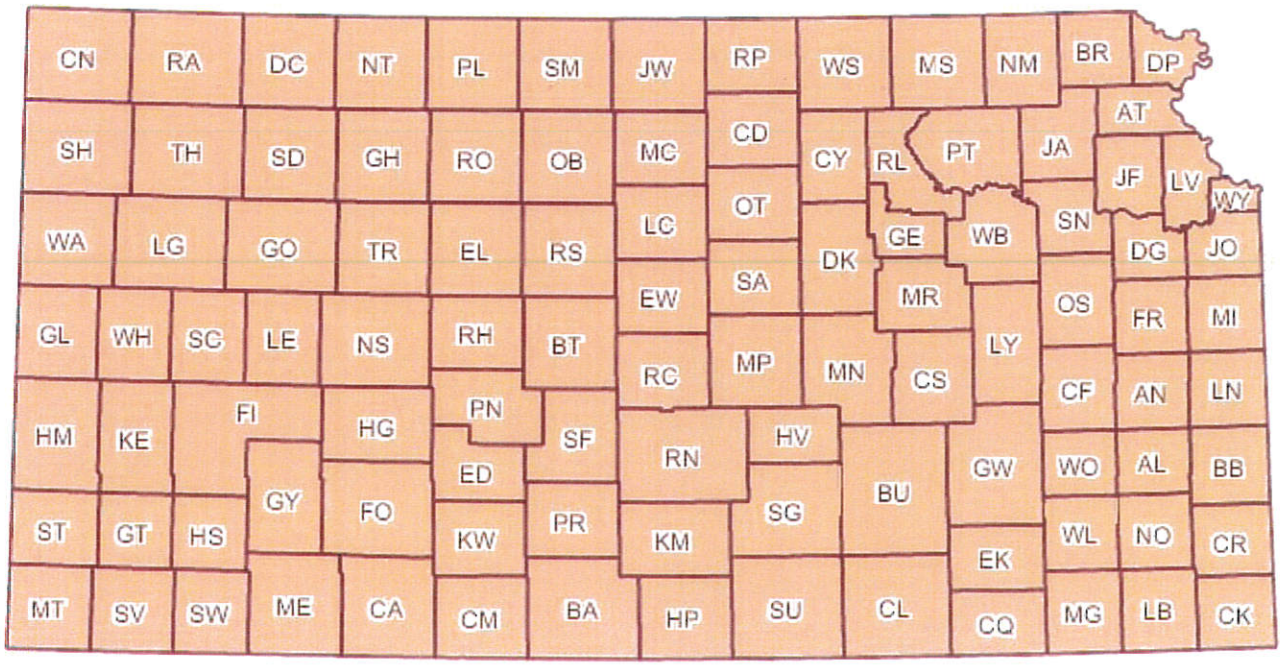
CHILDREN'S INITIATIVE FUND
Briefing Binder
November 8, 2006

Section Four: CIF Program Location Information

ATTENDANT CARE FOR INDEPENDENT LIVING

Available in the following counties:

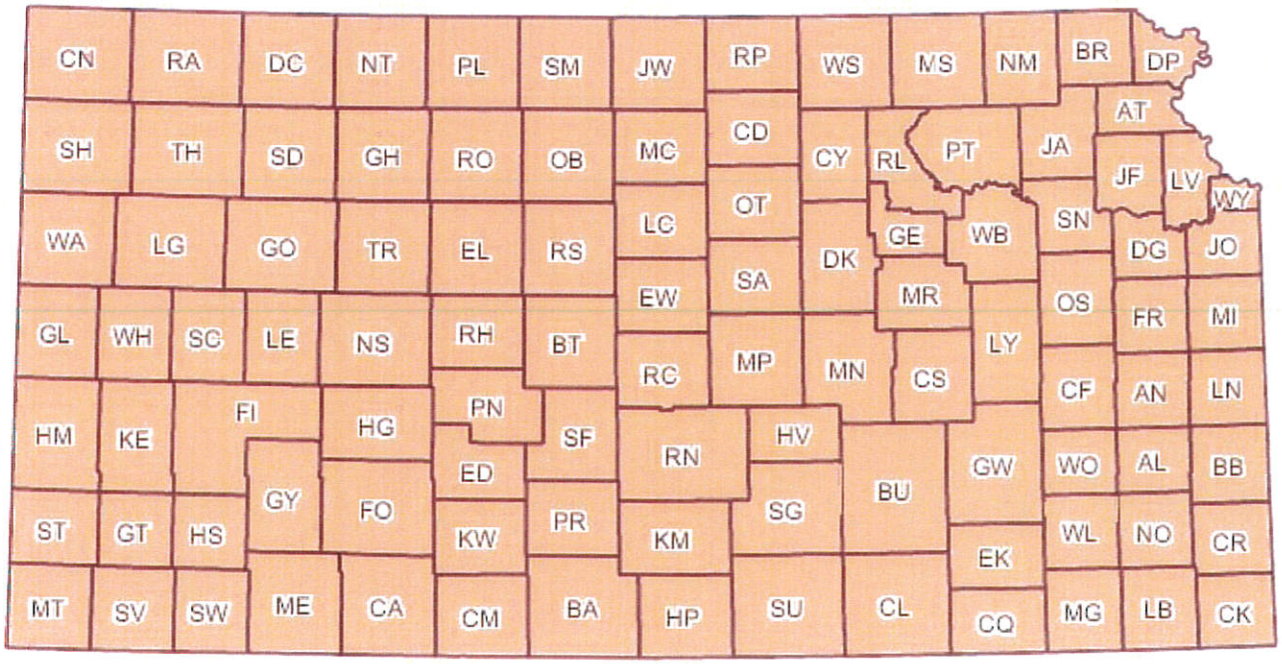
- Available in all 105 counties



CHILDCARE ASSISTANCE PROGRAM

Available in the following counties:

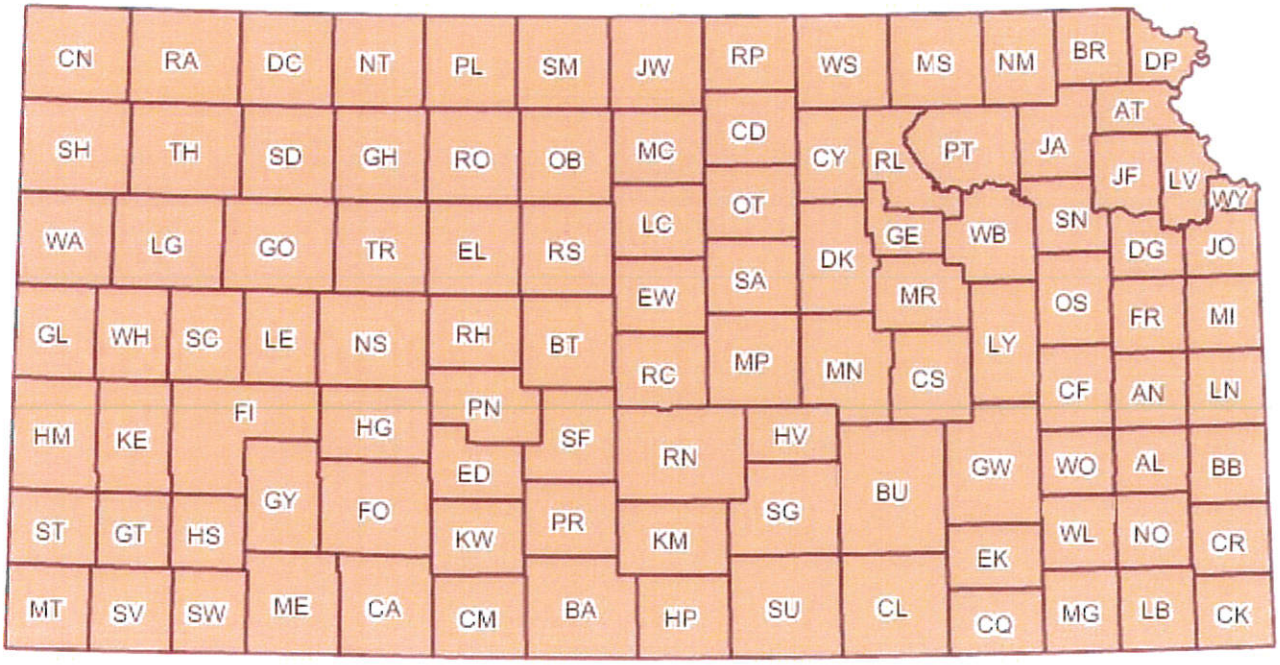
- Available in all 105 counties



CHILDREN'S MENTAL HEALTH INITIATIVE

Available in the following counties:

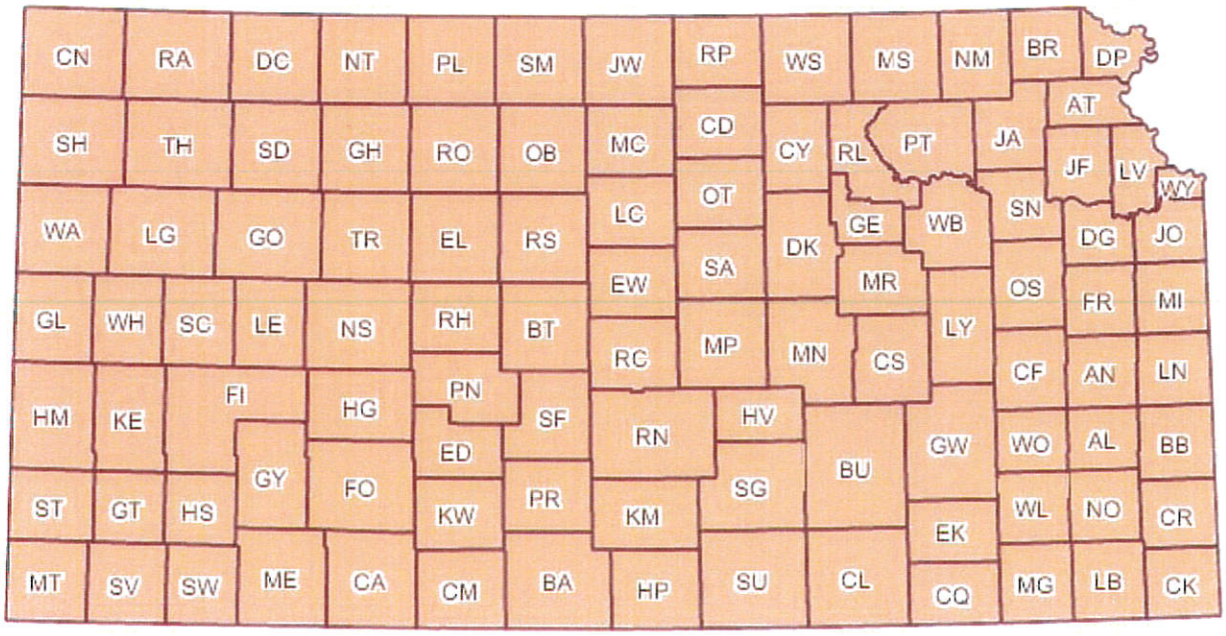
- Available in all 105 counties



COMMUNITY SERVICES FOR CHILD WELFARE (HCBS/SED)

Available in the following counties:

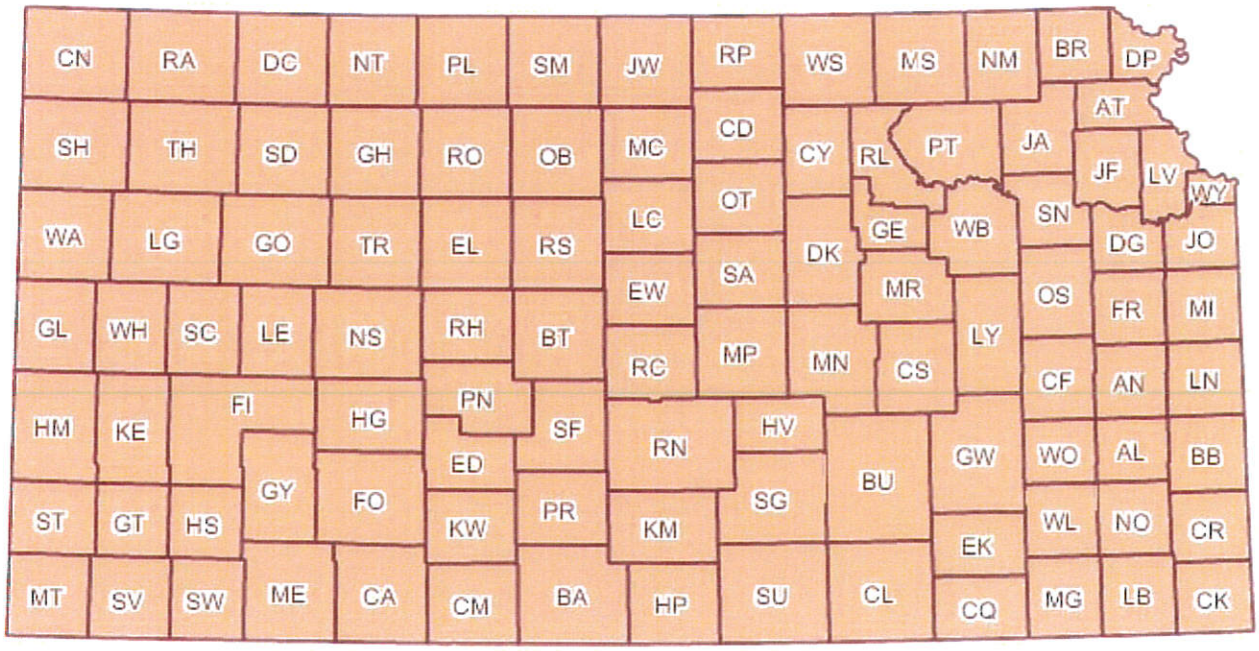
- Available in all 105 counties



FAMILY CENTERED SYSTEMS OF CARE

Available in the following counties:

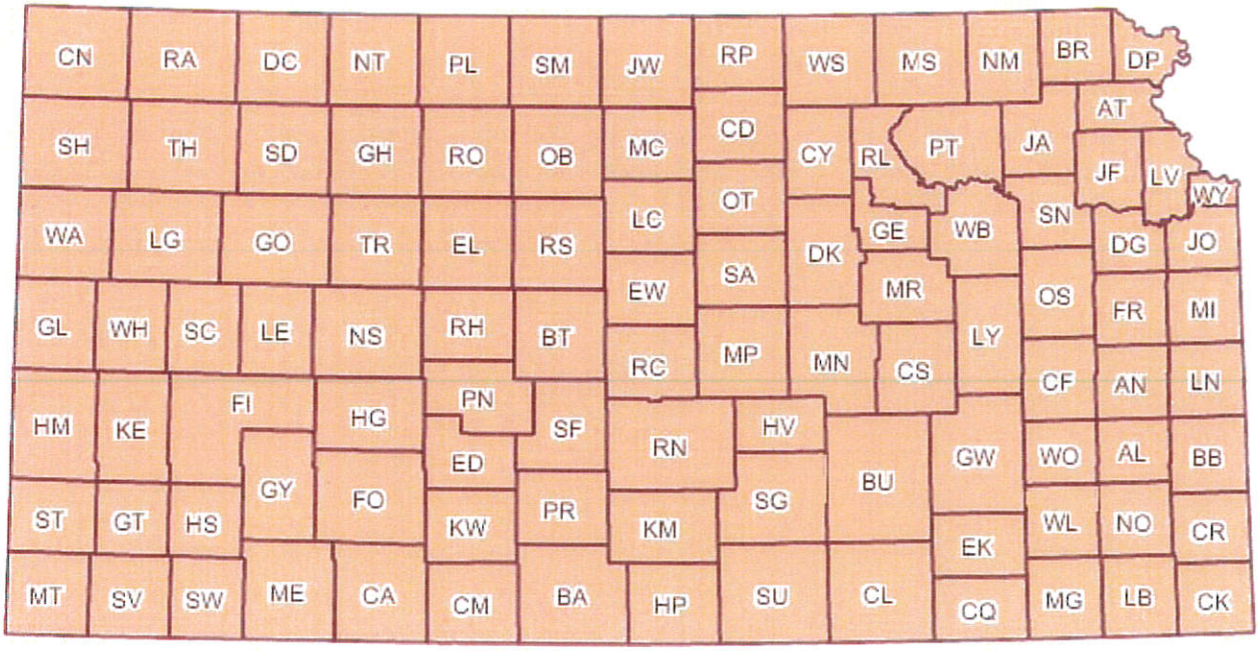
- Available in all 105 counties.



FAMILY PRESERVATION SERVICES

Available in the following counties:

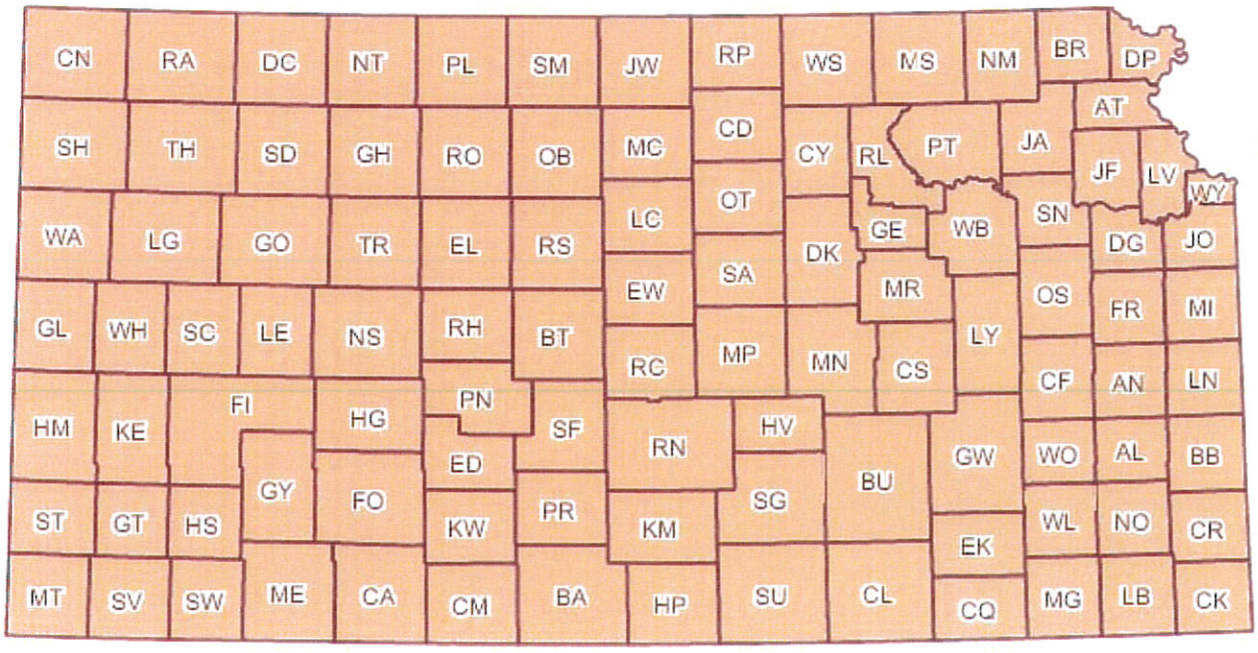
- Available in all 105 counties.



HEALTHWAVE

Available in the following counties:

- Available in all 105 counties.

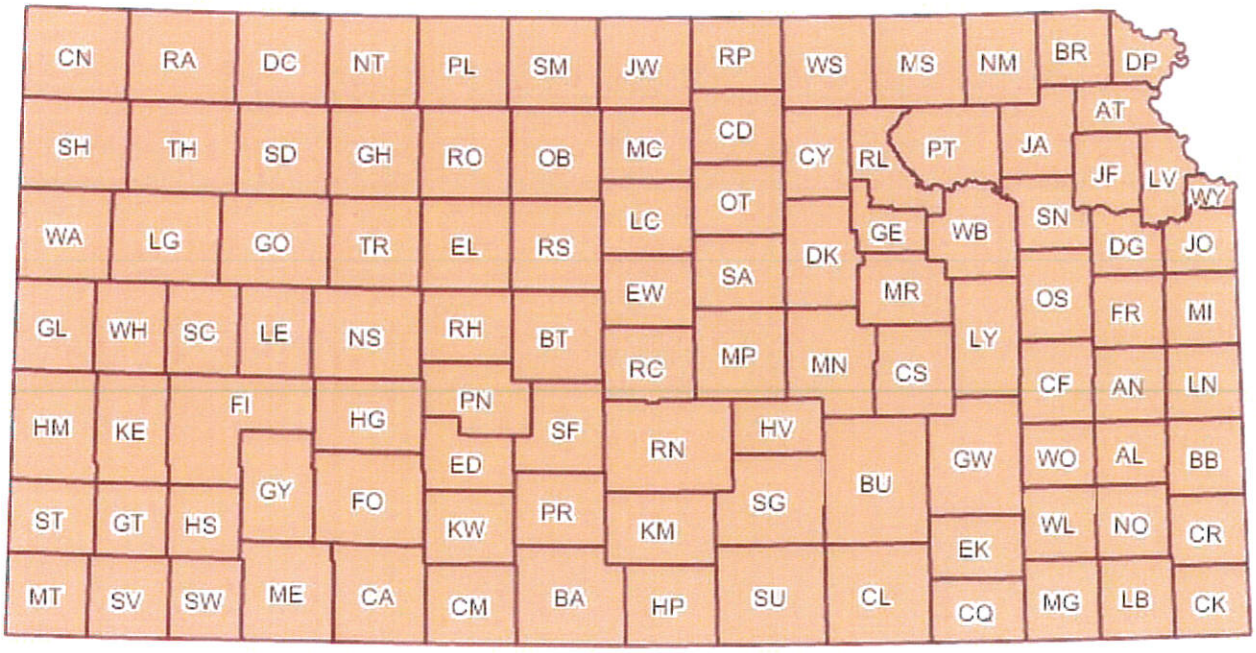


5-64

HEALTHY START HOME VISITORS

Available in the following counties:

- Available in all 105 counties.

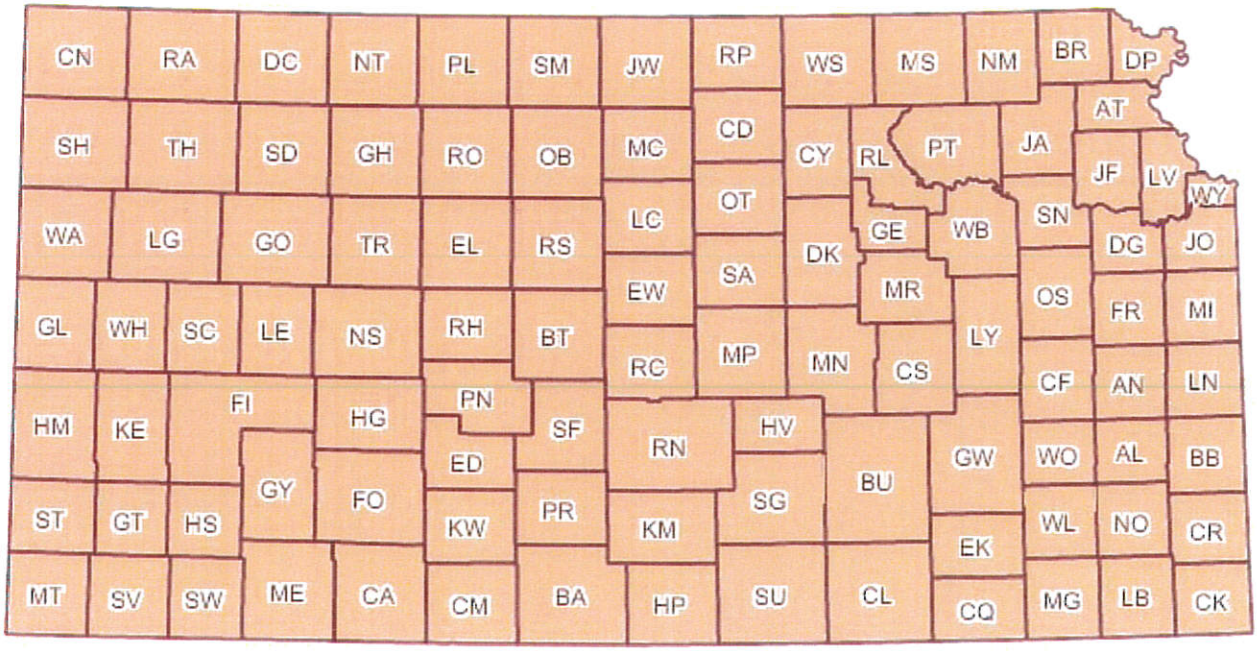


5-65

IMMUNIZATION OUTREACH

Available in the following counties:

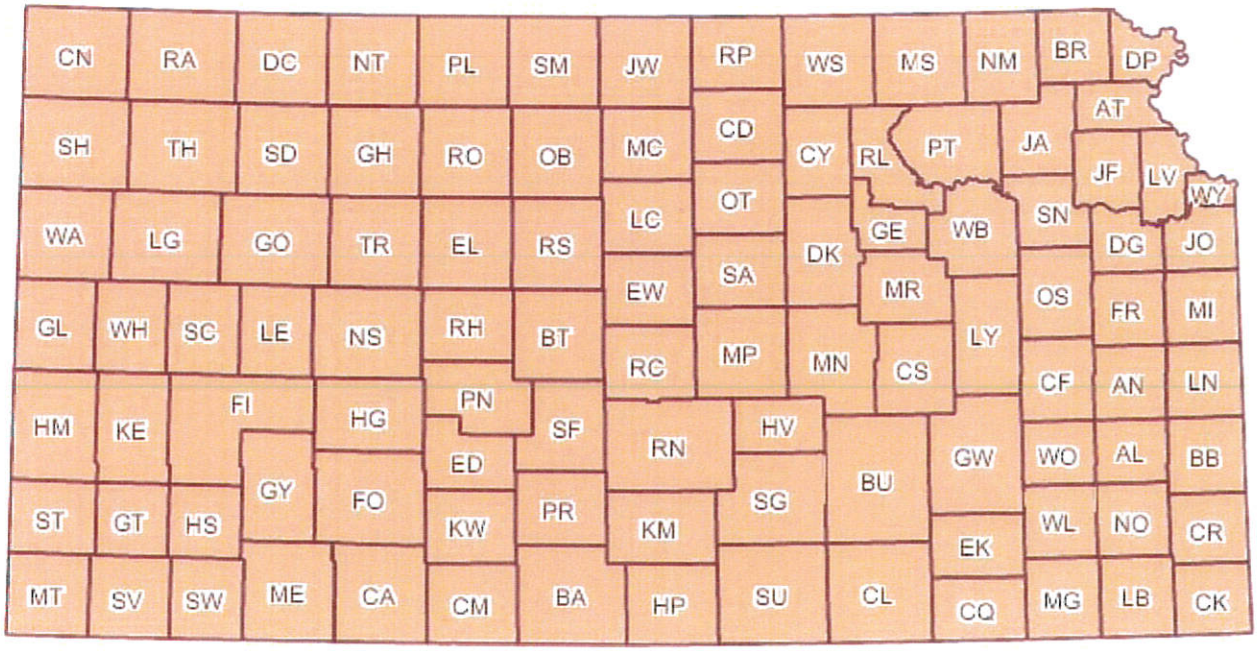
- Available in all 105 counties.



INFANTS AND TODDLERS PROGRAM

Available in the following counties:

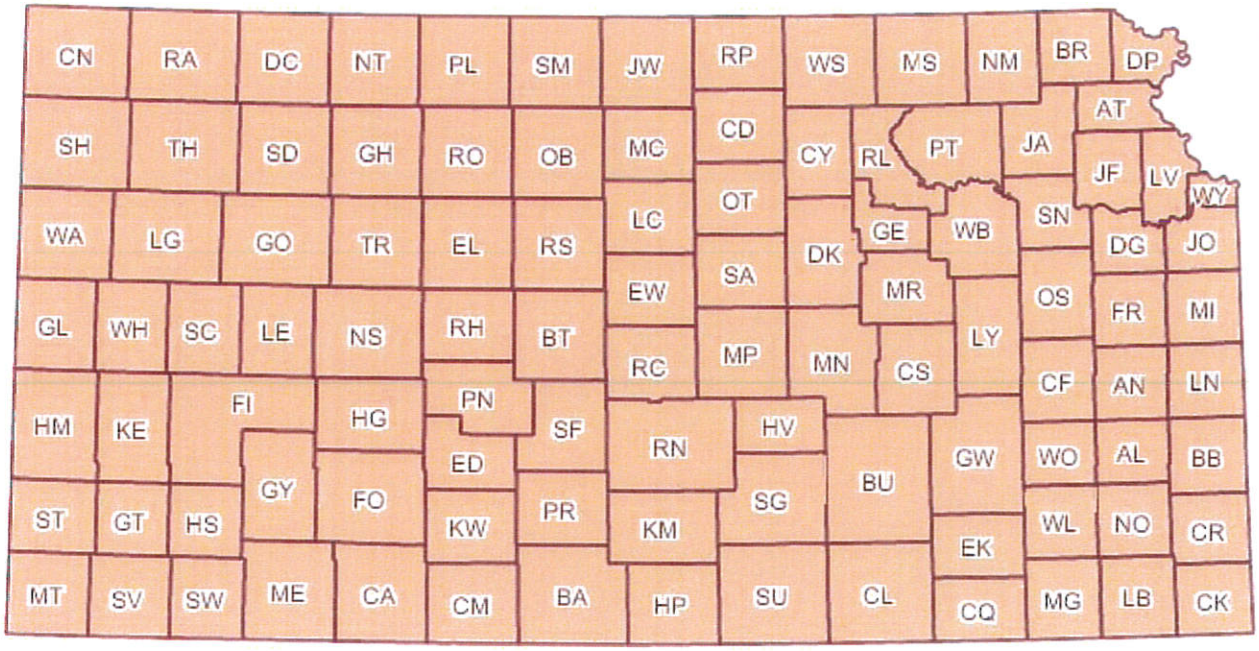
- Available in all 105 counties.



JUVENILE GRADUATED SANCTIONS GRANTS

Available in the following counties:

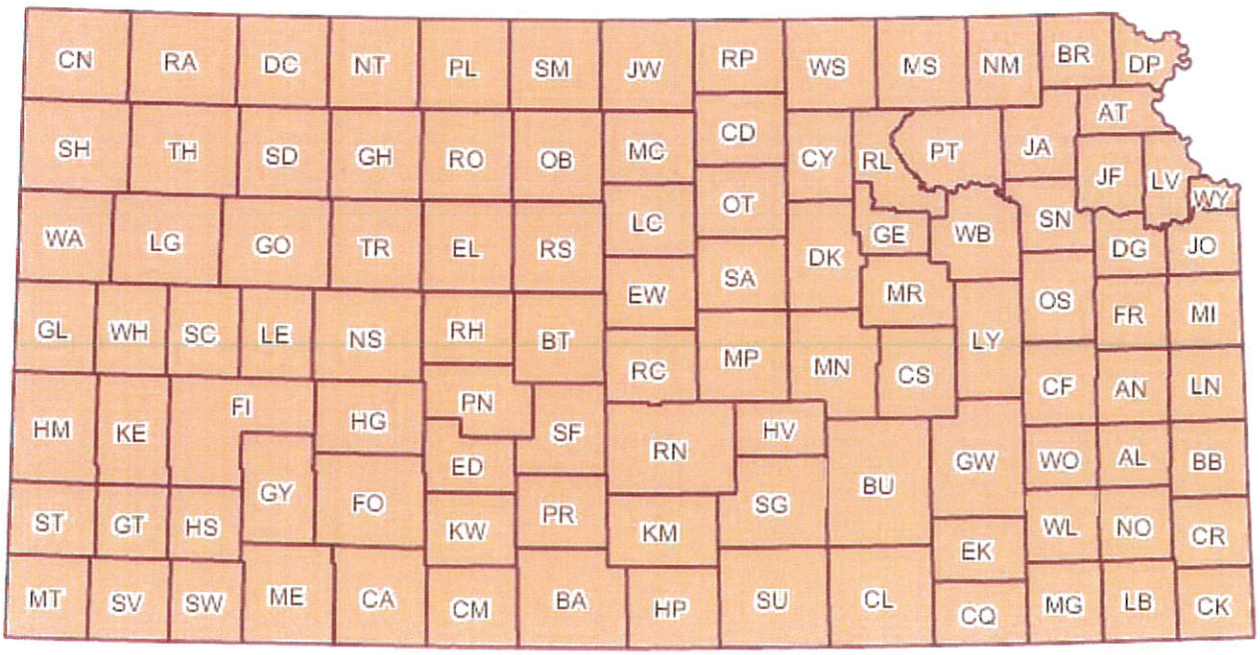
- Available in all 105 counties.



JUVENILE PREVENTION AND INTERVENTION PROGRAM GRANTS

Available in the following counties:

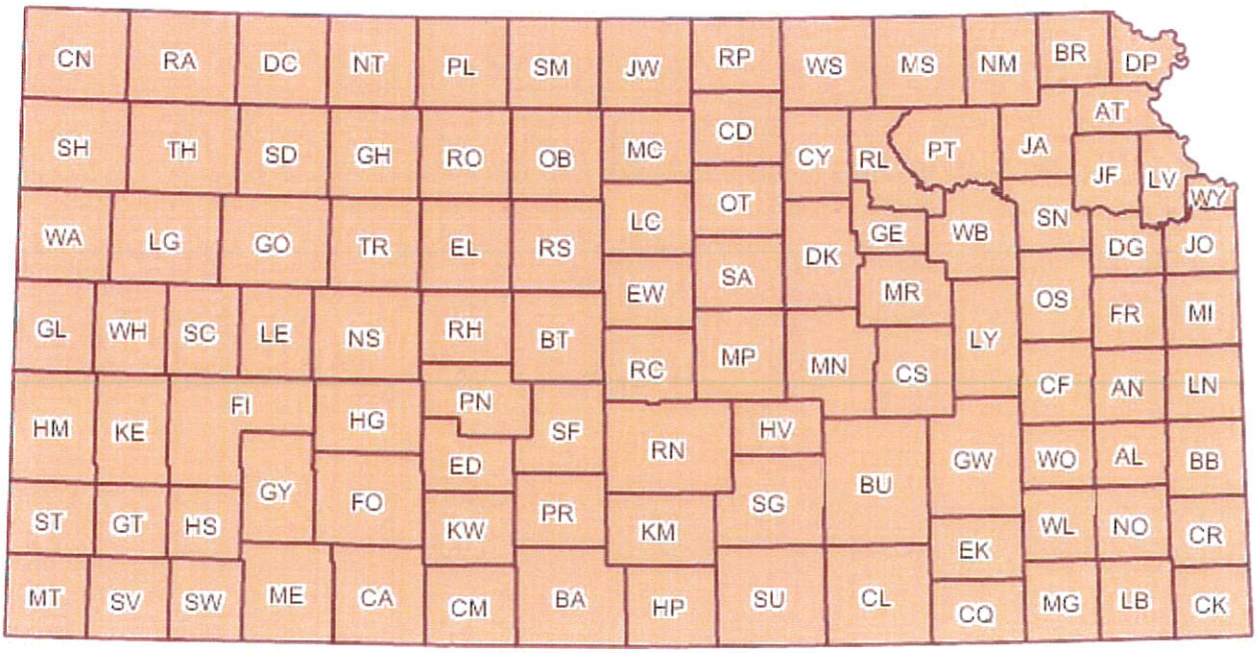
- Available in all 105 counties.



MEDICAL ASSISTANCE

Available in the following counties:

- Available in all 105 counties.

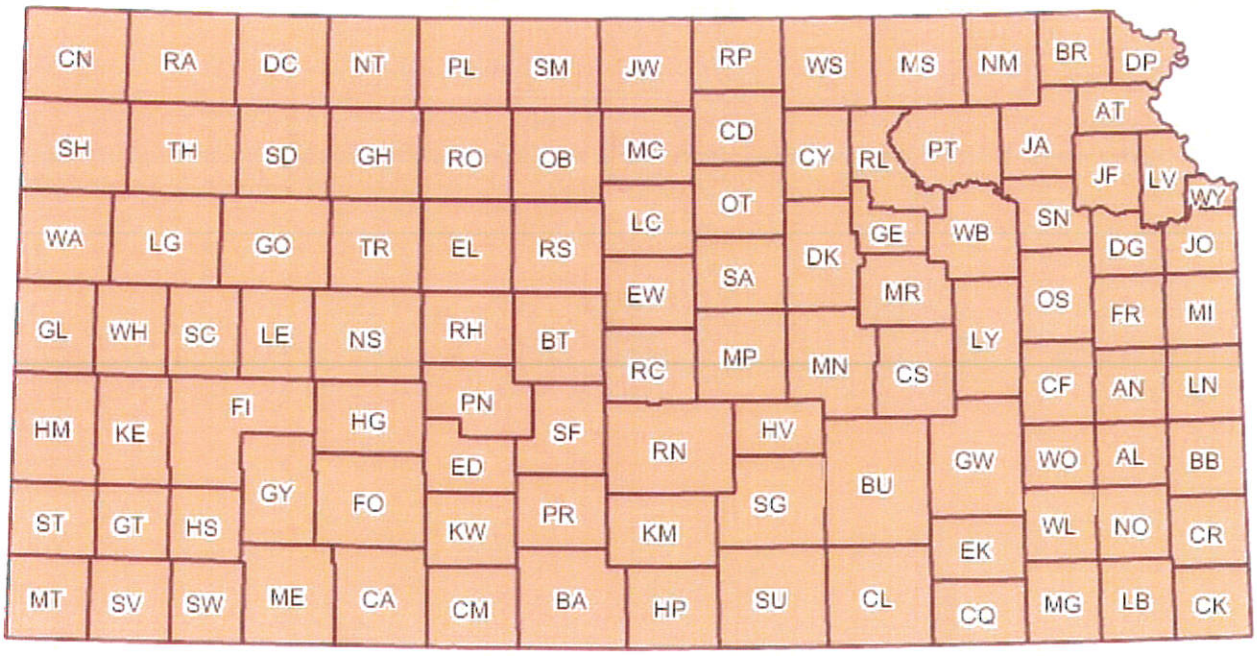


5-70

PKU AND HEMOPHILIA SERVICES

Available in the following counties:

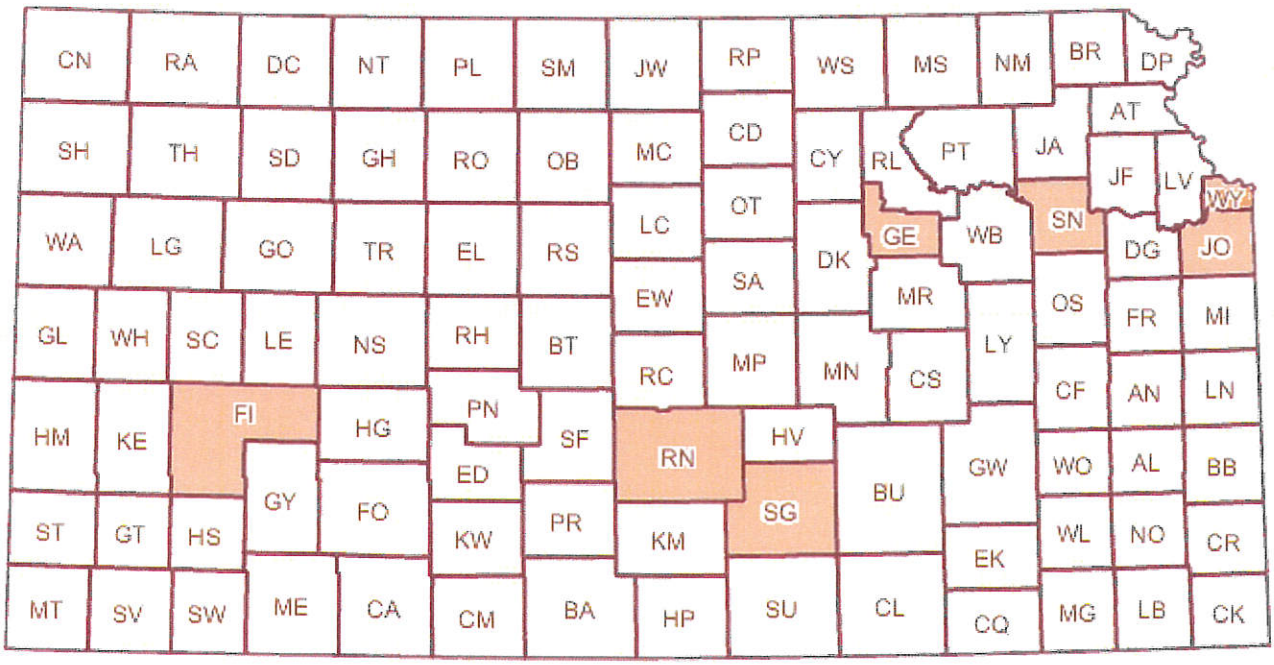
- Available in all 105 counties



PRE-K PILOT

Available in the following counties:

- Finney
- Geary
- Johnson
- Reno
- Sedgwick
- Shawnee
- Wyandotte

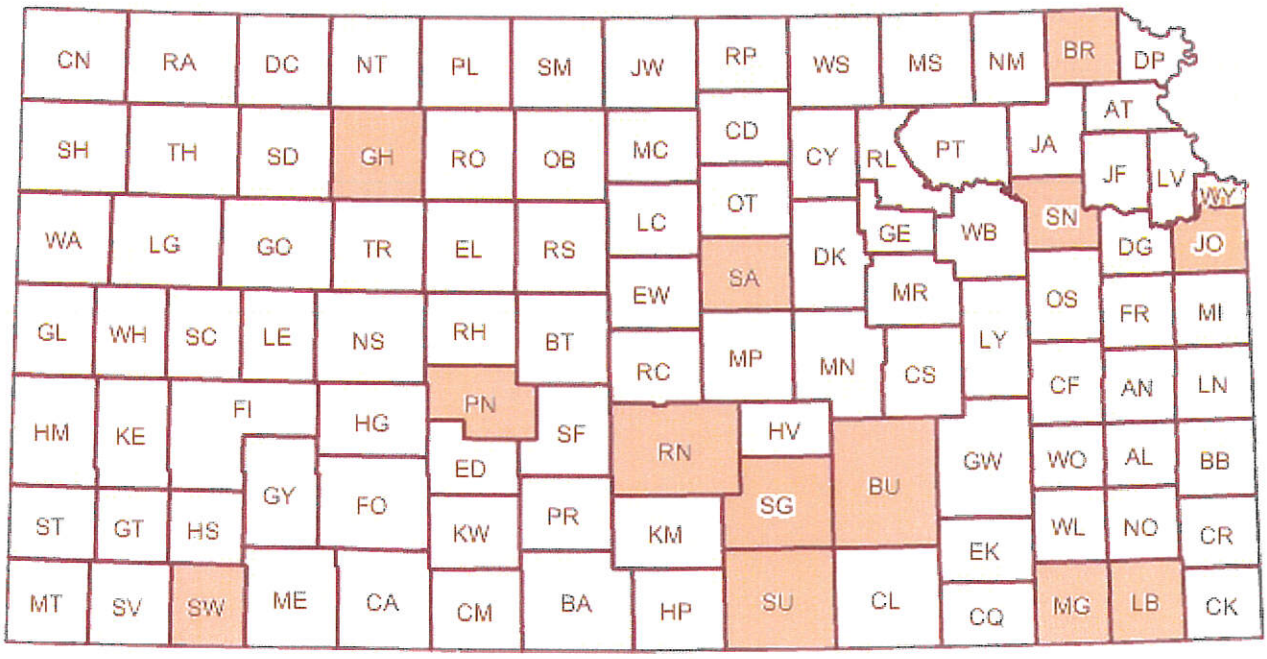


5-72

READING AND VISION RESEARCH

Available in the following counties:

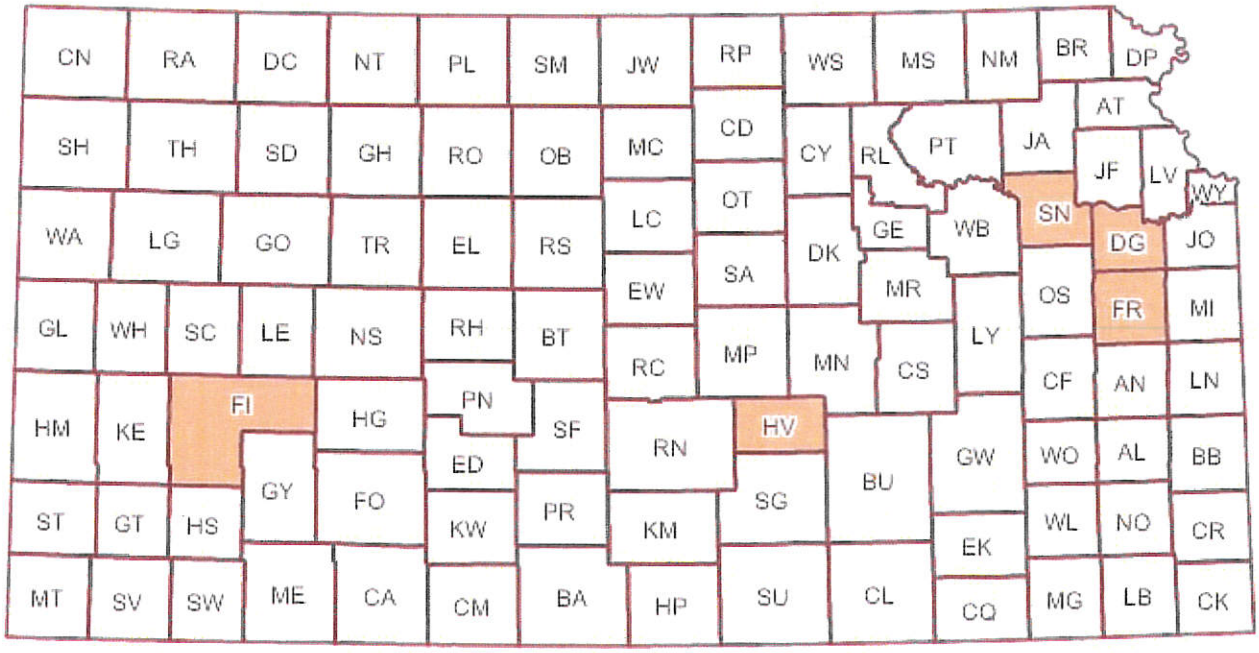
- Brown
- Butler
- Graham
- Gove
- Johnson
- Labette
- Montgomery
- Pawnee
- Reno
- Saline
- Sedgwick
- Seward
- Sumner



SCHOOL VIOLENCE PREVENTION

Available in the following counties:

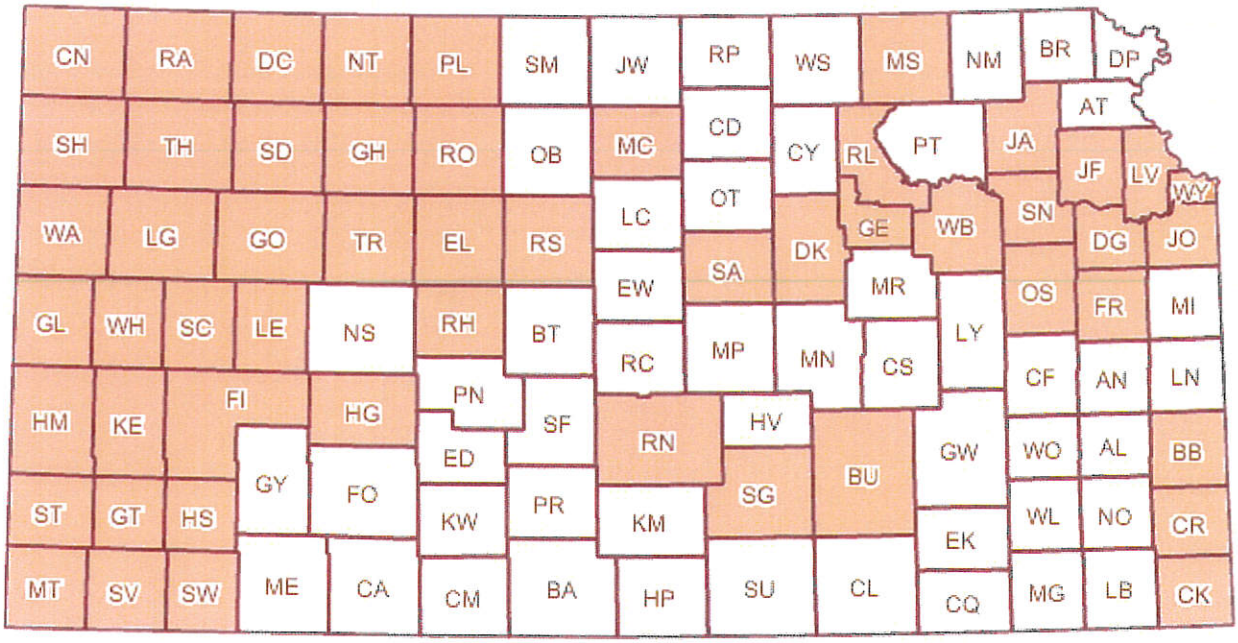
- Douglas
- Finney
- Franklin
- Harvey
- Shawnee



SMART START KANSAS

Available in the following counties:

- Bourbon
- Butler
- Cherokee
- Cheyenne
- Crawford
- Decatur
- Dickinson
- Douglas
- Ellis
- Finney
- Geary
- Gove
- Graham
- Grant
- Greeley
- Hamilton
- Haskell
- Jackson
- Jefferson
- Johnson
- Kearny
- Lane
- Leavenworth
- Logan
- Marshall
- Mitchell
- Morton
- Norton
- Osage
- Phillips
- Rawlins
- Reno
- Riley
- Rooks
- Rush
- Russell
- Saline
- Scott
- Sedgwick
- Seward
- Shawnee
- Sheridan
- Sherman
- Stanton
- Stevens
- Thomas
- Trego
- Wabaunsee
- Wallace
- Wichita
- Wyandotte

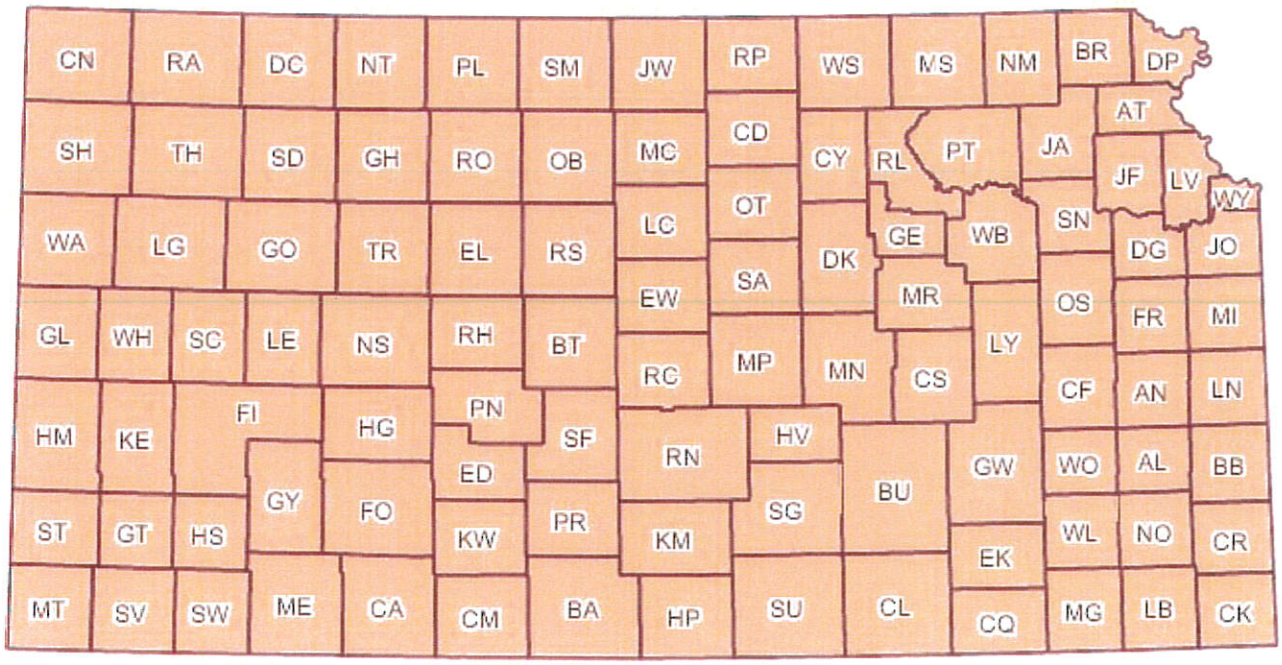


5-75

SMOKING PREVENTION GRANTS

Available in the following counties:

- Available in all 105 counties

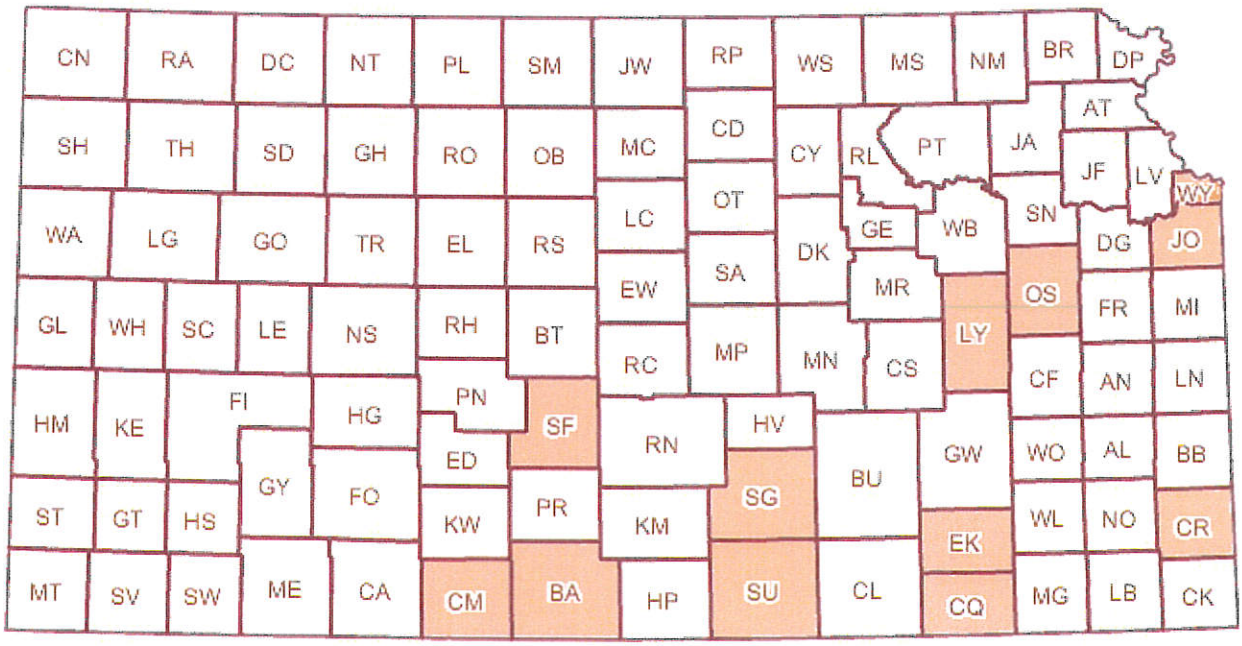


5-76

TELEKIDCARE PROJECT

Available in the following counties:

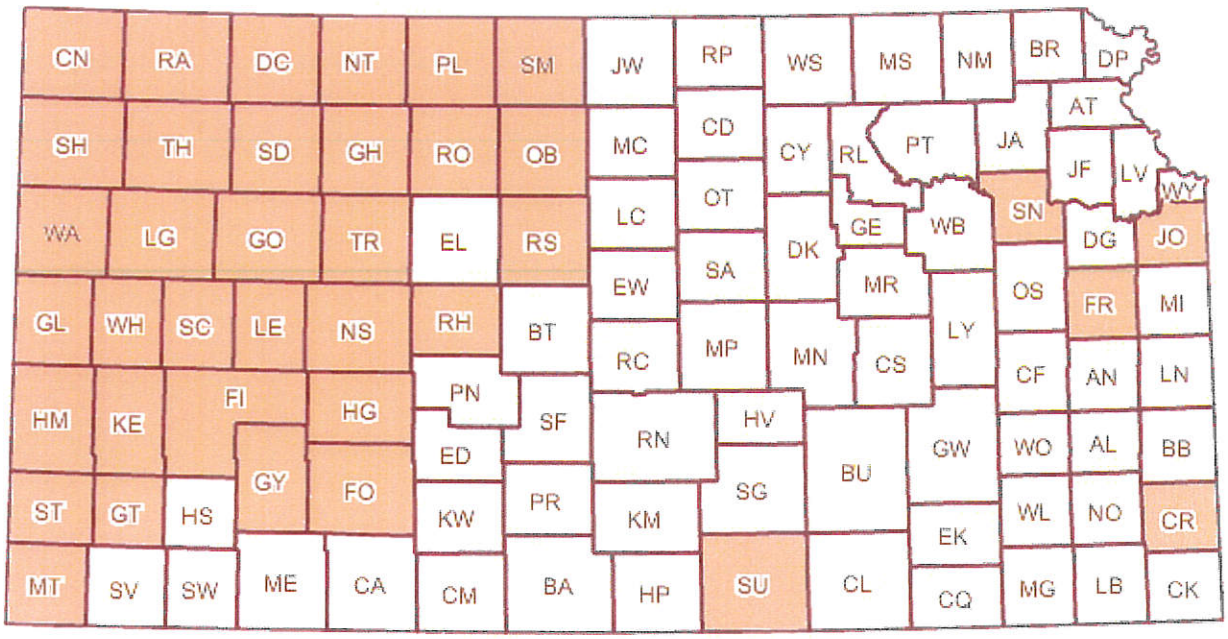
- Barber
- Chautaqua
- Comanche
- Crawford
- Elk
- Johnson
- Lyon
- Osage
- Sedgwick
- Stafford
- Sumner
- Wyandotte



THERAPEUTIC PRESCHOOL SERVICES

Available in the following counties:

- Cheyenne
- Crawford
- Decatur
- Finney
- Ford
- Franklin
- Gove
- Graham
- Grant
- Gray
- Greeley
- Hamilton
- Hodgeman
- Johnson
- Kearny
- Lane
- Logan
- Morton
- Ness
- Norton
- Osborne
- Phillips
- Rawlins
- Rooks
- Rush
- Russell
- Scott
- Shawnee
- Sheridan
- Sherman
- Smith
- Stanton
- Sumner
- Thomas
- Trego
- Wallace
- Wichita



5-78

CHILDREN'S INITIATIVE FUND
Briefing Binder
November 8, 2006

Section Five: Appendices

Children's Initiative Fund Framework

Priorities

"Benefit the overall well-being of children in Kansas"

- KCCTF Priorities
- Governor's Priorities
- Legislative Priorities

Information Gathering

May - November 2006

Reality

- Current programs
- Evaluation plans
- Funding levels

Program Assessments & Recommendations

Alignment with Priorities

Program Results

Evidence Based Practices

Quality Evaluation

Programmatic Suitability

Recommendations

Accountability

DRAFT 9/25/06

5-81

Evidence Based Practice Level Key

0	1	2	3	4
Evidence Unknown	**Emerging Practices & Programs**	**Promising Programs & Practices**	**Supported Programs & Practices**	**Well Supported Programs & Practices**
The program does not articulate a theory of change and/or has no evaluation process.	The program has a theory of change, writings that describe the components of the program, and has research evaluating the program (either in process or completed).	The program has a theory of change, writings that describe the components of the program, has at least one study utilizing a control or comparison group establishing the efficacy of the program, and the local program can demonstrate adherence to model fidelity.	The program has a theory of change, writings that describe the components of the program, has at least two randomized controlled trials establishing the efficacy of the program, the local program can demonstrate adherence to model fidelity, and the program has been shown to have a sustained effect at least one year beyond the end of treatment.	The program has a theory of change, writings that describe the components of the program, has at least two randomized controlled trials conducted in different usual care or practice settings establishing the efficacy of the program, the local program can demonstrate adherence to model fidelity, and the program has been shown to have a sustained effect at least one year beyond the end of treatment. The local program also has participated in research that helps to solidify program outcome findings.

Note: Although programs were not assigned a level this year, it is expected that most CIF programs would have been categorized as Level 1 or 2 this fiscal year.

Appendix C

Program:_____

CIF Evidence-Based Practice Checklist

	Question	Levels	COMMENTS	Criterion
		Level 0: Evidence Unknown		
☐	The program is NOT able to articulate a theory of change that specifies clearly identified outcomes and describes the activities that are related to those outcomes.	• Theory of change refers to the causal processes through which changes comes about as a result of a program's strategies and actions. • Outcomes are the results of program operations or activities; the effects triggered by the program (increased knowledge, changed attitudes or beliefs, or altered behavior). Check this box if the program provides NO reference to a theory of change that (1) specifies outcomes and (2) the activities that are related to those outcomes.		A check means program does not meet threshold for Level 1.
☐	The program has no evaluation process.	Check this box if the program provides NO reference to an evaluation process.		A check means program does not meet threshold for Level 1.

Appendix C

Program:_____

CIF Evidence-Based Practice Checklist

	Question	Levels	COMMENTS	Criterion
		Level 1: Emerging Practices & Programs		
		Practice/ Program Characteristics for Level 1: Practices & programs must meet all the criteria as indicated in the last column order to be categorized as a Level 1 Practice or Program. The Level 1 practice/ program criteria are necessary but not sufficient to meet additional EBP levels.		
☐	The program is based on a theory of change.	• Theory of change refers to the causal processes through which changes comes about as a result of a program's strategies and actions. Check this box if the program provides any reference to a theory of change.		Must have for Level 1 and above.
☐	The program or practice specifies clearly identified outcomes *and* describes the activities that are related to those outcomes.	• Outcomes are the results of program operations or activities; the effects triggered by the program (increased knowledge, changed attitudes or beliefs, or altered behavior). Check this box if the program provides any reference to outcomes and the activities that are related to those outcomes.		Must have for Level 1 and above.
☐	The program has a (1) book, manual, other available writings, or training materials that describe the components of the program and describes how to administer it OR (2) an action plan AND implementation standards.	Check this box if the program is based on a book, manual, or other materials that describe the components of the program and describes how to administer it OR in the case of an overall agency as grantor, the RFP or other materials must have an action plan AND implementation standards. These materials have to be sufficient such that others could implement and replicate the program. Indicate below which materials the program provides: 1. ☐ Manual or other writings describing components of the program & how to administer (sufficient for overall check for this category) **OR** 2. ☐ Action Plan AND ☐ Implementation Standards (must have BOTH Action Plan & Implementation Standards to get an overall check for this category)		Must have for Level 1 and above.
☐	The program provides anecdotal reports suggesting the value of the program or practice.			
☐	The program or practice creators are committed and actively working on building stronger evidence through ongoing evaluation and continuous quality improvement activities.			
		Research Characteristics for Level 1 (these will vary according to Level)		

Appendix C

Program:_____

CIF Evidence-Based Practice Checklist

☐	a) The program has an evaluation in process, but the results are not yet available.			MUST have *either* (a) or (b) to meet criteria for Level 1 only.
☐	b) The program has research evaluating the program.	Check this box if programs and practices have been evaluated using **less rigorous** evaluation designs that have **no comparison group**, including "pre-post" designs that examine change in individuals from before the program or practice was implemented or afterward, without comparison to an untreated group.		MUST have *either* (a) or (b) to meet criteria for Level 1 only.
Level 2: Promising Programs & Practices (meets above criteria & the following criteria)				
Practice/ Program Characteristic for Level 2 (must meet Level 1 Practice/ Program Criteria as well as the following criterion to be categorized as Level 2).				
☐	The *local* program can demonstrate adherence to model fidelity in program or practice implementation.	Fidelity refers to the extent to which an intervention is implemented as intended by the designers of the intervention. Check this box if the program provides a demonstration of model fidelity.		MUST have to meet criteria for Level 2 and above.
Research Characteristics for Level 2				
☐	The program has at least **one study utilizing some form of control or comparison group** that has established the practice's efficacy over placebo, or found it comparable to a comparison practice.	Check this box if the research evaluating the program has established the practice's efficacy over placebo or found it comparable to a comparison practice AND a formal, independent report has been produced that documents the program's positive outcomes.		MUST have to meet criteria for Level 2 only.
Level 3: Supported Programs & Practices				
Practice/ Program Characteristics for Level 3 (must meet Level 1 & 2 Practice/ Program Criteria as well as the following criteria to be categorized as Level 3).				
☐	The program or practice has been shown to have a sustained effect at least one year beyond the end of treatment.			MUST have to meet criteria for Level 3 and above.
☐	The outcome measures used are reliable and valid measures.			MUST have to meet criteria for Level 3 and above.

Appendix C

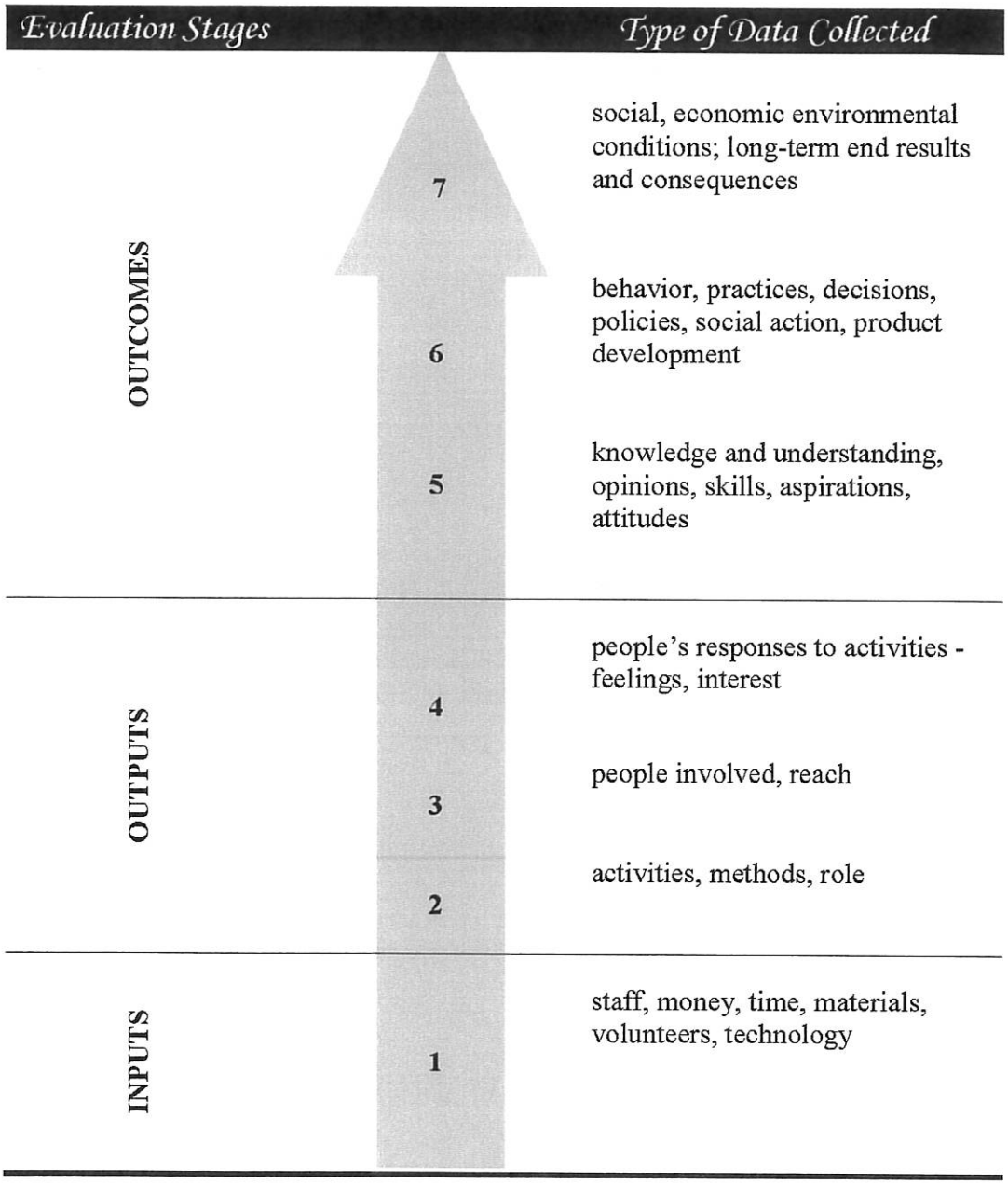
Program:_____

CIF Evidence-Based Practice Checklist

Research Characteristics for Level 3				
☐	The program or practice has been evaluated with **at least two randomized, controlled trials (RCTs) or two between-group designs** that have found the practice or program to result in improved outcomes compared to usual care.	Check this box if the program has been evaluated with: a) at least two RCTs in highly controlled settings (e.g., university laboratory) have found the practice to be superior to an appropriate comparison practice. The RCTs have been reported in published, peer-reviewed literature **OR** b) at least two between- group design studies using either a matched comparison or regression discontinuity have found the practice to be equivalent to another practice that would qualify as supported.		MUST have to meet criteria for Level 3 and above.
Level 4: Well Supported Programs & Practices				
Research Characteristics for Level 4				
☐	The RCTs or comparable methodologies have been **conducted in different usual care or practice settings** and have found the practice to be superior to an appropriate comparison practice or program.			MUST have to meet criteria for Level 4.
Local Program Research Characteristics				
☐	The *local* program has examined long-term outcomes and/ or participated in research that would help solidify program outcome findings.			
☐	The *local* program has conducted ongoing evaluation and continuous quality improvement activities.			

Note: This checklist is based upon the CBCAP PART Efficiency Measure and the California Evidence-Based Clearinghouse for Child Welfare.

Data Collection Stages Key



Source: Adapted from Bennett & Rockwell, 1995.

DRAFT 10/20/06

Appendix E

Program Name_____

CIF QUALITY EVALUATION CHECKLIST
RATING FORM

	FACTOR	DESCRIPTION	COMMENTS
☐	A1. Resources are identified.	Resources are the ***investments*** in the program, such as • Staff • Time • Money • Equipment and supplies • Facilities • Volunteers Check this box if the program provides references to *any* of the resources listed above. Resource information only needs to be provided for CIF funding.	
☐	A2. *Needs* of target population are described.	Needs are measurable discrepancies (gaps) between the current (what is) state of affairs of a specific group or organization and the desired (what should be) state in regard to the variables of interest. Needs can be defined as: • Basic needs – needs related to sustaining life such as food, clothing, shelter • Expressed Needs – the things we consciously recognize we want, above and beyond basic needs • Normative – needs that relate to a standard or norm • Comparative – needs identified when we compare our situation to others Evidence of need is generally provided with quantitative data (statistics), but qualitative data (anecdotes, community interviews, etc.) are also accepted. Examples of needs statements are provided below: • 20% of adults in City X are homeless • County Y has an obesity rate of 75% as compared to the national rate of 50%. Check this box if 1) a needs statement(s) is provided (with source information) and 2) the "needy" population is defined.	
☐	A3. Services/activities are identified.	Services are the activities conducted by the program to achieve its goals. Services constitute all of the program's "action steps." Examples of services include: • Conduct workshops, meetings • Deliver services • Develop products, resources • Train • Provide counseling • Assess • Work with media • Develop partnerships Check this box if the program provides a basic description of its services. Service information only needs to be provided for CIF funding.	

Appendix E

CIF QUALITY EVALUATION CHECKLIST
RATING FORM

	FACTOR	DESCRIPTION	COMMENTS
☐	A4. The context within which the program operates is analyzed.	Context is the site, location, environment, or milieu for a given program. Context includes: • Descriptive and demographic characteristics of setting (numbers, characteristics, diversity of people) • Material and economic features of setting (buildings, resources such as books, along with other indicators of material wealth or scarcity) • Institutional and organizational climate in a setting (organizational norms, decision-making structures, interpersonal features, climate structures) • Political dynamics (contested issues and interests in terms of power, influence, and privilege) • History and origin of program (how it started) Check this box if the program provides a basic explanation of the context within which it operates.	
☐	A5. Collaboration with other ongoing efforts is described.	Collaboration refers to coordinated efforts to communicate and/or share resources with other programs. Programs should monitor and record these linkages, including: • Shared resources (staff, materials, money, time, etc.) • Common goals • Efforts to build/enhance relationships • Efforts to reduce duplication of services Check this box if the program provides documentation of ongoing efforts in their field/setting.	
☐	A6. The program goals indicate the intended effect of the program on the need and population.	Program goals are broad statements describing the long-term results that the organization hopes to achieve. Goal statements identify the improved condition or altered status that will result from changes in behavior over a period of time. The goals statement and needs statement should be aligned; the needs of the population, as outlined in the needs statement, should be addressed by the program goals. Examples of goal statements include: • Need: Students in grades 1-3 in City X are performing below the national average in reading. • Goal: Reduce academic failure through enhanced reading instruction for children in grades 1-3 Check this box if program goals are tied to needs of target population.	
☐	A7. Program theory is provided.	Program theory is a description of the critical elements of the program focusing on what the program is intending to achieve and how it is intended to do so. Program theory provides a *model* for why the program elements should bring about the desired change. Program theory may make use of research findings and/or program planner's perceptions. Program theory can be presented in the form of a logic model, a series of "if-then" statements, a path model, or narrative describing the anticipated sequence of events and outcomes. Check this box if program theory is provided.	
☐	A8. The intended outcomes are truly outcomes rather than services or outputs.	Outputs refer to the services and the recipients of these services. Outcomes refer to the impact of those services. Outcomes tap into changes of 1) skills/knowledge, 2) attitude/opinion, 3) behavior, and/or 4) circumstance. Check this box if the outcomes reflect true outcomes (intended effects not number of participants or services).	

Appendix E

CIF QUALITY EVALUATION CHECKLIST
RATING FORM

	FACTOR	DESCRIPTION	COMMENTS
☐	B1. The use(s) of the evaluation are defined.	Evaluations can be used for various purposes: 1) convey information about the program: build awareness and support, 2) demonstrate results, accountability, and/or 3) improve the program. Check this box of the program articulates the use(s) of the evaluation.	
☐	B2. Evaluation questions/topics are provided.	Evaluation questions/topics specify exactly what the evaluation will answer and guide the design and planning of the evaluation. Examples of evaluation questions include: • Are preschool teachers exhibiting gains in literacy knowledge as a consequence of their participation in training activities? • Are students satisfied with the after school program? Check this box if program provides a list of explicit evaluation questions or topics.	
☐	B3. A written protocol that summarizes the evaluation procedure is presented.	A written protocol provides a timeline of activities and identifies the person(s) responsible for completing the work. Check this box if a written protocol is provided.	
☐	B4. A description of the methods for sampling, data collection, and data analysis is provided.	Sampling refers to the process of selecting participants for study that will be representative of the target population. There are three basic types of sampling plans: • Random • Purposive (Evaluator selects participants) • Convenience (Evaluator takes participants who are easy to access) Data collection refers to the process of securing data. A data collection plan should outline methods for protecting rights of human subjects. It should also articulate the primary data sources. Common data sources include: surveys, focus groups and interviews, observations, tests, and archival data. Data analysis refers to the methods for examining the data. Methods generally fall into two categories, although mixed-method approaches are also common. • Qualitative (content analysis, key incident approach, etc.) • Quantitative (descriptive statistics, inferential statistics, etc.) Check this box if the program provides a description of the sampling plan, data collection plan, and data analysis approach.	
☐	B5. Procedures to safeguard the confidentiality of information and information sources are described.	Evaluation should be designed and conducted to respect and protect the rights and welfare of human subjects. The program should document the steps taken as part of the evaluation to 1) ensure that participants are not threatened or harmed, 2) secure consent/assent from participants, and 3) protect the confidentiality of clients. Check this box if the program provides evidence that the rights of human subjects are protected.	

Appendix E

CIF QUALITY EVALUATION CHECKLIST
RATING FORM

	FACTOR	DESCRIPTION	COMMENTS
☐	C1. The number of participants are identified for each service.	The *number* of participants refers to the number of individuals who received services as part of the program. This number should be provided for each service/activity. Check this box if the number of participants is identified for each service activity (funded with CIF dollars)	
☐	C2. The number of events/processes are listed.	The *number* of events/processes refers to the products, goods, and services provided to the program's participants. Examples of processes include: • Number of classes taught • Number of counseling sessions • Number of educational materials distributed • Number of hours of service delivered Check this box if the number of processes, funded with CIF dollars, is identified. Programs should provide time frames for each event/process listed.	
☐	C3. Frequency and intensity of services are identified.	Frequency of services refers to the frequency with which participants receive program services. Common measures of frequency include sessions/week, hours/day, or times/year. Intensity of services refers to the quality or concentration of the services. Low intensity services are services necessary for the program to run but not necessarily focused on achieving program goals. At the beginning of a program, for example, staff may be focused on getting to know the clients rather than achieving specific program goals. High intensity services, on the other hand, describe services that are highly focused on achieving program outcomes. Check this box if the program provides information about the frequency and intensity of services.	
☐	C4. Dropouts are addressed.	Dropouts are program participants who choose to discontinue services. The number of dropouts should be documented. Programs should also provide a general explanation for the discontinuation of services (moved away, unhappy with services, services no longer necessary, etc.) Check this box if dropouts are addressed.	
☐	C5. The indicators are stated in specific and measurable terms.	Indicators are measures that are used to gauge program performance. They are measures that help quantify the achievement of an output or an outcome. Measurable indicators must have a *quantifiable* component. Percent increase/decrease (e.g. 15% increase), target rate (100% attendance) or target number (ACT composite score of 20) are common formats for indicators. Specificity is also important. Indicators should reference data source (e.g., DIBELS test, CTC, etc.) and population for whom the indicator applies (e.g. 8th graders). Check this box if the indicators are measurable and specific.	

CIF QUALITY EVALUATION CHECKLIST
RATING FORM

	FACTOR	DESCRIPTION	COMMENTS
☐	C6. The indicators are valid measures of the outcomes	A valid measure is one that measures what it supposed to. Examples of valid and invalid measures are provided below: • **Outcome**: Improved preschool reading achievement • **Valid measure**: Preschool DIBELS two-minute test • **Invalid measure**: Preschool DIBELS two-minute test given in a one-minute block of time (Measures speed rather than literacy skill) Check this box if the program provides evidence that the indicators are valid indicators of the outcomes.	
☐	C7. Attributes of information sources and the rationale for their selection are provided	Attributes of information sources that might be discussed include: • Psychometric properties of instruments (validity, reliability) • Perception by others in the field (e.g., if it is endorsed by experts) • Ease of data collection Check this box if attributes of information sources are described.	
☐	C8. Fidelity of implementation is monitored.	Fidelity of implementation refers to how well the services match those that were planned. Programs that are using an established curriculum, program model, or evidenced-based practice (e.g., PROJECT ALERT) should document the implementation of the practice and any discrepancies from the prescribed delivery/use. Check this box if fidelity of implementation is monitored.	

Appendix E

CIF QUALITY EVALUATION CHECKLIST
RATING FORM

	FACTOR	DESCRIPTION	COMMENTS
☐	D1. Appropriate methods of data analysis and synthesis are utilized.	Methods of data analysis and synthesis are appropriate if they are 1) selected because they address the evaluation questions and 2) can be used responsibly given the constraints of the data. In many cases, descriptive statistics will be used. Programs should report summary statistics in a clear and transparent way. Problems with missing or corrupted data should be addressed. In the cases where programs use inferential statistics, evidence of an adequate sample size should be provided. If random sampling is not used and group comparisons are conducted, program should provide evidence of equivalence between groups prior to treatment. Check this box if appropriate methods of data analysis and synthesis are utilized.	
☐	D2. Conclusions are consistent with data.	Conclusions are specific statements, providing information about the program's impact. Solid conclusions reference data sources, highlighting the key findings from the data analysis. Both negative and positive findings should be reported in the conclusion section. The conclusion section should also include any limitations of the data they might warrant caution in interpretation. Check this box if conclusions are consistent with data.	
☐	D3. Recommendations logically follow conclusions.	Recommendations are actions for consideration resulting from an evaluation. Forming recommendations is a distinct element of program evaluation that requires information beyond what is necessary to form judgments regarding program performance. Making recommendations requires information regarding the context, particularly the organizational context, in which programmatic decisions are made. Check this box if recommendations follow conclusions.	

Appendix E

CIF QUALITY EVALUATION CHECKLIST
RATING FORM

	FACTOR	DESCRIPTION	COMMENTS
☐	E1. Persons involved in or affected by the evaluation are identified.	Stakeholders can include policymakers, program administrators or managers, practitioners, primary consumers (students, clients, patients) and secondary consumers (citizens or community groups). The program should identify the program's key stakeholders and document their input in the evaluation process. Check this box if the program provides documentation of stakeholders and their role in the evaluation.	
☐	E2. Continuous feedback to stakeholders is provided.	Regular feedback should be disseminated to stakeholders and program staff so that problems can be detected and adjustments made in a timely fashion. Feedback can be provided in a variety of ways, including interim reports, briefings, and/or through formal/informal presentations. Check this box if continuous feedback is provided to stakeholders.	
☐	E3. An annual report is provided to stakeholders.	An annual report provides information about the program's progress toward its intended goal(s). The performance report documents the outputs and, if applicable, intended outcomes of the program. Check this box if an annual report is provided to stakeholders.	
☐	E4. The procedures used and the lessons learned from the evaluation are shared with stakeholders.	Evaluation reports should clearly describe the purpose and procedures of the evaluation so that the focus of the evaluation and its limitations are clearly understood. The program should also identify lessons learned from the evaluation, such as • Effective reporting strategies • Efficient ways to interview clients • Obstacles to stakeholder involvement Check this box if the procedures used and lessons learned from the evaluation are provided.	

Tobacco Free Kansas Coalition, Inc.

Testimony before the
Kansas Senate Committee on Ways and Means
January 29, 2007
by
Mary Jayne Hellebust
Executive Director
Tobacco Free Kansas Coalition

Mr. Chairman. Members of the Committee. Thank you inviting us to speak to you about the health benefits and savings that will come from adopting of a comprehensive statewide tobacco prevention program.

The Tobacco Free Kansas Coalition is an organization with members from more than 80 health associations, state and local health agencies, and local coalitions. Since 1992, TFKC's primary focus has been to help reduce the economic and health damages caused by tobacco use, especially for our children.

Tobacco Prevention Programs Will Work
When Funded Adequately

We strongly support investing on an annual basis the expected increase of $16 million in Master Settlement Agreement (MSA) payments to fund proven comprehensive tobacco use prevention programs. Tobacco use, the leading cause of preventable death and disease, costs Kansas an enormous toll in lives and in health care dollars.

Tobacco use constitutes a public health crisis that cuts across all areas of chronic diseases suffered by Kansans. Preventing widespread tobacco use has a major and positive impact on nearly all primary sources of death and disease, including cancer, cardiovascular disease, lung disease, diabetes, pediatric illnesses, women's health and surgical complications. Research has established that there is a $3 savings for every $1 invested in tobacco prevention.

Allocating small increases to a tobacco prevention program or splintering these new MSA funds over a variety of areas, even health areas, will not achieve a public health impact as significant as

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Sen. Ways & Means
1-29-07
Attachment 6

drastically reducing adult and youth smoking rates. In addition, the annual allocation of this expected bonus increase in MSA payments to tobacco prevention will not adversely affect existing Children's Cabinet funding for other essential children's programs.

Costs of Treating Tobacco Illnesses

Treating the illnesses caused by tobacco use annually costs the state $927 million in direct health care, of which $196 million is for treating Medicare patients. Tobacco continues to kill 3,900 people every year in Kansas. A $16 million annual investment in tobacco prevention from the 2008 MSA payment increase is relatively tiny when compared to the escalating costs caused by tobacco use in the state.

The U.S. Centers of Disease Control (CDC) research predicts Kansas could cut smoking rates in half in five years by investing $18 million in CDC's "Best Practices for Tobacco Prevention." This is the minimum amount recommended by the CDC. Currently Kansas is 41st in the ranking of states providing such programs. The current Kansas funding level of $2 million ($1 million from current MSA funds and approximately $1 million from CDC grants) merely nibbles around the edge of the tobacco-use health crisis. If trends continue, 54,000 of our children under 18 today will die prematurely because of tobacco addiction.

Tobacco Prevention Must Start in Childhood

First and foremost, tobacco use is a pediatric disease. It begins in childhood and kills one out of two long-term smokers.

The stated purpose of the Attorneys General suit against the tobacco companies was not only to stop the drain on states' budgets for smoking-related treatment for Medicaid patients, but also to help smokers quit and children to never start. Currently only 45 of Kansas counties receive limited funding for tobacco prevention aimed at helping children grow up tobacco free.

Some Successes in Kansas

The cigarette tax increase combined with minimal funding levels for tobacco control has allowed state and local agencies and tobacco control partners to achieve some success in Kansas.

- 17.8% smoking prevalence levels for Kansas adults in 2005. That is down from 22.1% in 2002.
- Establishment of a Kansas Quitline for phone counseling for tobacco users, with many Kansans calling in for cessation help.
- 17 cities and one county with new smokefree policies since 2002
- More school districts and hospitals adopting policies for tobacco free campuses.

- Kansas Department of Health and Environment's development of a statewide infrastructure to provide 45 counties limited funding for some tobacco prevention programs.
- TASK youth groups for tobacco prevention continuing in many Kansas communities.
- Saline County, the first to be funded for tobacco prevention programs, was also the first to adopt a significant smokefree ordinance in Kansas. Saline County now has tobacco-free school grounds for all its schools, has maintained one of the highest consistent compliance rates for the youth access law, shows strategic attitude changes in youth tobacco surveys, and in Communities that Care data has achieved one of the lowest rates for youth smoking.

Inadequate Tobacco Control Funding

However, Kansas still faces complications related to its failure to provide a concentrated funding stream to reduce tobacco use, particularly by our teens.

- 21% high school smoking prevalence rate remains unchanged since 2002.
- 17.4% of high school boys in Kansas report using smokeless tobacco, an increase from the 14.5% rate several years back. This rate is one of the highest in the nation.
- Many smokers are still unaware of the availability of the toll-free Kansas Quitline for cessation assistance.
- The 38% rate in 2005 for retail sales of tobacco to minors forced Kansas to commit $2.3 million in penalty funding for enforcement and retailer education to bring the state into at least 20% compliance. The alternative was the potential loss of almost $5 million in mental health and substance abuse treatment funds.
- 60 counties in Kansas receive no specific tobacco prevention assistance.

Components and Funding Levels for a Comprehensive Statewide Tobacco Prevention Program

Funding decisions could follow CDC Best Practices guidelines for programs, based on an $18 million dollar budget that would include $16 million in new MSA funds, $1 million from existing MSA funding through the Children's Cabinet, and approximately $1 million in KDHE funding from CDC. State funds could be deposited in KDHE's already existing Tobacco Prevention Fund. As per CDC studies, a fully-funded program implementing all recommended program components can cut a state's tobacco-use prevalence rates in half over a five-year time span.

Community Programs: $12.5 million

KDHE's existing infrastructure and grant process could quickly get the majority of prevention funding to individual community agencies to foster individual and community behavioral changes regarding tobacco use. Community agencies would be responsible for establishing a coordinated grouping of programs, including school-based educational programs; youth empowerment programs; programs that lead to local policy changes related to tobacco-free school campuses and public places and retailer education and enforcement of youth access to tobacco restrictions; prevention and cessation assistance for special populations, such as, pregnant women, minority populations, young adults, blue collar workers, etc.; and educational programs to reduce children's exposure to secondhand smoke in the home. Some technical assistance and evaluation programs would be included in this area.

Cessation Assistance: $2.5 million

The Kansas Quitline would be expanded to reach the almost 50% of Kansas smokers who have tried to quit smoking at least once in the past year but have been unable to do so. This effort would include providing some nicotine replacement therapy and/or pharmaceuticals known to making quitting efforts more successful.

Statewide Counter-Media Campaign: $3 million

Statewide multi-media campaign support would compliment both community and cessation programs through a variety of ads and other communication strategies to promote youth awareness of tobacco marketing ploys, the availability of the Kansas Quitline and cessation assistance, reduction of easy access to retail tobacco products, and tailored marketing to meet the needs of specific populations most adversely affected by tobacco use.

Conclusion

Kansas will soon have a unique opportunity to provide workable and proven programs to reduce health care costs for all Kansans and for the state as a whole, as well as save lives. Committing the $16 million increase in MSA payments will put Kansas at the CDC-recommended funding level and allow the state to fulfill the promise set out in the MSA that Kansas will not tolerate the continued pediatric addiction of its children by tobacco, a legal but absolutely deadly product. It is time for Kansas to prevent tobacco use, save lives and save health costs.

Thank you for your consideration of this very important issue.

Supplementary Materials

Endorsing Organizations in Support of Funding
for Comprehensive Tobacco Prevention for Kansas
As of January 26, 2007

American Cancer Society
American Lung Association
American Heart Association
Tobacco Free Kansas Coalition
Kansas Academy of Family Physicians
Kansas State Nurses' Association
Kansas Medical Society
Kansas Comprehensive Cancer Partnership
Kansas Synar Advisory Group
Prevention and Recovery Group, RPC, Topeka
Regional Prevention Center Association of Kansas

American Cancer Society®

American Heart Association® | American Stroke Association®
Learn and Live.

AMERICAN LUNG ASSOCIATION®
serving Kansas, Missouri, Nebraska, Oklahoma and Texas
CURES | CLEAN AIR | SMOKEFREE KIDS
Improving Life, One Breath at a Time

Kansas Organizations Support Increase in State Funding For Statewide Comprehensive Tobacco Prevention and Control

Whereas, tobacco use is the leading cause of preventable death in Kansas, claiming 3,900 lives and costing the state $927 million in health care bills each year (including $196 million of Kansas's annual Medicaid expenditures); and

Whereas, when adequately funded, comprehensive state tobacco prevention programs are proven to quickly and substantially reduce tobacco use, save lives, and cut smoking-caused costs; and

Whereas, if current trends continue, 54,000 youth under age 18 could die prematurely from cigarette smoking; and

Whereas, protecting the health of children and families against tobacco-caused addiction and disease is an attainable and worthwhile goal, wherein Kansas can achieve significant reductions in reduce adult and children's smoking rates as outlined in Healthy Kansans 2010, and

Whereas, Kansas currently dedicates to tobacco prevention and cessation less than 1% of the more than $170 million in tobacco-generated revenue collected annually from tobacco settlement payments and tobacco taxes; and

Whereas, tobacco prevention and cessation is an integral component of the Kansas Comprehensive Cancer Control Plan and essential for reducing heart, circulatory, lung and other diseases;

Whereas, in 2008 Kansas will receive a planned increase that will boost annual tobacco settlement revenues in Kansas by approximately $16 million in new funds from tobacco companies; and

Whereas, 2008 provides Kansas with a rare opportunity to fund proven tobacco prevention and cessation programs near the level recommended by the U.S. Centers for Disease Control and Prevention, and

Whereas, this $16 million increase in tobacco settlement payments can be appropriately dedicated to tobacco prevention and cessation without compromising those children's health and prevention initiatives that currently receive this Master Settlement Agreement (MSA) funding, therefore be it resolved that

We, the following named organizations, do urge the Kansas Legislature to assign an urgent priority to combating tobacco use, by dedicating the $16 million in new MSA funds to proven programs that prevent kids from smoking and help smokers quit. We support the ongoing and future use of this new increase of MSA payments solely for the purpose of increasing state efforts to reduce the enormous burden of tobacco disease in Kansas.

SAVING LIVES & SAVING MONEY: KANSAS HAS A SECOND CHANCE TO DO BOTH!

UPCOMING TOBACCO SETTLEMENT BONUS PAYMENTS WILL PROVIDE KANSAS WITH BRAND NEW FUNDING TO PREVENT AND REDUCE SMOKING AND ITS HARMS

The 1998 multi-state tobacco settlement – the Master Settlement Agreement (MSA) - provided for massive annual payments to the states from the major cigarette companies to settle the states' lawsuits against them, reimburse the states for smoking-caused costs, and provide funds the states promised to use to prevent and reduce tobacco use, especially among youth.[1] Unfortunately, most states (Kansas included) have failed to allocate an adequate amount of their tobacco settlement payments for tobacco prevention. But now they have a second chance. Starting in 2008, each of the MSA states, including Kansas, will receive bonus payments that will boost their annual tobacco settlement revenues and provide brand new funds that can be used to fund tobacco prevention programs, which reduce smoking, save lives and cut costs.[2]

- *Minimum amount CDC recommends Kansas spend annually on tobacco prevention: $18.1 million*
- *Annual amount Kansas now spends on tobacco prevention: $1.0 million [Nationwide rank: 43rd]*
- *Tobacco settlement annual bonus payments to Kansas starting in 2008: $16.2 million*

Tobacco use is still a BIG problem for Kansas and its businesses and residents. Tobacco use not only takes a devastating toll in health an lives in Kansas, it also increases public and private sector costs, burden's household budgets, takes scarce funds away from more productive uses, reduces worker productivity, and weakens the State's economy.

- *Adults in the State who smoke: 17.8% High school kids who smoke: 21%*
- *Kansas kids (under 18) who become new regular, daily smokers each year: 3,400*
- *Deaths in Kansas each year because of smoking: 3,900*
- *Kansas Kids alive today who will ultimately die from smoking (at current smoking levels): 54,000*
- *Cigarette company marketing in Kansas each year: $125.9 million*
- *Annual health care costs and productivity losses in the State directly caused by tobacco use: $1.79 billion*
- *State Medicaid program expenditures caused by smoking each year: $196.0 million*
- *Smoking-caused federal-state tax burden per Kansas household each year: $582*

Kansas would benefit tremendously from allocating its MSA bonus payments to tobacco prevention. Investing just the minimum amount recommended by the Centers for Disease Control and Prevention (CDC) to run a comprehensive state program to prevent and reduce tobacco use should cut state smoking rates, on average, by about one percentage point per year over just the first five years.[3] The related cost savings would start small but grow rapidly, soon exceeding the state's tobacco prevention expenditures.

Benefits to Kansas From Each One Percentage Point Reduction in State Smoking Rates

- *Fewer current adult smokers: 20,700 Fewer current high school smokers: 1,600*
- *Fewer kids alive today who will become addicted adult smokers: 6,700*
- *Fewer future deaths from smoking: 2,100*
- *Fewer smoking-affected births over the next five years: 1,980*
- *Savings from smoking-affected birth reductions over the next five years: $3.4 million*
- *Savings from heart attack & stroke reductions over the next five years: $8.1 million*
- *Overall reduction to future health costs from adult smoking decline: $196.7 million*
- *Overall reduction to future health costs from youth smoking decline: $117.3 million*

Campaign for Tobacco-Free Kids, January 4, 2007/Meg Gallogly

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[1] See, e.g., Campaign for Tobacco-Free Kids (CFTFK) factsheet, *MSA Calls for States to Invest Tobacco Settlement Funds to Prevent and Reduce Tobacco Use*, http://tobaccofreekids.org/research/factsheets/pdf/0203.pdf.

[2] For more detail, see CFTFK factsheet, *Coming Increases to State MSA Payments in April 2008 - New Funding for Tobacco Prevention,* http://tobaccofreekids.org/research/factsheets/pdf/0286.pdf.

[3] For more detail, see CFTFK factsheet, *Comprehensive State Tobacco-Control Programs Save Money,* http://tobaccofreekids.org/research/factsheets/pdf/0168.pdf.

Additional Sources

CDC recommended tobacco prevention spending levels for Kansas. U.S. Centers for Disease Control & Prevention (CDC), Office on Smoking and Health, *Best Practices for Comprehensive Tobacco Control Programs* (August 1999). See, also, American Legacy Foundation, *Saving Lives, Saving Money: Why States Should Invest in a Tobacco-Free Future*, March 2002, http://www.americanlegacy.org.

Current Kansas spending to reduce tobacco use and ranking. Above data is for fiscal year 2006. See Campaign for Tobacco-Free Kids, et al., *A Broken Promise To Our Children: The 1998 State Tobacco Settlement Seven Years Later* (November 30, 2005), http://tobaccofreekids.org/reports/settlements.

Adult and youth smoking in Kansas. Adult: 2005 *Behavioral Risk Factor Surveillance System* (BRFSS), http://apps.nccd.cdc.gov/brfss/list.asp?cat=TU&yr=2005&qkey=4396&state=UB;Youth: CDC, Youth Tobacco Surveillance (YTS) Survey and Youth Risk Behavioral Surveillance (YRBS) survey, and state-specific surveys.

New youth smokers each year in Kansas. Estimate based on data from the U.S. Dept of Health & Human Services *2005 Nat'l Survey on Drug Use and Health,* http://www.oas.samhsa.gov/nsduh/2k5nsduh/tabs/2k5tabs.pdf, with the state share of the national number allocated through the formula in U.S. Centers for Disease Control & Prevention (CDC), "Projected Smoking-Related Deaths Among Youth -- United States," *Morbidity & Mortality Weekly Report (MMWR)* 45(44): 971-74 (November 8, 1996), [based on state young adult smoking rates, as updated in CDC, *Sustaining State Programs for Tobacco Control, Data Highlights, 2006*].

Kansas smoking deaths. CDC's STATE System, http://apps.nccd.cdc.gov/StateSystem/systemIndex.aspx. (avg annual deaths 1997-2001); *Sustaining State Programs for Tobacco Control, Data Highlights, 2006;* CDC, "Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Economic Costs -- United States 1995-1999," *MMWR*, April 11, 2002; Nat'l Cancer Inst, *Health Effects of Exposure to Environmental Tobacco Smoke: The Report of the California Environmental Protection Agency*, Smoking & Tob. Control Monograph no. 10, 1999, http://cancercontrol.cancer.gov/tcrb/monographs/10. See, also, California EPA, *Proposed Identification of Environmental Tobacco Smoke as a Toxic Air Contaminant*, http://www.arb.ca.gov/toxics/ets/finalreport/finalreport.htm, June 24, 2005.

Kansas youth who will become adult smokers and die prematurely from it (given current trends). CDC, *Sustaining State Programs for Tobacco Control, Data Highlights, 2006.* CDC, "Projected Smoking-Related Deaths Among Youth -- United States," *MMWR* 45(44): 971-974, www.cdc.gov/mmwr/mmwr_wk.html, November 11, 1996.

Tobacco company marketing in Kansas. U.S. Federal Trade Commission (FTC), *Cigarette Report for 2003,* 2005 [data for top 6 manufacturers only], http://www.ftc.gov/reports/cigarette05/050809cigrpt.pdf; FTC, *Federal Trade Commission Smokeless Tobacco Report, August 2003* http://www.ftc.gov/os/2003/08/2k2k1smokeless.pdf (top 5 manufacturers). State total a prorated estimate based on cigarette pack sales in the state.

Health and productivity costs in Kansas caused by tobacco use. CDC, *Data Highlights 2006* [and underlying CDC data/estimates]. CDC's *Data Highlights 2006* provides cost estimates that have been adjusted for inflation and put in 2004 dollars. To make the other cost data similarly current and more comparable, they have also been adjusted for inflation and put in 2004 dollars, using the same CDC methodology.

Cost savings to Kansas from investing in tobacco prevention. The listed overall reductions in future health costs occur during the lifetimes of the adults or youth who quit smoking or never start. Miller, P, et al., "Birth and First-Year Costs for Mothers and Infants Attributable to Maternal Smoking," *Nicotine & Tobacco Research* 3(1): 25-35, February 2001 [avg. cost per smoking-affected birth: $1,142]. Lightwood, J.M., et al., "Short-Term Health and Economic Benefits of Smoking Cessation: Low Birth Weight," *Pediatrics* 104(6): 1312-1320, December 1999; Lightwood, J. & S. Glantz, "Short-Term Economic and Health Benefits of Smoking Cessation -- Myocardial Infarction and Stroke," *Circulation* 96(4): 1089-1096, August 19, 1997. Hodgson, T., "Cigarette Smoking and Lifetime Medical Expenditures," *Millbank Quarterly* 70(1), 1992 [average smoker's lifetime health costs $16,000 more than nonsmoker's despite earlier death]. CFTFK factsheet, *Lifetime Healthcare Costs: Smokers v. Non-Smokers*, http://tobaccofreekids.org/research/factsheets/pdf/0277.pdf. See, also, Warner, K.E., et al., "Medical Costs of Smoking in the United States: Estimates, Their Validity, and Their Implications," *Tobacco Control* 8(3): 290-300, Autumn 1999. CFTFK factsheet, *Rough Formula for Estimating Future State Tobacco-Control Savings*, http://tobaccofreekids.org/research/factsheets/pdf/0119.pdf.

For more information on the many benefits to Kansas from increasing its efforts to prevent and reduce tobacco use, please contact the Campaign for Tobacco-Free Kids.

COMPREHENSIVE TOBACCO PREVENTION AND CESSATION PROGRAMS EFFECTIVELY REDUCE TOBACCO USE

Tobacco control programs play a crucial role in the prevention of many chronic conditions such as cancer, heart disease, and respiratory illness. Comprehensive tobacco prevention and cessation programs prevent kids from starting to smoking, help adult smokers quit, educate the public, the media and policymakers about policies that reduce tobacco use, address disparities, and serve as a counter to the ever-present tobacco industry.

Recommendations for state tobacco prevention and cessation programs are best summarized in the Center for Disease Control and Prevention's, Best Practices for Comprehensive Tobacco Control Programs. In this guidance document, CDC recommends that states establish tobacco control programs that are comprehensive, sustainable, and accountable and include the following programmatic elements: public education efforts, community and school based programs, cessation programs, enforcement efforts, and monitoring and evaluation.[1]

The empirical evidence regarding the effectiveness of comprehensive tobacco prevention and cessation programs is vast and growing. Data from numerous states that have implemented programs consistent with CDC guidelines show significant reductions in youth and adult smoking. The most powerful evidence, however, comes from national studies that look across states and control for as many of the relevant confounding factors as possible. These rigorous studies consistently show effects of tobacco prevention and cessation programs.

A 2005 study published in the *American Journal of Public Health* provides powerful evidence of the effectiveness of comprehensive tobacco prevention and cessation programs. The study concluded that if every state had spent the minimum amount recommended by the CDC for tobacco prevention, youth smoking rates nationally would have been between three and fourteen percent lower during the study period, from 1991 to 2000. Further, if every state funded tobacco prevention at CDC minimum levels, states would prevent nearly two million kids alive today from becoming smokers, save more than 600,000 of them from premature, smoking-caused deaths, and save $23.4 billion in long-term, smoking-related health care costs.[2]

A 2003 study published in the *Journal of Health Economics* found that states with the best funded and most sustained tobacco prevention programs during the 1990s – Arizona, California, Massachusetts and Oregon – reduced cigarette sales more than twice as much as the country as a whole (43% compared to 20%). This study, the first to compare cigarette sales data from all the states and to isolate the impact of tobacco control program expenditures from other factors that affect cigarette sales, demonstrates that the more states spend on tobacco prevention, the greater the reductions in smoking, and the longer states invest in such programs, the larger the impact. The study concludes that cigarette sales would have declined by 18% instead of 9% between 1994 and 2000 had all states fully funded tobacco prevention programs.[3]

A 2006 study published in the *American Journal of Health Promotion* provides further evidence of the effectiveness of comprehensive tobacco control programs and tobacco control policies. The study's findings suggest that well-funded tobacco control programs combined with strong tobacco control policies increase cessation rates. Quit rates in communities that experienced both policy and programmatic interventions were higher than quit rates in communities that had only experienced policy interventions (excise tax increases or secondhand smoke regulations). This finding supports the claim that state-based tobacco control programs can accelerate adult cessation rates in the population and have an effect beyond that predicted by tobacco-control policies alone.[4]

Additionally, the Surgeon General and the Institute of Medicine have reviewed the evidence on comprehensive statewide tobacco control efforts and concluded that comprehensive programs are effective at reducing tobacco use among both adults and youth.[5]

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Data from numerous states provide additional evidence of the effectiveness of comprehensive tobacco prevention and cessation programs. States that have implemented comprehensive programs have achieved significant reductions in tobacco use among both adults and youth. The experiences in states from around the country who have invested in comprehensive prevention programs establish the following key points:

- When adequately funded, comprehensive state tobacco prevention programs quickly and substantially reduce tobacco use, save lives, and cut smoking-caused costs.
- State tobacco prevention programs must be insulated against the inevitable attempts by the tobacco industry to reduce program funding and otherwise interfere with the programs' successful operation.
- The programs' funding must be sustained over time both to protect initial tobacco use reductions and to achieve further cuts.
- When program funding is cut, progress in reducing tobacco use erodes, and the state suffers from higher levels of smoking and more smoking-caused deaths, disease, and costs.

Unfortunately, many states faced with budget difficulties have recently made the penny-wise but pound-foolish decision to slash the funding of even the most effective tobacco control programs, which will cost lives and money.*

Program Success – California

In 1988, California voters approved Proposition 99, a ballot initiative that increased state cigarette taxes by 25 cents per pack, with 20 percent of the new revenues (over $100 million per year) earmarked for health education against tobacco use. California launched its new Tobacco Control Program in Spring 1990. Despite increased levels of tobacco marketing and promotion, a major cigarette price cut in 1993, tobacco company interference with the program, and periodic cuts in funding, the program has still reduced tobacco use and its attendant devastation substantially.

- California's comprehensive approach has reduced adult smoking significantly. Adult smoking declined from 22.8% in 1988 to 14.0% in 2005, resulting in more than two million fewer smokers.[6] If every state had California's current smoking rate, there would be more than 14 million fewer smokers in the United States.
- Since the passage of Proposition 99, between 1988 and 2003, cigarette consumption in California declined by 60 percent, compared to just 38 percent for the country as a whole.[7] Even after the tobacco industry's successful efforts to reduce the state's tobacco prevention funding, cigarette consumption still declined more in California than in the rest of the country.[8]
- In the 10 years following the passage of Proposition 99, adult smoking in California declined at twice the rate it declined in the previous decade.[9]
- Between 1988 and 2001, lung and bronchus cancer rates in California declined at three times the rate of decline as the rest of the U.S.[10] Surveillance, Epidemiology, and End Results (SEER) data associated lower lung cancer incidence with California's program.[11]
- According to the California Student Tobacco Survey, from 1996 to 2004, smoking declined by more than 60% among eighth grade students and by more than half among tenth grade students. From 2000 to 2004 alone, smoking prevalence decreased by more than 31 percent among twelfth grade students.[12]

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* This factsheet focuses on the extensive public health benefits obtained by state tobacco prevention programs. Other Campaign factsheets show that these programs also reduce smoking-caused costs, including those incurred by state Medicaid programs. See, e.g., *Comprehensive Statewide Tobacco-Prevention Programs Save Money*, http://tobaccofreekids.org/research/factsheets/pdf/0168.pdf.

The California tobacco control program produced much larger smoking reductions in the early years, when it was funded at its highest levels, than during subsequent years, when the state cut its funding. For example, when California cut the program's funding in the mid 1990s, its progress in reducing adult and youth smoking rates stalled, but it got back on track when program funding was partially restored.[13]

Program Success – Maine

In 1997, Maine increased its cigarette excise tax and used a portion of those funds to establish a comprehensive tobacco prevention program known as the Partnership for a Tobacco-Free Maine. Maine has subsequently augmented its program with proceeds from the 1998 state tobacco settlement, which also resulted in a further increase in cigarette prices (the state also raised cigarette taxes again in 2001, to $1.00 per pack, and in 2005 to $2.00 per pack). Prior to launching this effort, Maine had one of the highest youth smoking rates in the country. Now, it has one of the lowest.

- Smoking among Maine's high school students declined a dramatic 59 percent between 1997 and 2005, falling from 39.2 percent to 16.2 percent. Smoking among Maine's middle school students declined by 64 percent, from 21 percent to 7.5 percent, over the same time period. [14] The Maine Department of Health (DOH) has calculated that, as a result of these declines, there are now 26,031 fewer youth smokers in Maine and 14,317 youth will be saved from premature, smoking-caused deaths. Based on estimates that smokers, on average, have $16,000 more in lifetime health care costs than non-smokers, the DOH calculated that these declines will save Maine more than $416 million in long-term health care costs.

Program Success – Washington

The Washington State Tobacco Prevention and Control program was implemented in 1999 after the state Legislature set aside money from the Master Settlement Agreement to create a Tobacco Prevention and Control Account. Tobacco prevention and control received additional funds in 2001 when the state's voters passed a cigarette tax increase that dedicated a portion of the new revenue to tobacco prevention and cessation. As the data below demonstrate, Washington's comprehensive program is working.

- Washington's tobacco prevention efforts have cut smoking by 57 percent among sixth graders, 49 percent among eighth graders, 48 percent among tenth graders, and 44 percent among twelfth graders.[15] Because of these declines, there are 65,000 fewer youth smokers in Washington, and the state has saved more than $1 billion in long-term health care costs.

- Since the tobacco control program was implemented, adult smoking has declined by 20 percent, from 22.4 percent in 1999 to 17.8 percent in 2005, one of the lowest smoking rates in the country.[16] According to the Washington Department of Health, this decline translates to about 205,000 fewer smokers in the state.

Program Success – New York

The New York State Tobacco Control program was implemented in 1999 with funds from the Master Settlement Agreement and revenue from the state cigarette tax. As the data below demonstrate, New York's comprehensive program is working.

- Between 1999 and 2005, smoking among high school students declined by 40 percent, (from 27.4 percent to 16.2 percent).[17]

- Between 2001 and 2004, adult smoking declined by 15 percent, moving New York's smoking rate from the 26th highest in the nation to the 13th highest in the nation.[18]

Program Success – Indiana

In 2000, Indiana implemented a comprehensive tobacco prevention and cessation program with revenue received from the state's tobacco settlement. Indiana's program is modeled after other comprehensive programs that have been successful in reducing tobacco use. Indiana's program includes public

education efforts, a counter-marketing campaign, community and school-based programs, and enforcement initiatives.[19] Data indicate that this comprehensive approach was working when the program was fully funded.[20]

- Between 2000 and 2004, smoking among high school students declined by 32.5 percent, (from 31.6 percent to 21.3 percent).

- Smoking among middle school students declined by 20 percent, from 9.8 percent to 7.8 percent, over this same time period.

Program Success – An Experiment in Texas

Rather than using settlement money to fund a comprehensive statewide tobacco prevention program, the state of Texas decided to use a small portion of its tobacco settlement money to test tobacco prevention interventions of varying intensity and comprehensiveness in selected parts of the state. Not surprisingly, this experiment found that the largest effects on both youth smoking rates occurred in those areas where comprehensive programs were implemented and sustained. Data show that youth smoking in the comprehensive program area decreased at more than four times the state rate of decline.[21]

- Between 2000 and 2005, smoking among high school students dropped by 46%, from 34.2% to 18.3%, in the Beaumont/Port Arthur comprehensive program area. Statewide, youth smoking only declined by 9.3%, from 24.7% in 2001 to 22.4% in 2004.

- From 2000 to 2005, current cigarette use among middle school students decreased by 34% (from 17% to 11.2%) in the Beaumont/Port Arthur comprehensive program area. Statewide, smoking among middle school students actually increased by 2%, from 10.2% to 10.4%, between 2001 and 2004.

Program Success -- Massachusetts

In 1992, Massachusetts voters approved a referendum that increased the state cigarette tax by 25 cents per pack. Part of the new tax revenues was used to fund the Massachusetts Tobacco Control Program (MTCP), which began in 1993. As in California, despite some reductions in funding encouraged by the tobacco industry, the program achieved considerable success until its funding was cut by more than 90 percent in 2003. Data from 2000 demonstrate that the program was successful in reducing tobacco use among both children and adults.

- Massachusetts cigarette consumption declined by 36 percent between 1992 and 2000, compared to a decrease of just 16 percent in the rest of the country (excluding California).[22]

- From 1995 to 2001, current smoking among Massachusetts high school students dropped by 27 percent (from 35.7% to 26%), while the nationwide rate dropped by 18 percent (34.8% to 28.5%)[23]

- Between 1993 and 2000, adult smoking prevalence dropped from 22.6 percent to 17.9 percent, resulting in 228,000 fewer smokers.[24] Nationally, smoking prevalence dropped by just 7 percent over this same time period.[25]

- Between 1990 and 1999, smoking among pregnant women in Massachusetts declined by more than 50 percent (from 25% to 11%). Massachusetts had the greatest percentage decrease of any state over the time period (the District of Columbia had a greater percent decline).[26]

Despite the considerable success achieved in Massachusetts, funding for the state's tobacco prevention and cessation program was cut by 95 percent - from a high of approximately $54 million per year to just $2.5 million in FY2004, although funding for the program has increased slightly in recent years. These drastic reductions in the state's investments to prevent and reduce tobacco use will translate directly into higher smoking rates, especially among kids, and more smoking-caused disease, death, and costs. In fact, a study released by the Massachusetts Association of Health Boards shows that the Massachusetts program funding cuts have already been followed by an alarming increase in illegal sales of tobacco products to children.[27]

- Between 2002 and 2003, cigarette sales to minors increased by 74 percent, from 8 percent to 13.9 percent in communities that lost a significant portion of their enforcement funding.
- Over the same time period, cigarette sales to minors increased by 98 percent in communities that lost all of their local enforcement funding.

Campaign for Tobacco-Free Kids. October 12, 2006 / Meg Gallogly

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