KANSAS
MATERNAL &
CHILD HEALTH

Kansas Maternal & Child Health Council

JULY 25, 2018 MEETING

KANSAS MATERNAL & CHILD HEALTH

Welcome
Approval of Minutes
Recognize New Members

DENNIS COOLEY, MD, CHAIR

KANSAS MATERNAL & CHILD HEALTH

Exploitation & Human Trafficking in Kansas

JENNIFER MONTGOMERY, KANSAS ATTORNEY GENERAL'S OFFICE

Kansas Attorney General
Derek Schmidt

Jennifer Montgomery

Director, Human Trafficking Education & Outreach

Kansas Attorney General Derek Schmidt

- **Human Trafficking** is based on recruiting, harboring and/or transporting people solely for the purpose of exploitation
- **No freedom to leave situation**
- Includes *labor trafficking* and *sex trafficking*
- Human Trafficking, a modern form of slavery, is the second largest and fastest growing criminal industry in the world
- Exploits a person's vulnerabilities
- Trafficking industry thrives on ignorance and preys upon the uneducated.

Trafficking is NOT the same as Smuggling, but they overlap

Human Trafficking

Victims do not consent to their situations

Entails forced exploitation of a person for labor/services

Crime against each persons fundamental rights

Occurs domestically-victims held captive in own country

Crime Against Person

Alien Smuggling

Includes those who consent to smuggling

Contract ends after border crossing

Smugglers need only to entail physical movement of "customers"

Is always international

Crime Against Border

Human Trafficking in Kansas

- More than 83% of human trafficking involves domestic victims and the majority of these are children. This means that most trafficking in Kansas involves ***local children***.

- Kansas has adopted new laws that seek to protect and rescue human trafficking victims.

Why Kansas?

- Centrally located
- Intersection of major federal interstates: I-70 and I-35
- Hub of mid-western commerce
- Exchange points

AGE

14 – 16

COMMON AGES

victims enter sex trafficking

Source: Shared Hope International

VENUES

Where traffickers find their victims

SOCIAL NETWORK

HOME NEIGHBORHOOD

CLUBS OR BARS

INTERNET

SCHOOL

Source: Shared Hope International

BUYERS

99

PERCENT

of buyers are

MALE

Source: Shared Hope International

RISK FACTORS

PRIOR SEXUAL ABUSE

FOSTER CARE

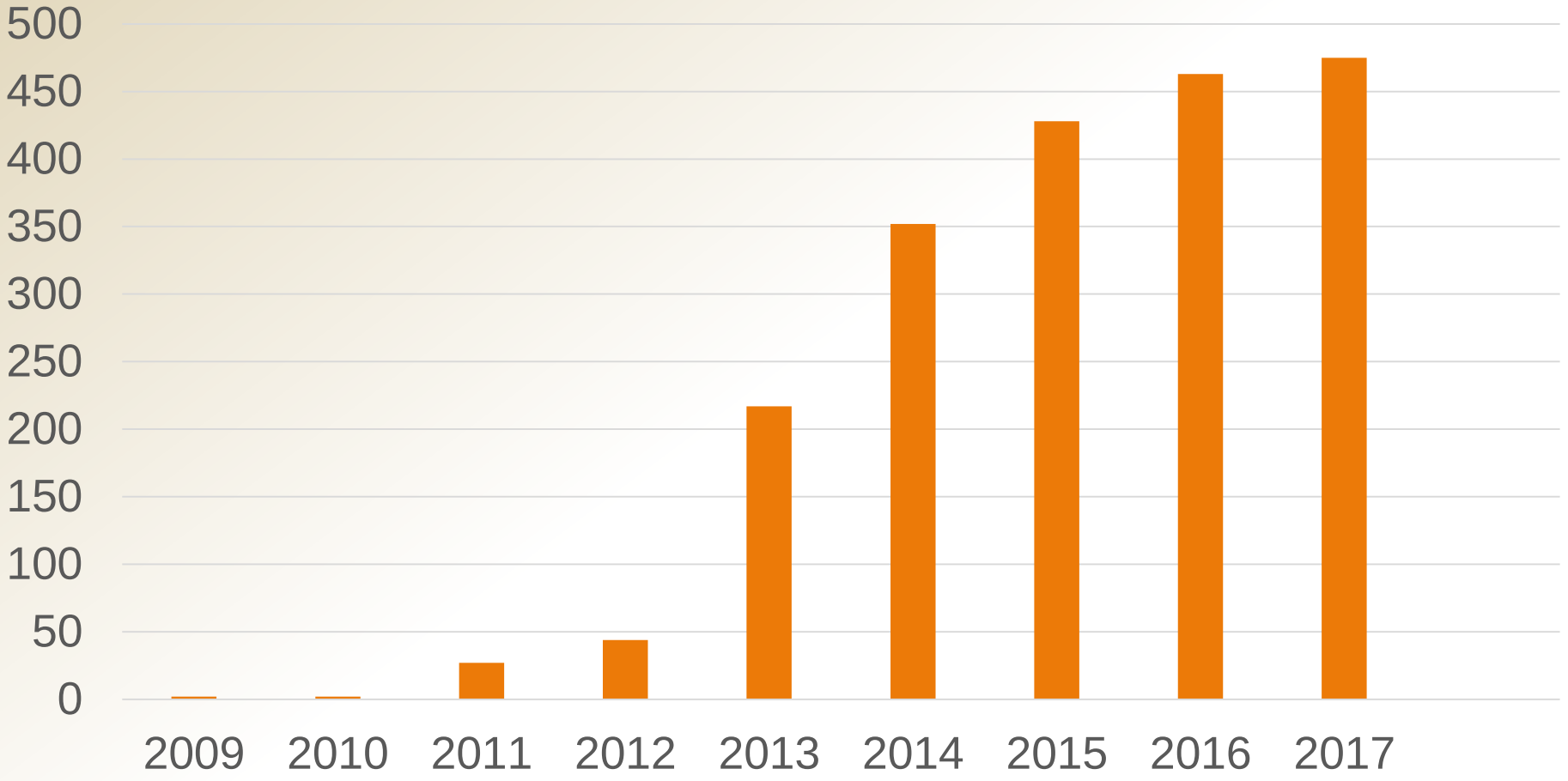
RUNAWAY/HOMELESS

Source: Shared Hope International

The Data

- Children represent 26% of the 20.9 million victims worldwide (International Labour Org. 2012)
- Both U.S. citizen and foreign national children are trafficked for sex and labor in the U.S. (U.S. Dept. Of State, 2013)
- Each year, as many as 100,000 – 300,000 American children are at risk of being trafficked for commercial sex in the U.S. (U.S. Dept. of Justice, NCMEC)
- *Many child victims of human trafficking are students in the American school system.*

Human Trafficking Victims Served by Grantees of the Office of the Attorney General Per Fiscal Year



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Human Trafficking

THE VICTIM

Characteristics of a Sex-Trafficking Victim

- Average age of entry is 14 years old
- Majority are runaway and/or youth within the foster care system & child protective services: some come from middle class, or wealth and prosperity
- 70-90% of sexually exploited children have a history of child sexual abuse
- Most are female
- Not likely to consider themselves as victims

Obstacles to Identification

- Almost never self-identify as trafficking victims
- View trafficker as “boyfriend”/trauma bonding
- Fear of retaliation/acting on threats
- Lured into false sense of “choice”
- May have been given new name, branded
- Conditioned to view others as “family”
- Fearful of law enforcement
- Street smart and difficult to interview

Source: National Human Trafficking Resource Center

Services Critical for Protection

- Medical needs
- Safety Planning
- Treatment for Major Trauma, Complex PTSD
- Long term counseling and assistance
- Housing
- Assistance dealing with and testifying against pimps/traffickers
- Addiction treatment
- Educational needs
- Employment assistance
- Specific Assistance

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Sex Trafficking:

THE TRAFFICKER

Characteristics

- Age 19-45 years old
- Average education is 9.3 years
- 50% completed high school or GED
- 95.5% had a history of drug or alcohol abuse
- 90.0% had a criminal record
- Made $220,000 – $500,000 a year

- *Photos redacted in this version (“they look like us”)*

How Traffickers Control Victims

- Physical abuse
  - Depravation of basic needs
  - Physical restraint, captivity or confinement
  - Withholding medical care
  - Physical assault
  - Murder
- Sexual abuse
  - Rape
  - Forced prostitution
  - Sexual humiliation
- Psych/emotional violence
  - Intimidation/fear
  - Lies, deception, blackmail
  - Unsafe environments
  - Isolation/forced dependency (controlling victims personal docs)
  - Shame and self blame

Additional ways…

- Substance abuse/misuse
  - Forced and coerced use of drugs & alcohol which can create longer-term addiction and monetary dependency.
- Manipulation/Romance
  - Many use romantic relationships to access victims (Romeo pimps).
- Cultural disorientation
  - Movement across state or international borders may put victims in areas where they don't speak the language = ***vulnerability***.

Child Trafficking

Child Sex Trafficking

- Commercial sex trade
- Survival sex
- Forced prostitution
- Stripping
- Pornography

Child Labor Trafficking

- Involuntary domestic servitude
- Underage agricultural labor
- Peddling or begging
- Traveling sales crews

Sex Trafficking
Who is Vulnerable?

- Chronic runaways.
- Children suffering serious abuse in their own homes
- Foster children who have been sexually exploited.
- The throwaway children – those runaways in Kansas who are not reported.
- The throwaway children who “age out” of the system.
- Missing and homeless children
- The 6% of all girls in Kansas: those with a developmental disability.

Sources: National Human Trafficking Resource Center, 2014; Kansas Law Enforcement Information, www.kslawenforcementinfo.com; Colloton interviews: EMCU, Wichita Police; Vice Unit, Overland Park Police; Human Trafficking Advisory Board Members 2014.

Labor Trafficking
Who is Vulnerable?

***Industries which require low skilled manual labor with limited public interaction*.**

- Forced to work against their own will
- Threat of violence or other punishment
- Freedom restricted
- Degree of ownership exerted
  - *Domestic servitude*
  - *Agricultural labor*
  - *Sweatshop factory*
  - *Janitorial/maintenance/food service*
  - *Begging*
  - *Landscaping*
  - *Construction*

Source: National Human Trafficking Resource Center, 2014

Risk Factors

- Isolation
- Emotional Distress
- Substance Abuse
- Poverty
- Family Dysfunction
- Homelessness
- Developmental Delay
- Learning Disabilities
- **Lack of Social Support**
- Childhood Sexual Abuse
- Mental Illness
- Lack of Personal Safety

Red Flags for Labor Trafficking

- Common Work and Living Conditions:* The individual(s) in question
- Is not free to leave or come and go as he/she wishes.
- Is unpaid, paid very little, or paid only through tips
- Works excessively long and/or unusual hours
- Is not allowed breaks or suffers under unusual restrictions at work

- Poor Mental Health or Abnormal Behavior
- Is fearful, anxious, depressed, submissive, tense, or nervous/paranoid
- Avoids eye contact
- Poor Physical Health
- Appears malnourished
- Shows signs of physical and/or sexual abuse.

- Lack of Control
- Has few or no personal possessions
- Is not in control of his/her own money, no financial records, or bank account
- Is not in control of his/her own identification documents (ID or passport)
- Is not allowed or able to speak for themselves (a third party may insist on being present and/or translating)

*National Human Trafficking Resource Center (Polaris) 2016

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Human Trafficking

THE DEMAND

What is Demand?

The desire for a particular commodity, labor or service.

In context of HT, demand is for labor that is exploitative or services which breach the human rights of the person delivering those services.

Sex Trafficking

Source: Veronica's Voice

Buyers

Age Range of Buyers:

18-89

42.5 median age

- 19% of buyers' professions involved working with children (teacher, sports coach, military recruiter, boy scout leader)
- 22% involved a position of authority or trust (attorney, law enforcement, military or minister

Demanding Justice Project Benchmark Assessment, 2014

Buyer education

- Restorative Justice
- Health/Safety Risk
- Connection to Trafficking & other crimes
- Addiction issues (pornography)
- Community impact
- Survivors panel
- Legal Consequences
- Diversion Program

Response

- It is important to prevent trafficking but also to discourage the demand that fosters all forms of exploitation of persons that leads to human trafficking.

- Further research and analysis of the demand side of the trafficking process is a critical component of counter-trafficking response.

Demand an End public awareness campaign

- Kansas has launched ***Demand an End*** which is a sex trafficking-specific public awareness campaign targeting the demand for commercial sex in KS.
- The campaign focuses on sex buyers − attacking the root of the problem – those who perpetuate the sex trafficking industry by purchasing individuals for sex.

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Human Trafficking

KANSAS LAW:
NEW DEVELOPMENTS

Human Trafficking Advisory Board

- Advise on creation and implementation of new laws
- Members include law enforcement, prosecutors, court personnel, advocates, service providers, survivors and relevant state agencies.
- The official state board for anti-human trafficking policy in Kansas under the oversight of the Attorney General. KSA 75-757

Change in Kansas Law

The law recognizes the victimization of minors who are commercially exploited in selling sexual relations –even when they don't believe they are victims.

In 2015, new law was passed allowing victims of human trafficking to seek civil remedies and restitution from convicted traffickers.

Human Trafficking Crimes- KS

Victim under 18:

- Commercial sexual exploitation of a child
- Aggravated Human Trafficking

Victim 18 and older:

- Human trafficking if coerced into labor or sexual exploitation.
- Related crimes that can involve trafficking:
  - Buying sexual relations.
  - Promoting the sale of sexual relations.
  - Selling sexual relations

2017 SB 40/179 New Crimes

- Use of any “communication facility”: Trafficker Level 7 Person Felony; Buyer Class A Misdemeanor
- Sex tourism: promoting and selling travel services for sexual exploitation. Level 5 Person Felony
- Internet trading in child pornography. Level 5 Person Felony; Aggravated - Level 3 Person Felony; Under 14 is Off-Grid

2017 SB 40/179 Amended Crimes

Human Trafficking – K.S.A. 21-5426

- (b)(4) No force, fraud or coercion required; affirmative defense if actions are because the victim being trafficked at the time;
- (b)(5) Hiring a child in reckless disregard of age. Level 1 Person Felony;
- Not a defense to Aggravated HT: consent of victim or defendant had no knowledge of age.

Sexual Exploitation of a Child – K.S.A. 21-5510(a)(1) and (4)

- Penalty rise from Level 5 to Level 3 Person Felony.

Commercial Sexual Exploitation of a Child – K.S.A. 21-6422

- Hiring a child language replaces current language regarding procuring a child. Penalty for all subsections rises to Level 4 Person Felony.

Fines for Buying Sexual Relations - K.S.A. 21-6421

- Amount not less than $1200 and split 50/50 with district court, municipal court and Human Trafficking Victim Assistance Fund.

2017 SB40/179 Other Changes

- Those Promoting Sale of Sexual Relations (K.S.A. 21-6420) added to sex offender registration list.
- Expungement time for juvenile selling sexual relations made immediate.
- Crime Victims Compensation Board rules that disqualify HT victims are eliminated.
- Commercial driver license adds test on identifying/reporting HT.
- National Human Trafficking Hotline new name for NHTRC

Federal Crime

The Trafficking Victims Protection Act (TVPA) of 2000 is the first comprehensive federal law to address trafficking in persons. The law provides a three-pronged approach that includes prevention, protection, and prosecution. The TVPA was reauthorized through the Trafficking Victims Protection Reauthorization Act (TVPRA) of 2003, 2005, 2008, and 2013.

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Human Trafficking

THE ROLE OF HEALTHCARE PRACTITIONERS

- In a unique position to identify and help minor and adult victims of HT.
- Potentially the only person a victim meets outside of their trafficking situation.

Indicators of Exploitation/Red Flags – healthcare providers

- Disoriented. Unaware of current location/city/town.
- Claims to be “just visiting” community.
- No healthcare coverage/pays in cash.
- Not in control of personal ID/few personal possessions.
- Someone accompanying them who speaks for them.
- Avoids eye contact with provider.
- Demeanor (fearful, anxious, submissive, flat affect)
- Inconsistent story (try re-wording their story and see if they correct you).
- Under 18 and in the sex industry/multiple sex partners

Red Flags (cont'd)

- Signs of malnourishment.
- Injuries (multiple, old & new).
- Signs of physical abuse (bruises, scars, cuts, burns)
- STIs/bacterial and/or yeast infections
- Tattoos they are reluctant to explain (branding).
- Behavior change when law enforcement is mentioned.

U.S. Department of HHS

Kansas Brand Examples

- *Photos of example tattoos redacted in this version*

Source: EMCU

Health Issues Associated with Sex Trafficking

1. Infectious diseases
2. Non-infectious diseases
3. Reproductive health problems
4. Substance abuse
5. Mental health
6. Violence

U.S. Department of State, 2006

Common presentations

Victims of human trafficking may look like many of the people you help.

Classic presentations found in trafficking victims:

- Bruises in various stages of healing caused by physical abuse
- Scars, mutilations, or infections due to improper medical care
- Urinary difficulties, pelvic pain, pregnancy, or rectal trauma caused from working in the sex industry
- Chronic back, hearing, cardiovascular, or respiratory problems as a result of forced manual labor in unsafe conditions
- Poor eyesight and/or eye problems due to dimly lit work sites
- Malnourishment and/or serious dental problems
- Disorientation, confusion, phobias, or panic attacks caused by daily mental abuse, torture, and culture shock

Report suspicious activity to local law enforcement, or call 1.866.347.2423

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www.dhs.gov/bluecampaign

Challenges in identification of trafficking victims

- Distrust of service providers (possible past bad experiences, grooming)
- Lies and false stories (protection of “safety”, not lying because they like the situation…)
- Untrustworthy interpreters (interpreter can be trafficker)
- “One Shot” (unlikely they will present again)
- Difference between intimate partner violence and HT

Adverse Childhood Experiences

Research shows that early trauma, ACEs, can be linked to sexual exploitation.

- Abuse
- Neglect
- Parental detachment
- Exposure to addiction

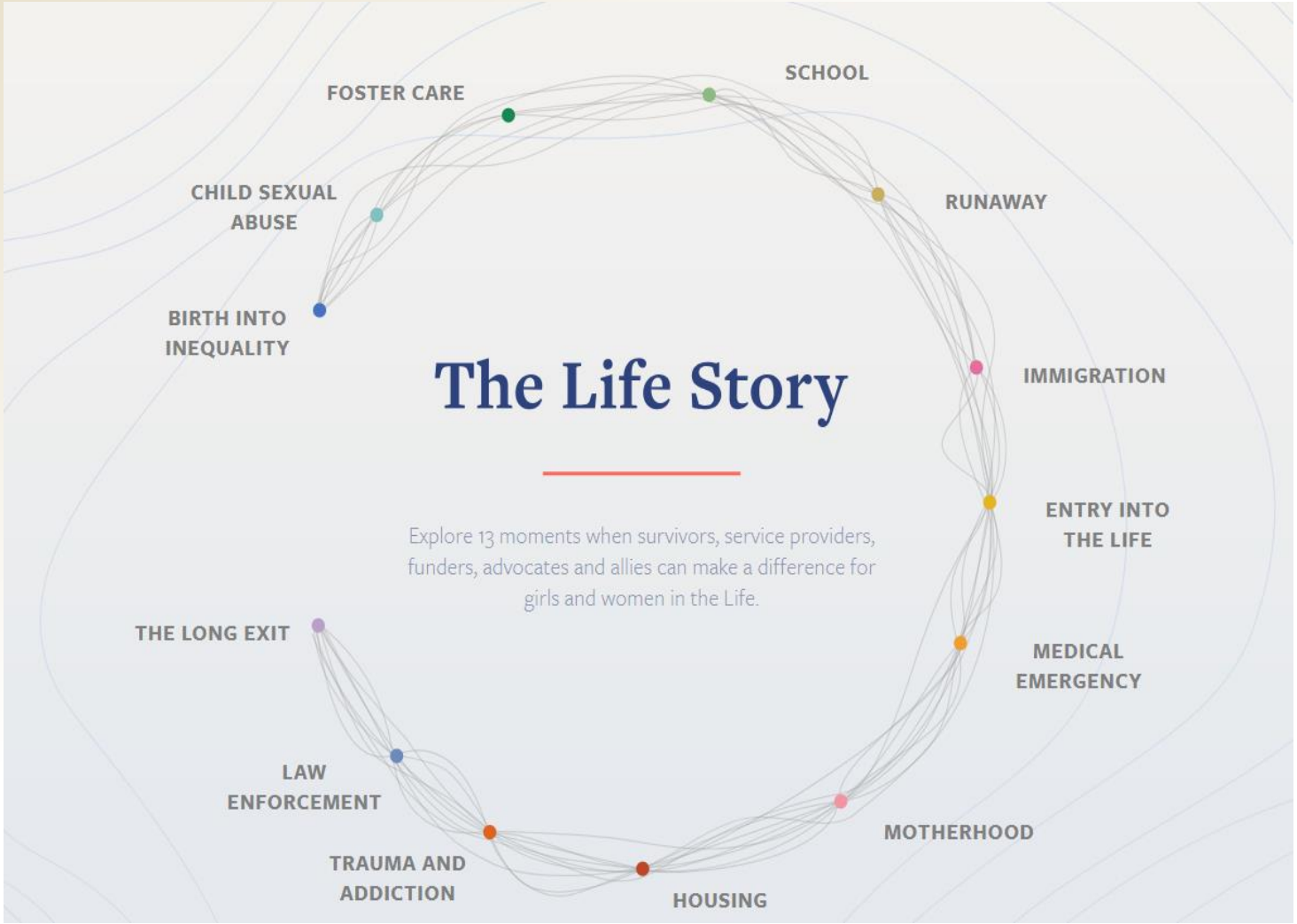
The Connection

- Sex trafficked youth experience more adversity than other juvenile offenders.
- Most significant differences in ACE scores between the trafficked youth v. non-trafficked youth were for sexual abuse, physical abuse and physical neglect.
- Most of the sexually trafficked offenders have histories of victimization.

"Youth Arrested for Trading Sex Have the Highest Rates of Childhood Adversity: A Statewide Study of Juvenile Offenders, *Sexual Abuse: A Journal of Research and Treatment,* September 2015

33% of women with a trafficking history had ACE scores of 4-7 while 48% had scores of 8 or higher.

The Life Story



thelifestory.org

Recommendations

- Mistreated youth – especially those w/histories of sexual abuse – need consistent, protective environments w/adults who can monitor their behavior and be alert to signs of sex trafficking & re-victimization.
- Juvenile justice systems should utilize screening tools to identify offending youth with histories of mistreatment.
- Services for both mistreated and offending youth should be tailored to assist in first meeting their most basic needs – **safety and security** – and then identifying appropriate relationships with adults.

"Youth Arrested for Trading Sex Have the Highest Rates of Childhood Adversity: A Statewide Study of Juvenile Offenders, *Sexual Abuse: A Journal of Research and Treatment,* September 2015

Cont'd.

- *Stewards of Children – Darkness to Light* training for those who work with children to recognize and identify those who may be at risk for sexual abuse and future victimization.

Best practices

- Building trust is #1 priority.
- Reassure potential victim (you are there to help & you care about them, you are not police and won't call police unless they want you to).
- One-on-one interactions are ideal.
- More in-depth assessment. (only if there is specific, immediate intervention available)
- Provide them with referrals for other services if appropriate.
- If victim is <18, follow child abuse protocol and comply with mandatory reporting requirements.
- If victim is >18 and wants to contact law enforcement, assist in calling 911.

Assessment

- Utilize existing assessment & examination protocols for victims of abuse/sexual (Via Christi protocol)
- Utilize existing culturally sensitive protocols
- Obtain appropriate consents (WHO Guidelines)
- Use age-appropriate language when working with minors
- If you ask about sexual history, be sure to distinguish between consensual experiences and non-consensual experiences
- Conduct in a confidential setting
- Separate patient from his/her belongings and escort/interpreter
- If patient is female, approach should be made by a female staff member (nurse, physician, psychologist, social worker)

U.S. Dept. of Health and Human Services

Via Christi HT Protocol

Physical indicators
(if present, proceed to step one):

- Signs of physical trauma
- Branding tattoos indicating "daddy," "property of" or trafficker's street name
- Unusual infections such as TB or immunizable diseases
- Multiple sexually transmitted infections
- Several somatic symptoms arising from stress
- Malnutrition, dehydration
- Multiple pregnancies or abortions
- Unusual occupational injuries

Red flags
(if present, proceed to step one):

- Inconsistent or scripted history
- Discrepancy between the history and clinical presentation
- Unable to give address
- Doesn't know current city
- Minor trading sex for something of value (food, shelter, drugs or money)
- Unusually high number of sexual partners
- Late presentation
- Carrying large amount of cash
- Appearance younger than stated age

Control indicators
(if present, proceed to step one):

- Accompanied by a controlling person
- Controlling person doesn't allow patient to answer
- Person interrupts or corrects the patient
- Patient exhibits fear, nervousness and/or avoids eye contact
- Patient not in control of passport (if a foreign national)
- Patient frequently receives texts or phone calls during the exam
- Patient exhibits hyper-vigilance, or subordinate demeanor

HT
assessment

REV. 03/2015

Via Christi HEALTH
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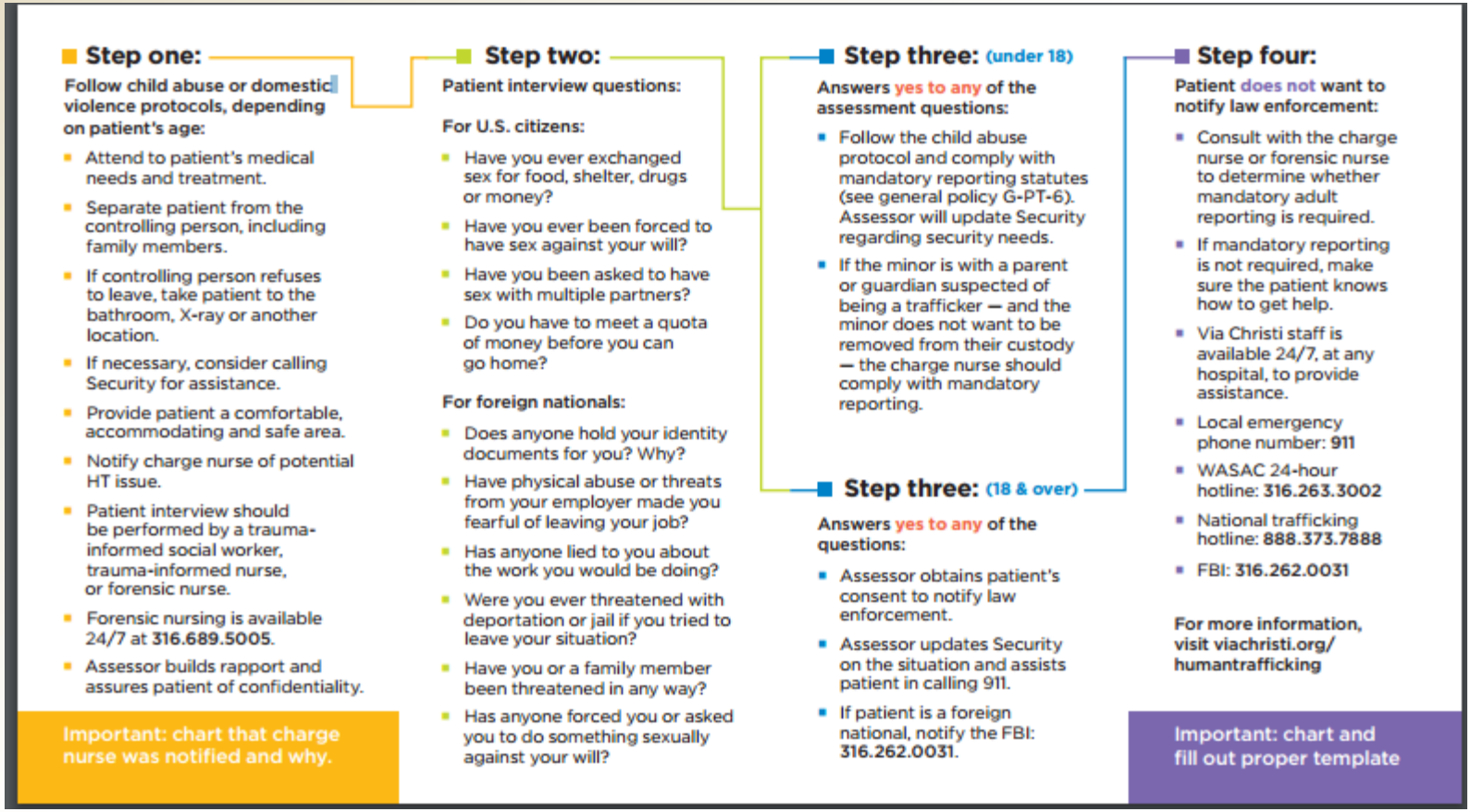
Cont'd


Step one:
Follow child abuse or domestic violence protocols, depending on patient's age:
Attend to patient's medical needs and treatment.
Separate patient from the controlling person, including family members.
If controlling person refuses to leave, take patient to the bathroom, X-ray or another location.
If necessary, consider calling Security for assistance.
Provide patient a comfortable, accommodating and safe area.
Notify charge nurse of potential HT issue.
Patient interview should be performed by a trauma-informed social worker, trauma-informed nurse, or forensic nurse.
Forensic nursing is available 24/7 at 316.689.5005.
Assessor builds rapport and assures patient of confidentiality.
Important: chart that charge nurse was notified and why.
Step two:
Patient interview questions:
For U.S. citizens:
Have you ever exchanged sex for food, shelter, drugs or money?
Have you ever been forced to have sex against your will?
Have you been asked to have sex with multiple partners?
Do you have to meet a quota of money before you can go home?
For foreign nationals:
Does anyone hold your identity documents for you? Why?
Have physical abuse or threats from your employer made you fearful of leaving your job?
Has anyone lied to you about the work you would be doing?
Were you ever threatened with deportation or jail if you tried to leave your situation?
Have you or a family member been threatened in any way?
Has anyone forced you or asked you to do something sexually against your will?
Step three: (under 18)
Answers yes to any of the assessment questions:
Follow the child abuse protocol and comply with mandatory reporting statutes (see general policy G-PT-6). Assessor will update Security regarding security needs.
If the minor is with a parent or guardian suspected of being a trafficker — and the minor does not want to be removed from their custody — the charge nurse should comply with mandatory reporting.
Step three: (18 & over)
Answers yes to any of the questions:
Assessor obtains patient's consent to notify law enforcement.
Assessor updates Security on the situation and assists patient in calling 911.
If patient is a foreign national, notify the FBI: 316.262.0031.
Step four:
Patient does not want to notify law enforcement:
Consult with the charge nurse or forensic nurse to determine whether mandatory adult reporting is required.
If mandatory reporting is not required, make sure the patient knows how to get help.
Via Christi staff is available 24/7, at any hospital, to provide assistance.
Local emergency phone number: 911
WASAC 24-hour hotline: 316.263.3002
National trafficking hotline: 888.373.7888
FBI: 316.262.0031
For more information, visit viachristi.org/humantrafficking
Important: chart and fill out proper template

Screening Questions for Healthcare Providers

- How safe do you feel right now? Are there times when you don't feel safe?
- Have you been physically harmed in any way?
- Is anyone forcing you to do something you do not want to do?
- Can you leave your job or situation if you want?
- Are you paid for the work you do?
- Can you come and go as you please?
- Where do you sleep and eat?
- How many hours do you work every day/week?

American Medical Student Association screening questionnaire

HIPAA – The Privacy Rule

- *Privacy Rule*: a set of guidelines and protocols for communicating patients' info to ensure privacy is maintained.
- There is currently nothing in the *Privacy Rule* that addresses reporting HT victims.
- However, HT can be considered amongst one of the 12 national priority purposes:

(3) Victims of abuse, neglect, or domestic violence

SS 164.512 (C) Standard: Disclosure about victims of abuse, neglect or domestic violence.

Role of healthcare provider in the ED

- Identify HT victims
- Treat chief complaint/illness and/or emergent issue.
- Offer and/or provide appropriate treatment.
- Provide referral to local social service agency.

**Medically, you treat symptoms but how you discharge can play a key role in potential victim restoration.*

6 Common Medical Referrals for CSEC/DMST

1. Primary care clinic/public health department (contraception, HPV vaccine, STI testing)
2. Obstetrician
3. Follow up medical exam with child abuse expert
4. Surgical follow up
5. Mental health services
6. Peds specialty referral

- Many victims do not self-identify as HT victims.
- Conditioned not to trust you.
- Canned stories are common – true story may not emerge until later.

Report Human Trafficking

- 911(local law enforcement)
- Homeland Security Investigations:1-866-DHS-2-ICE
- National Human Trafficking Hotline: 1-888-3737-888 or TEXT **INFO** or **HELP** to 233-733 (24 hours, 7 days a week)
- Minor patient = Mandatory Reporting protocols (child abuse). To report a sexually exploited or abused minor, call the National Center for Exploited and Missing Children (NCMEC) hotline 1-800-THE-LOST or cyber tip reporting http://www.cybertipline.org .
- *KSAG Victim Services Div: 1-800-828-9745*

Resources

sharedhope.org

NHTRC Hotline 1-888-3737-888

polarisproject.org

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Polaris

Freedom happens now.

Questions?

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Discussion: MCH's Role

- Was any information surprising or new to you?
- Are you already doing work related to trafficking, such as awareness of the characteristics of victims, traffickers and buyers, and awareness of red flags for sex trafficking and labor trafficking?
- Which aspect did you most relate to in terms of current or potential work?
- Are there potential gaps that came to mind that the MCH Council and the MCH community would be a natural fit to help address?
- Are there new connections that should be made or partnerships lacking?

Action

What is one activity the Council can do to address trafficking?

What is one thing you or your organization could do to help address trafficking in Kansas?

KANSAS MATERNAL & CHILD HEALTH

Title V MCH Block Grant Application Updates

RACHEL SISSON & HEATHER SMITH, KDHE

FFY2019 Title V MCH Block Grant

- Release/Writing: April 2-May 11
- Public input period: June 4-June 22
- 2019 Application/2017 Report Due: July 15
- Draft Plan & Annual Report Released: July 23
- **Federal Title V Block Grant Review: August 8**
- Application & Annual Report Re-submit: September 2018
- Final publications and resources published: October 2018
- Access: www.kdheks.gov/bfh or www.kansasmch.org

State Action Plan Changes

- Eliminate Priority 2
- Eliminate NPM 9 (bullying)
- Eliminate SPM 2 (ties to Priority 2)
- New SPM 5 (workforce development)
- Increased Alignment: Revised Objectives

State Priorities

States conduct a 5-year needs assessment to identify 7-10 state MCH priorities.

1. Women have access to and receive coordinated, comprehensive services before, during and after pregnancy.
2. ~~Services and supports promote healthy family functioning.~~
3. 2. Developmentally appropriate care and services are provided across the lifespan.
4. 3. Families are empowered to make educated choices about infant health and well-being.
5. 4. Communities and providers support physical, social, and emotional health.
6. 5. Professionals have the knowledge and skills to address the needs of maternal and child health populations.
7. 6. Services are comprehensive and coordinated across systems and providers.
8. 7. Information is available to support informed health decisions and choices.

National Performance Measures (NPMs) & Evidence-Based or -Informed Strategy Measures (ESMs)

States select 8 of 15 NPMs that address the state priority needs; at least one from each population domain area.*

NPM 1: Well-woman visit (Percent of women with a past year preventive medical visit)
- *ESM: Percent of women program participants (18-44 years) that received education on the importance of a well-woman visit in the past year*
- *ESM: Percent of women program participants (18-44 years) with a preventive medical visit in the past year*

NPM 4: Breastfeeding (Percent of infants ever breastfed; Percent of infants breastfed exclusively through 6 months)
- *ESM: Percent of WIC infants breastfed exclusively through six months in designated "Communities Supporting Breastfeeding"*

NPM 6: Developmental screening (Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool)
- *ESM: Percent of program providers using a parent-completed developmental screening tool during an infant or child visit (ages 10 through 71 months)*

NPM 7: Child Injury (Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9)
- *ESM: Number of free car seat safety inspections completed by certified child passenger safety technicians*

~~**NPM 9:** Bullying (Percent of adolescents, 12 through 17, who are bullied or who bully others)~~

NPM 10: Adolescent well-visit (Percent of adolescents, 12 through 17, with a preventive medical visit in the past year)
- *ESM: Percent of adolescent program participants (12-21 years) that received education on the importance of a well-visit in the past year*

NPM 11: Medical home (Percent of children with and without special health care needs having a medical home)
- *ESM: Percent of families who experience an improved independent ability to navigate the systems of care*

NPM 14: Smoking during Pregnancy and Household Smoking (Percent of women who smoke during pregnancy; Percent of children who live in households where someone smokes)
- *ESM: Percent of pregnant women program participants who smoke referred to the Tobacco Quitline and enrolled/accepted services*

State Performance Measures (SPMs)

States select measures to address state priorities not addressed by the National Performance Measures.

SPM 1: Preterm Birth (Percent of preterm births <37 weeks gestation)

~~**SPM 2:** Parent Support (Percent of children living with parents receiving emotional support/help with parenthood)~~

SPM 2 3: Physical Activity (Percent of children 6-11 and adolescents 12-17 physically active at least 60 minutes/day)

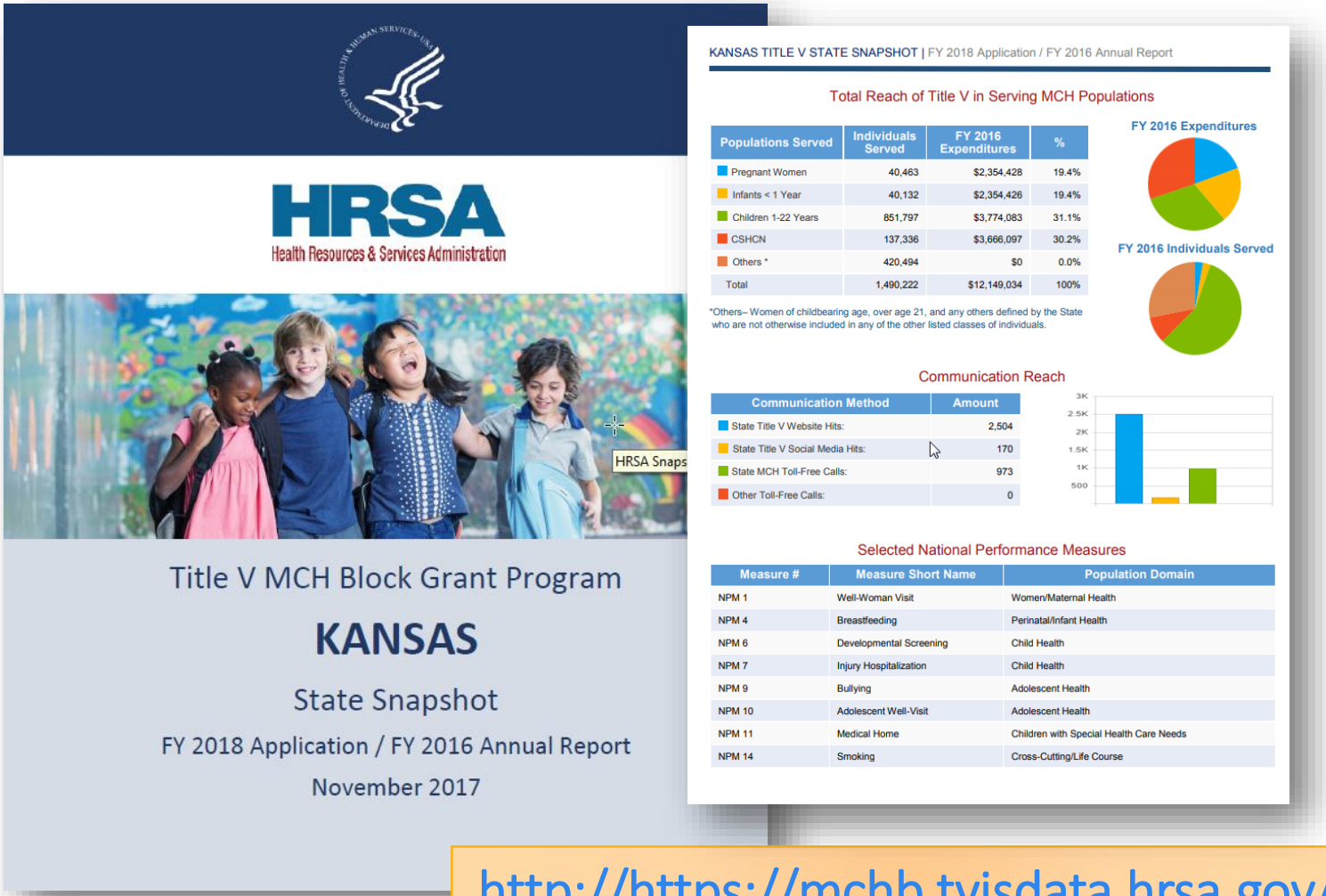
SPM 3 4: Safe Sleep (Number of Safe Sleep (SIDS/SUID) trainings provided to professionals)

SPM 4 5: Health Literacy (Percent of adults who report that it is somewhat difficult or very difficult to understand information from doctors, nurses and other health professionals)

SPM 5: Workforce Development (Number of MCH grantees, families and partners that participated in a state-sponsored workforce development event)

Published Links/Documents

KS Title V MCH Snapshot



HRSA
Health Resources & Services Administration

Title V MCH Block Grant Program

KANSAS

State Snapshot

FY 2018 Application / FY 2016 Annual Report

November 2017

KANSAS TITLE V STATE SNAPSHOT | FY 2018 Application / FY 2016 Annual Report

Total Reach of Title V in Serving MCH Populations

Populations Served	Individuals Served	FY 2016 Expenditures	%
Pregnant Women	40,463	$2,354,428	19.4%
Infants < 1 Year	40,132	$2,354,426	19.4%
Children 1-22 Years	851,797	$3,774,083	31.1%
CSHCN	137,336	$3,666,097	30.2%
Others *	420,494	$0	0.0%
Total	1,490,222	$12,149,034	100%

*Others– Women of childbearing age, over age 21, and any others defined by the State who are not otherwise included in any of the other listed classes of individuals.

FY 2016 Expenditures

FY 2016 Individuals Served

Communication Reach

Communication Method	Amount
State Title V Website Hits:	2,504
State Title V Social Media Hits:	170
State MCH Toll-Free Calls:	973
Other Toll-Free Calls:	0

3K
2.5K
2K
1.5K
1K
500

Selected National Performance Measures

Measure #	Measure Short Name	Population Domain
NPM 1	Well-Woman Visit	Women/Maternal Health
NPM 4	Breastfeeding	Perinatal/Infant Health
NPM 6	Developmental Screening	Child Health
NPM 7	Injury Hospitalization	Child Health
NPM 9	Bullying	Adolescent Health
NPM 10	Adolescent Well-Visit	Adolescent Health
NPM 11	Medical Home	Children with Special Health Care Needs
NPM 14	Smoking	Cross-Cutting/Life Course

http://https://mchb.tvisdata.hrsa.gov/

Kansas MCH Facebook Page

http://www.facebook.com/kansasmch

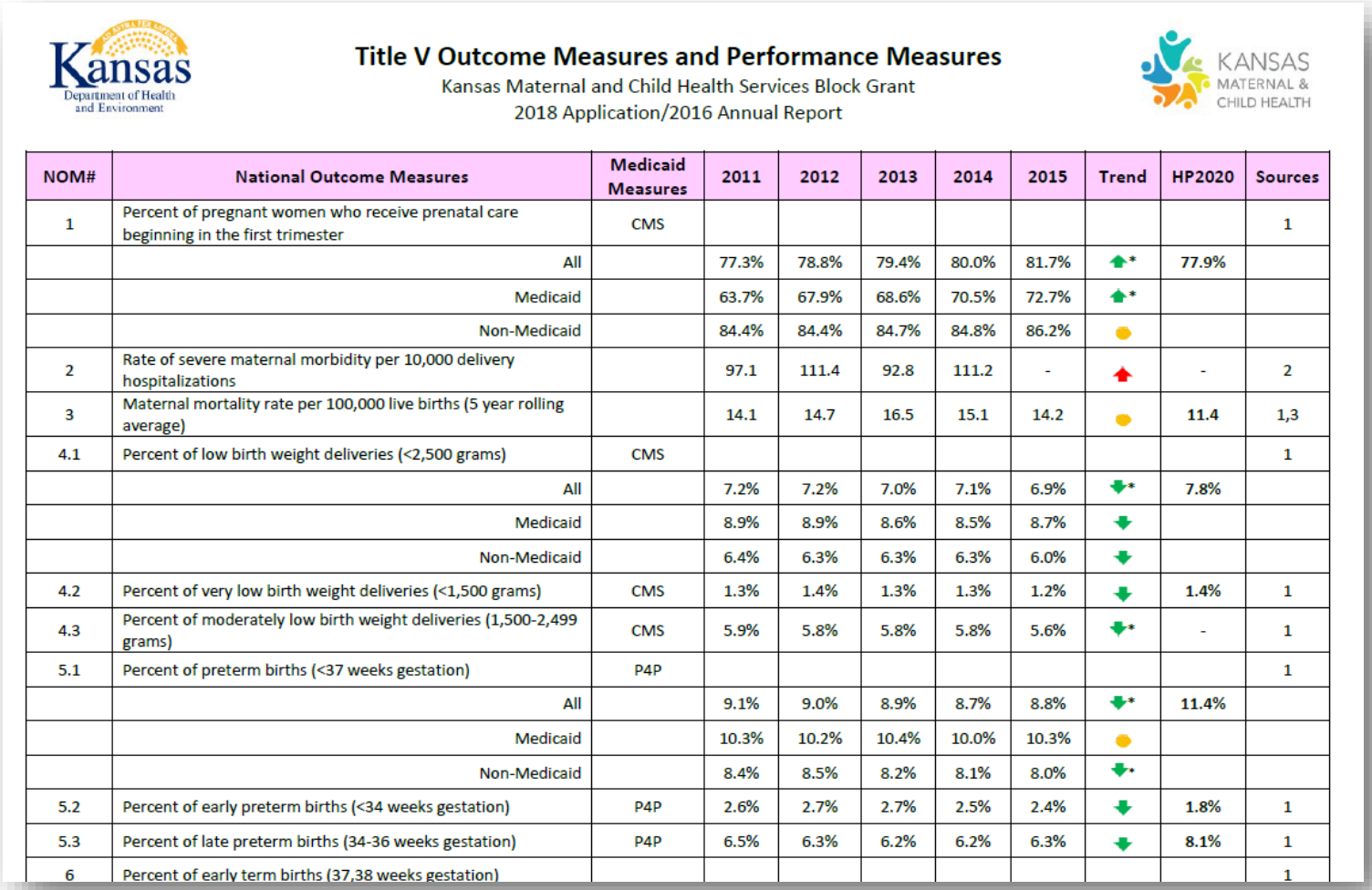
KANSAS MATERNAL & CHILD HEALTH

Kansas MCH: Selected Performance Measures

JULY 25, 2018

Jamie S. Kim, MPH
Maternal and Child Health Epidemiologist
Kansas Department of Health and Environment

Status of MCH Measures



Kansas Department of Health and Environment

Title V Outcome Measures and Performance Measures

Kansas Maternal and Child Health Services Block Grant

2018 Application/2016 Annual Report

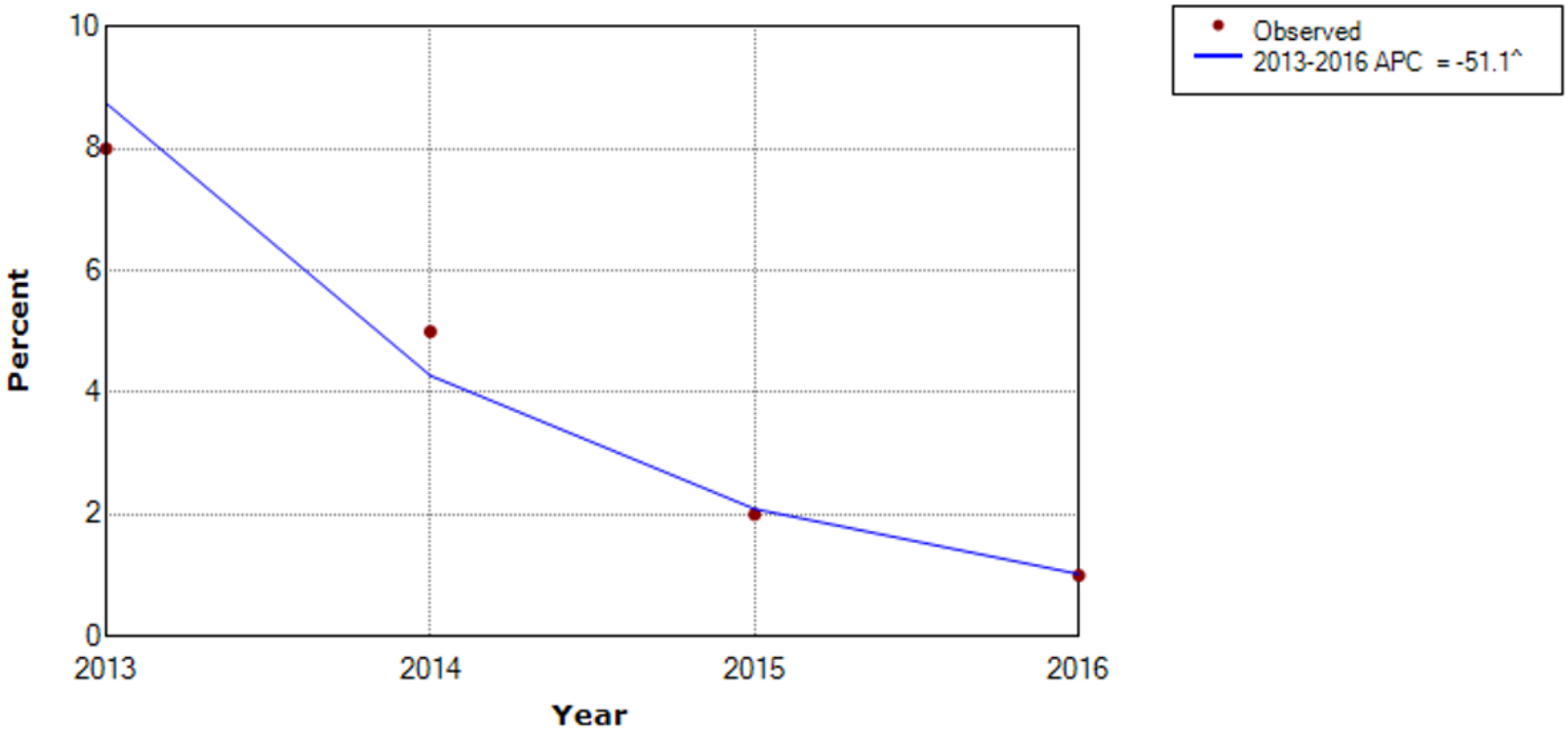
KANSAS MATERNAL & CHILD HEALTH

NOM#	National Outcome Measures	Medicaid Measures	2011	2012	2013	2014	2015	Trend	HP2020	Sources
1	Percent of pregnant women who receive prenatal care beginning in the first trimester	CMS								1
	All		77.3%	78.8%	79.4%	80.0%	81.7%	↑*	77.9%	
	Medicaid		63.7%	67.9%	68.6%	70.5%	72.7%	↑*		
	Non-Medicaid		84.4%	84.4%	84.7%	84.8%	86.2%	●		
2	Rate of severe maternal morbidity per 10,000 delivery hospitalizations		97.1	111.4	92.8	111.2	-	↑	-	2
3	Maternal mortality rate per 100,000 live births (5 year rolling average)		14.1	14.7	16.5	15.1	14.2	●	11.4	1,3
4.1	Percent of low birth weight deliveries (<2,500 grams)	CMS								1
	All		7.2%	7.2%	7.0%	7.1%	6.9%	↓*	7.8%	
	Medicaid		8.9%	8.9%	8.6%	8.5%	8.7%	↓		
	Non-Medicaid		6.4%	6.3%	6.3%	6.3%	6.0%	↓		
4.2	Percent of very low birth weight deliveries (<1,500 grams)	CMS	1.3%	1.4%	1.3%	1.3%	1.2%	↓	1.4%	1
4.3	Percent of moderately low birth weight deliveries (1,500-2,499 grams)	CMS	5.9%	5.8%	5.8%	5.8%	5.6%	↓*	-	1
5.1	Percent of preterm births (<37 weeks gestation)	P4P								1
	All		9.1%	9.0%	8.9%	8.7%	8.8%	↓*	11.4%	
	Medicaid		10.3%	10.2%	10.4%	10.0%	10.3%	●		
	Non-Medicaid		8.4%	8.5%	8.2%	8.1%	8.0%	↓*		
5.2	Percent of early preterm births (<34 weeks gestation)	P4P	2.6%	2.7%	2.7%	2.5%	2.4%	↓	1.8%	1
5.3	Percent of late preterm births (34-36 weeks gestation)	P4P	6.5%	6.3%	6.2%	6.2%	6.3%	↓	8.1%	1
6	Percent of early term births (37,38 weeks gestation)									1

KANSAS
MATERNAL &
CHILD HEALTH

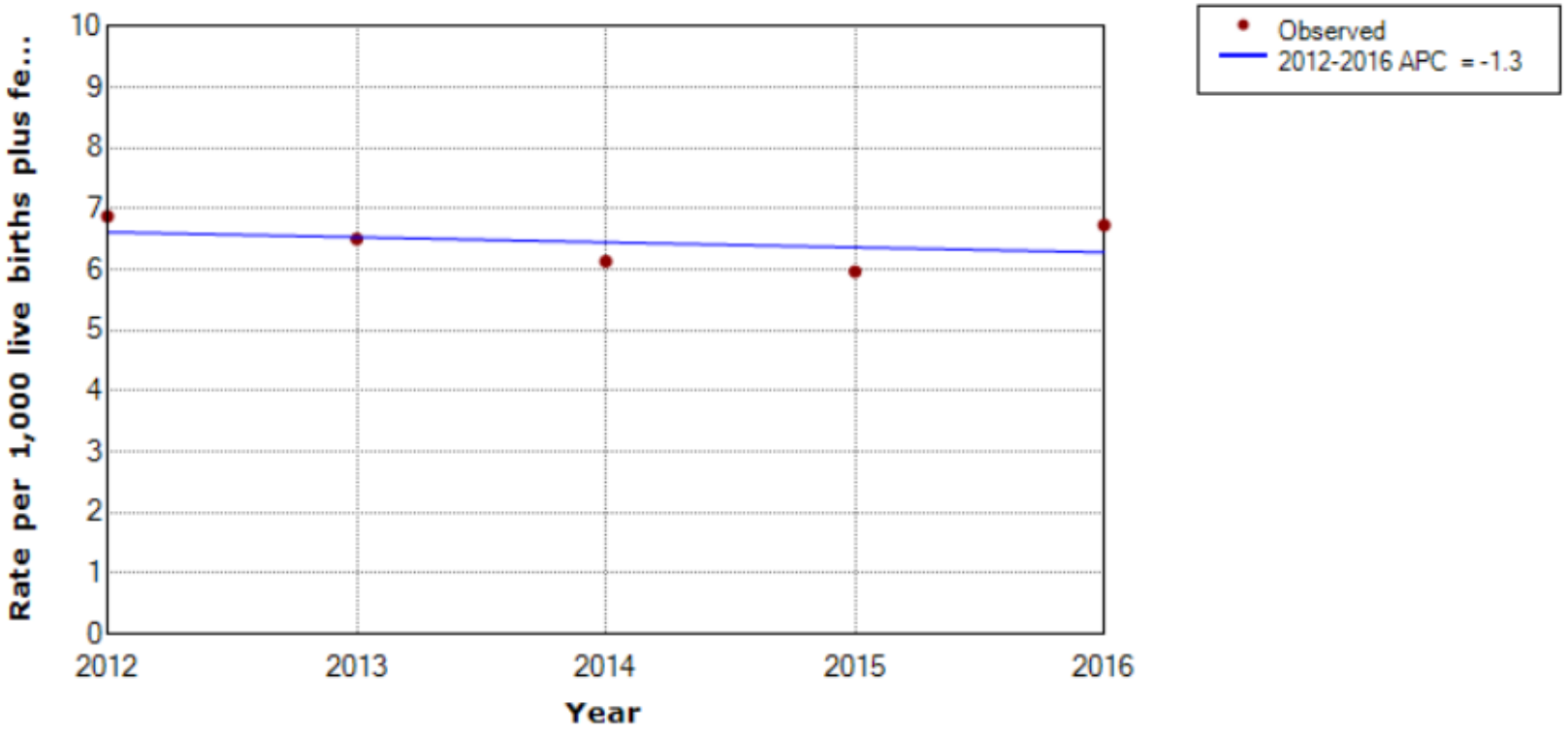
Positive Trends

NOM 7: Percent of non-medically indicated early elective deliveries



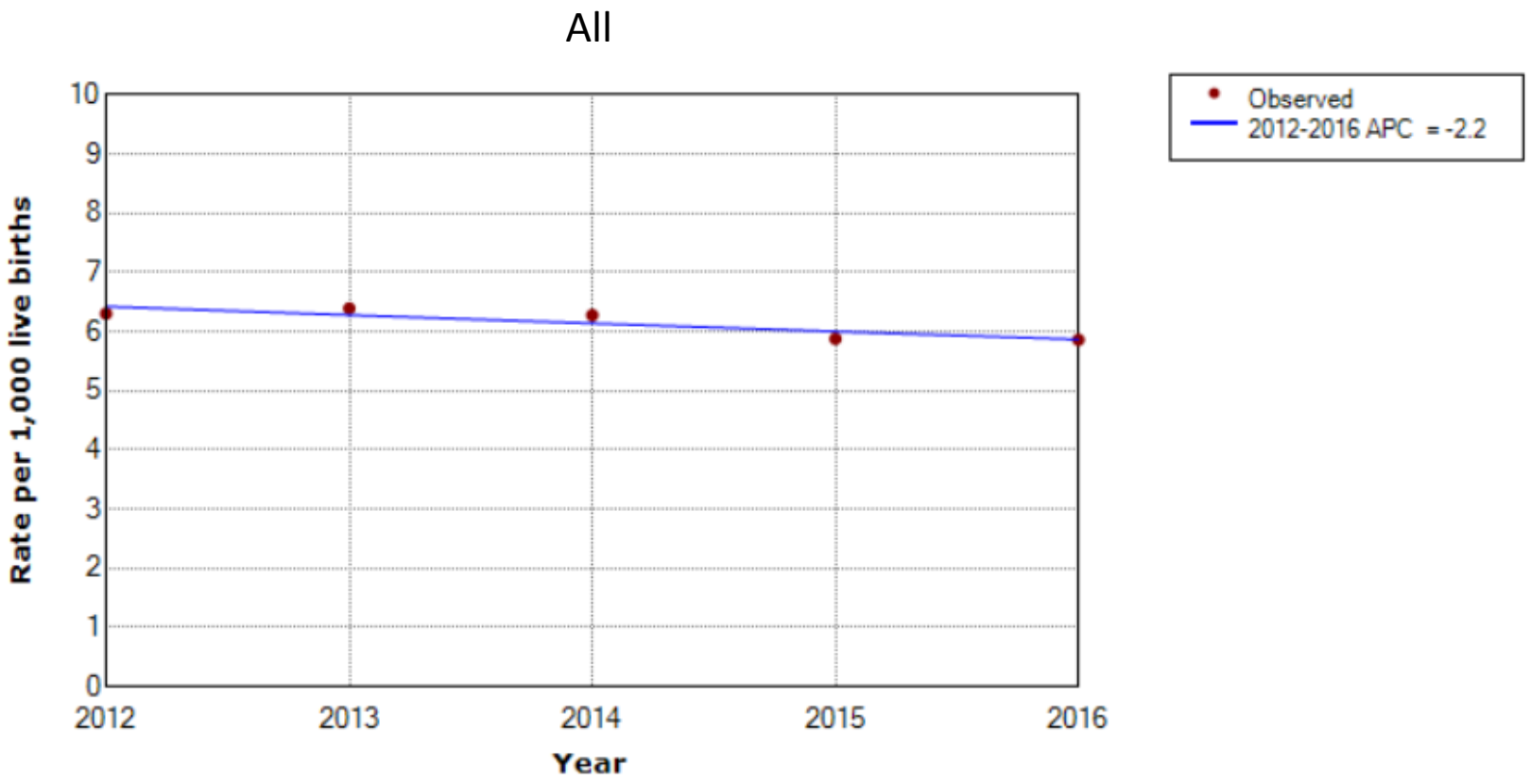
^The Annual Percent Change (APC) is significantly different from zero ($p<0.05$).
Note: Percents are plotted on a logarithmic scale.
Source: Centers for Medicare & Medicaid Services (CMS) Hospital Compare

NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths



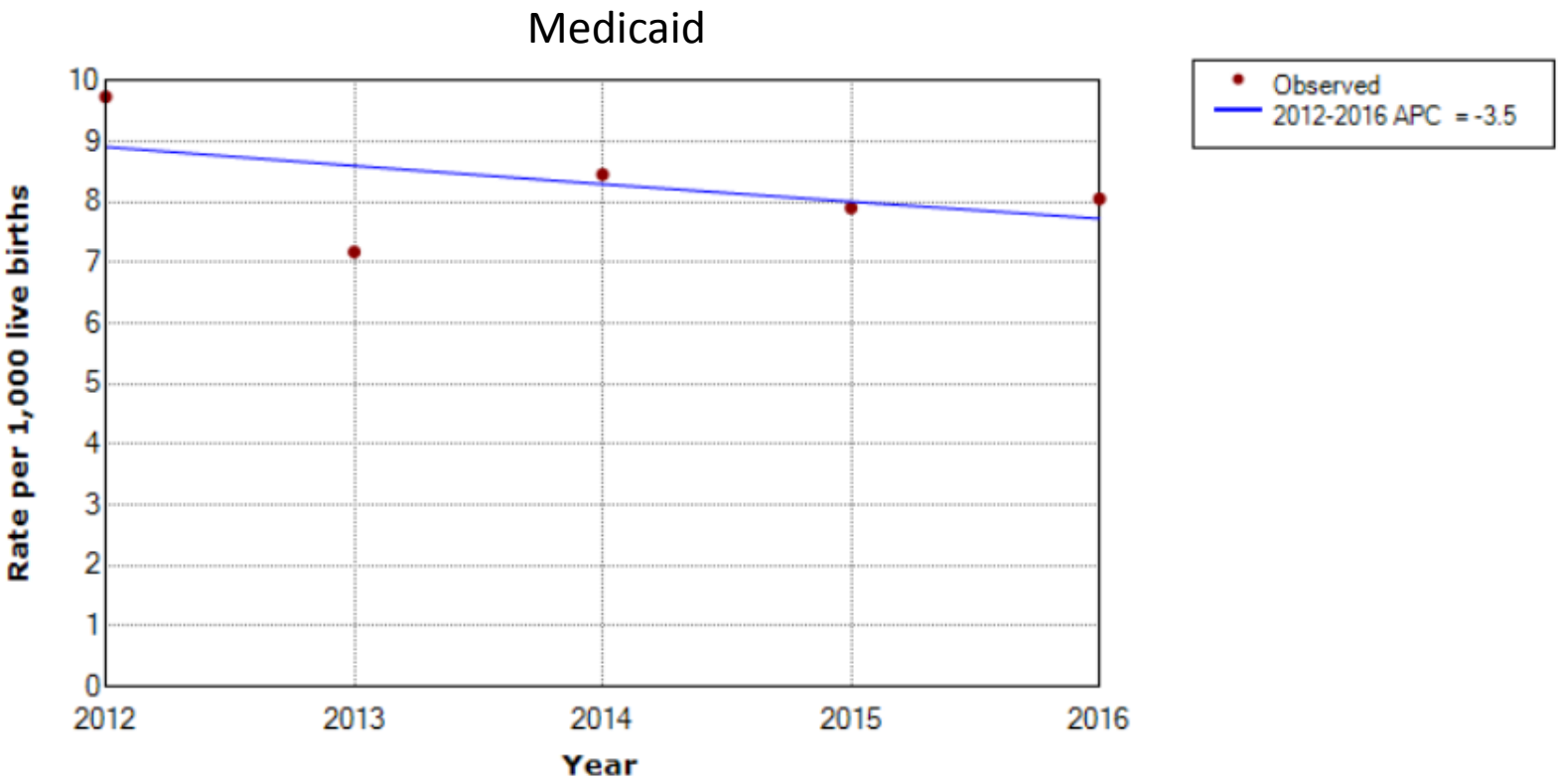
Note: Rates are plotted on a logarithmic scale.
Sources: Bureau of Epidemiology and Public Health Informatics, Kansas death and birth data (resident)

NOM 9.1: Infant mortality rate per 1,000 live births



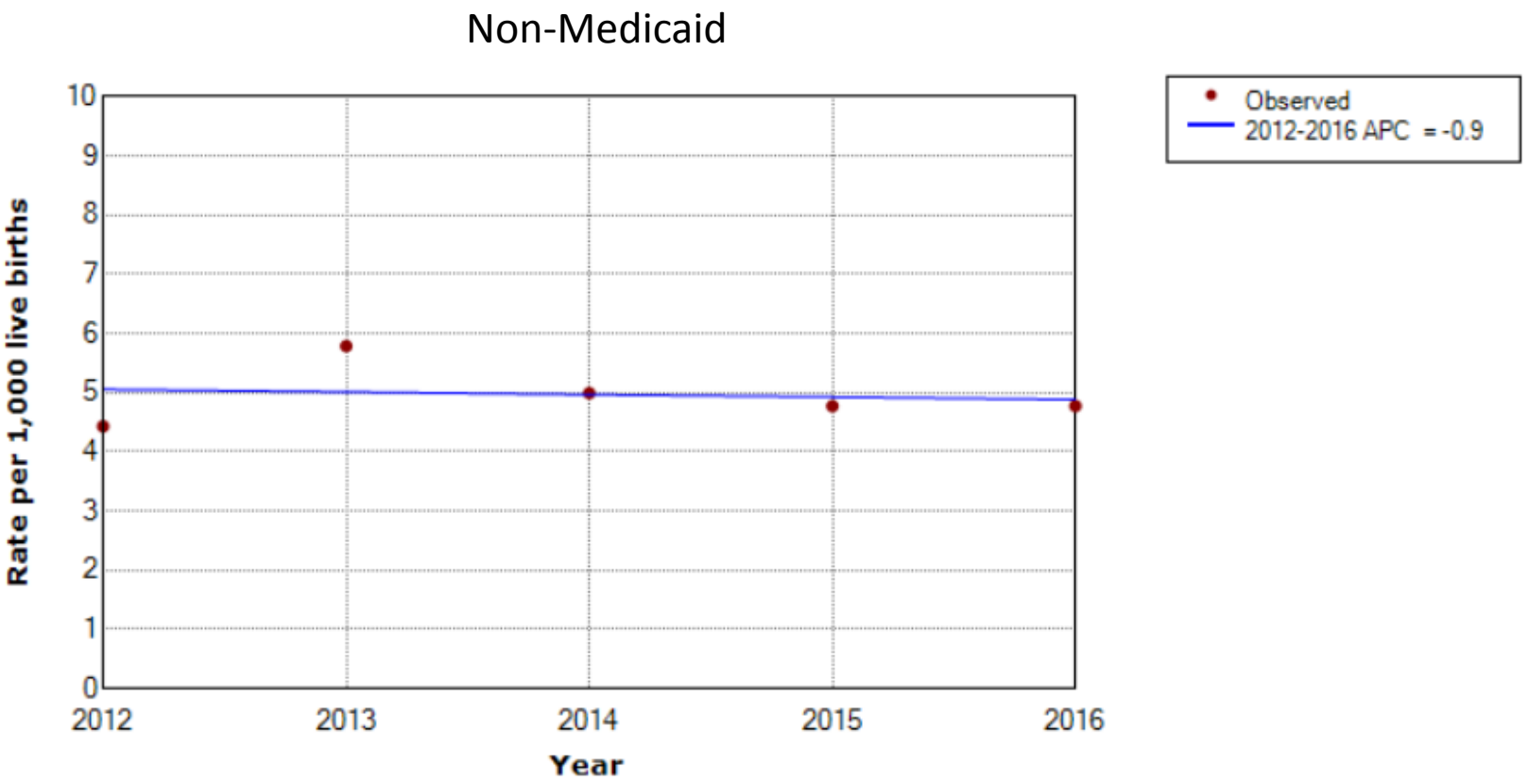
Note: Rates are plotted on a logarithmic scale.
Sources: Bureau of Epidemiology and Public Health Informatics, Kansas death and birth data (resident)

NOM 9.1: Infant mortality rate per 1,000 live births



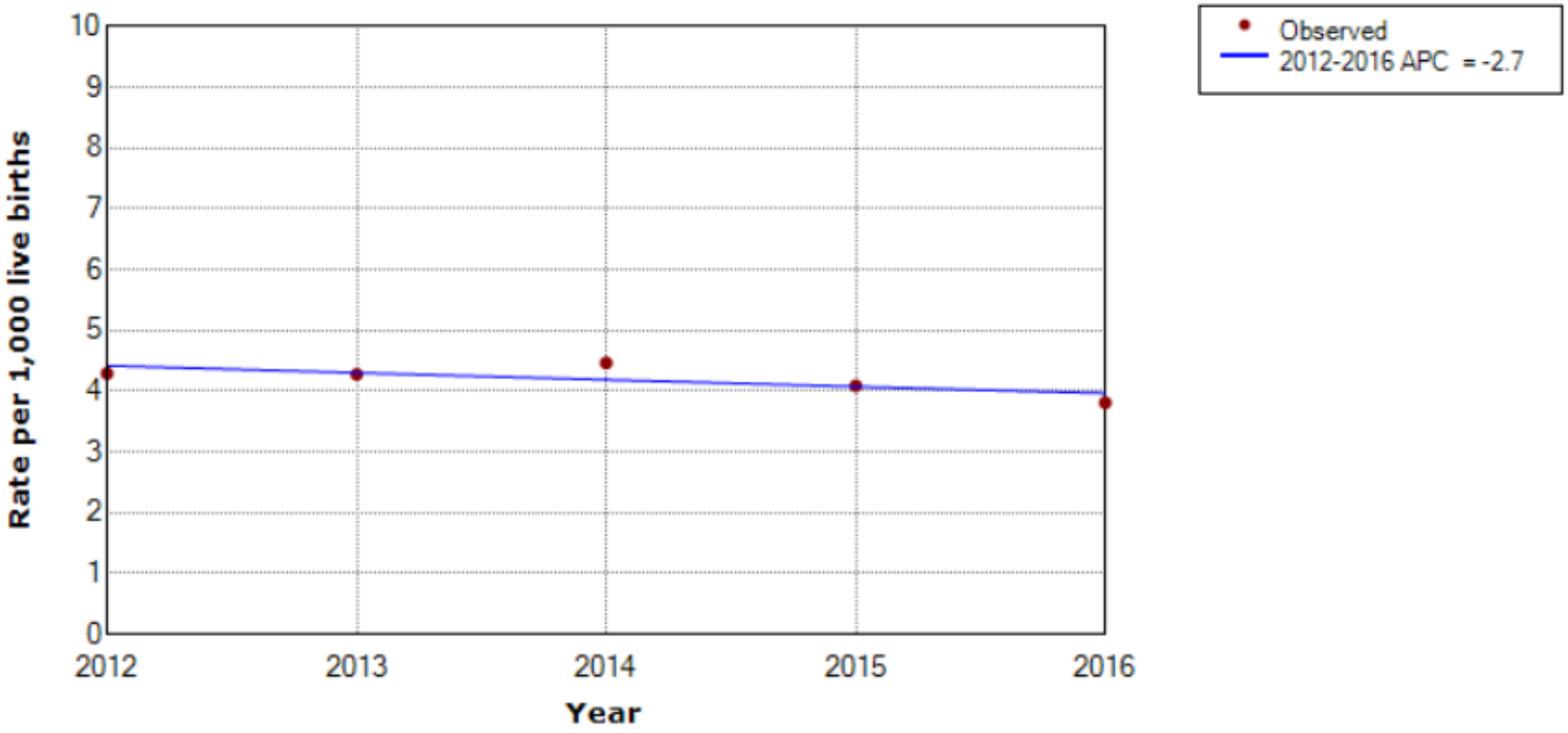
Note: Rates are plotted on a logarithmic scale.
Sources: Bureau of Epidemiology and Public Health Informatics, Kansas death and birth data (resident)

NOM 9.1: Infant mortality rate per 1,000 live births



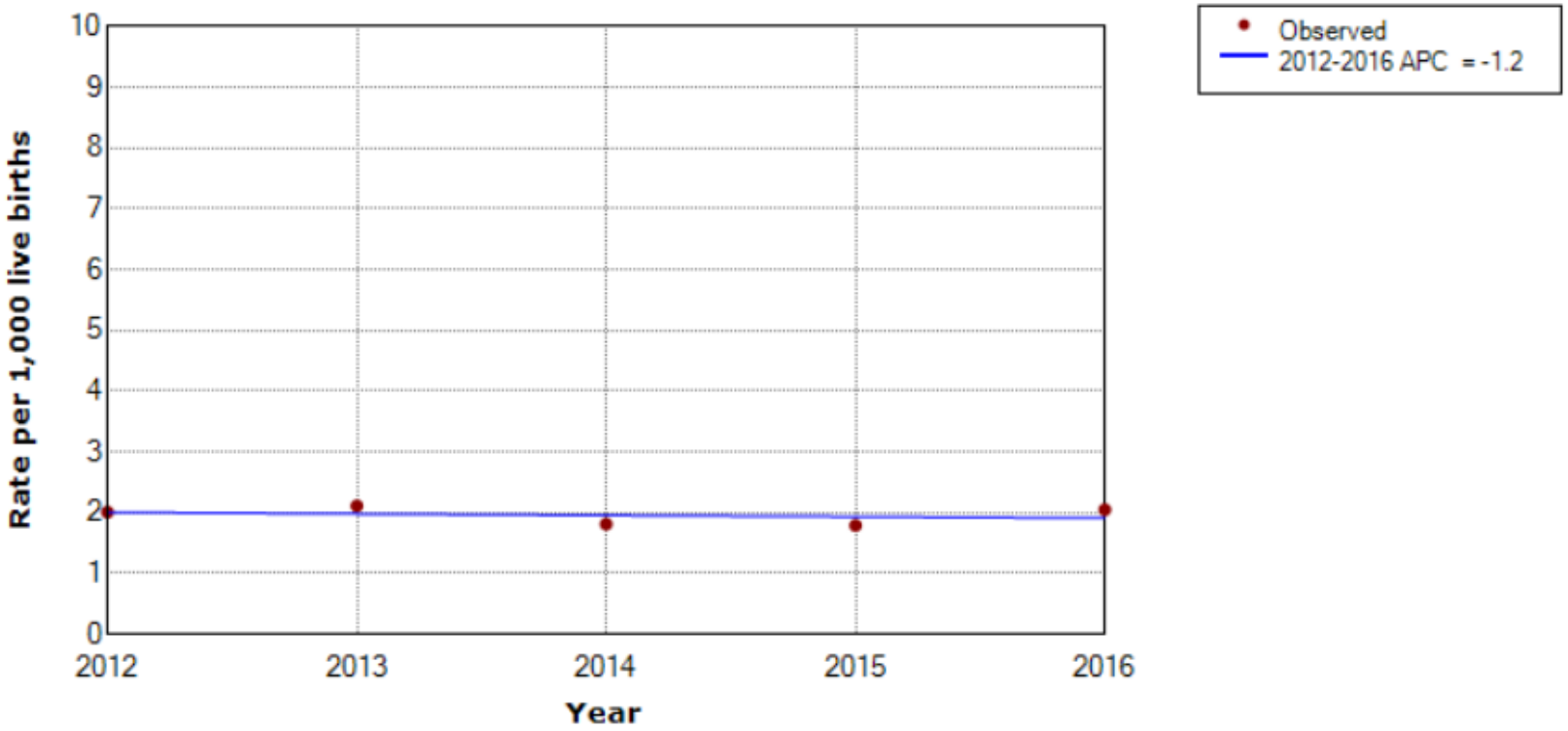
Note: Rates are plotted on a logarithmic scale.
Sources: Bureau of Epidemiology and Public Health Informatics, Kansas death and birth data (resident)

NOM 9.2: Neonatal mortality rate per 1,000 live births



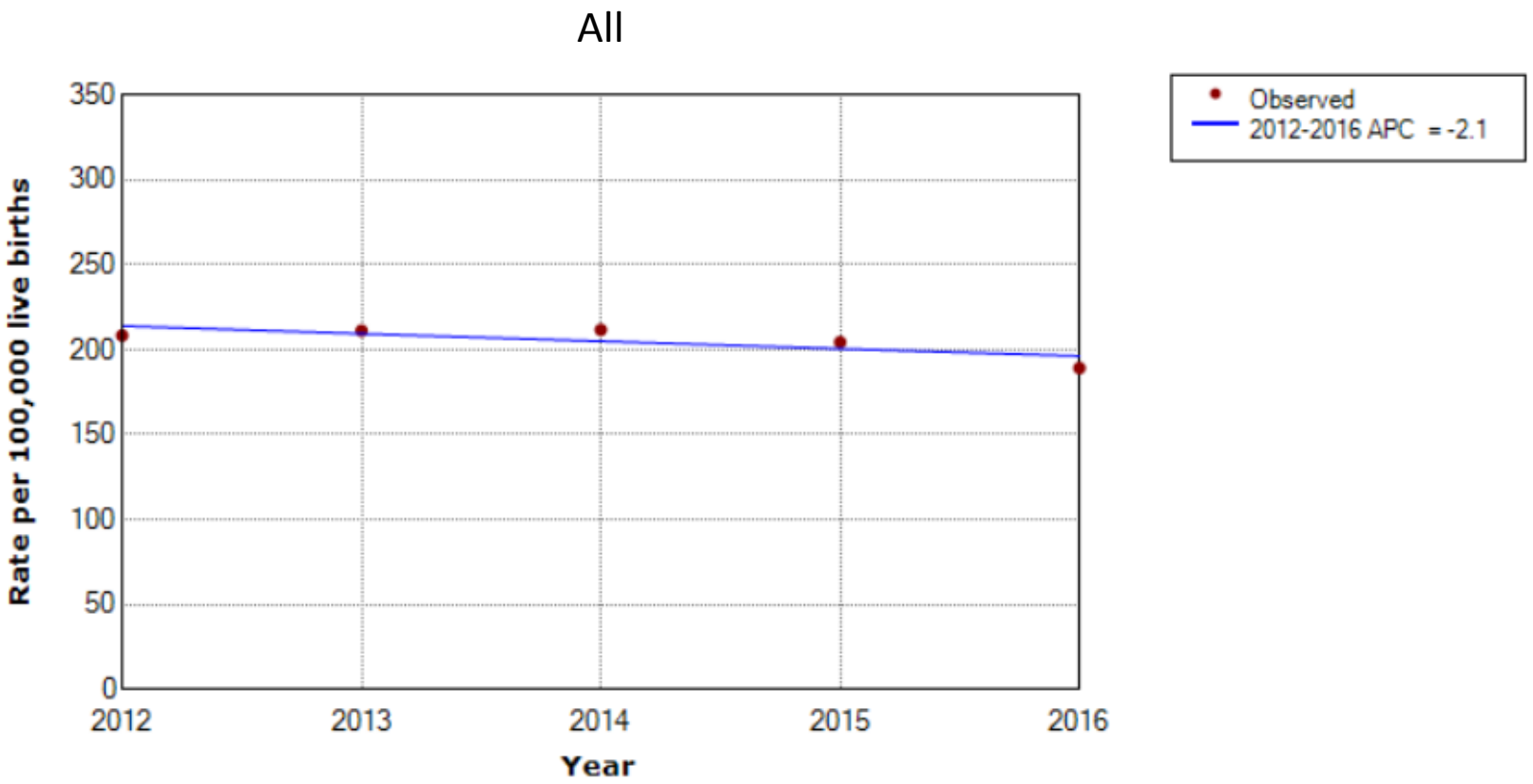
Note: Rates are plotted on a logarithmic scale.
Sources: Bureau of Epidemiology and Public Health Informatics, Kansas death and birth data (resident)

NOM 9.3: Postneonatal mortality rate per 1,000 live births



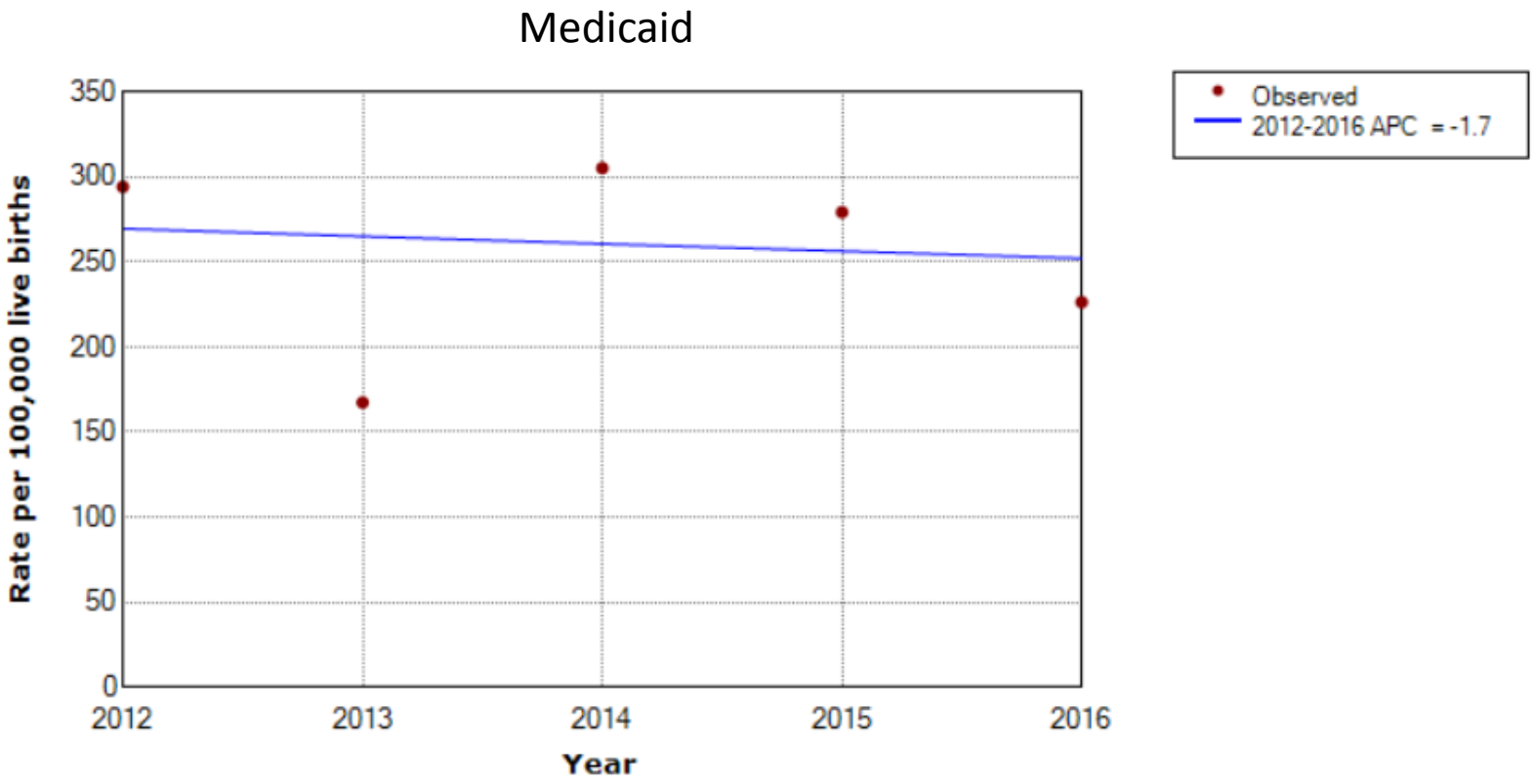
Note: Rates are plotted on a logarithmic scale.
Sources: Bureau of Epidemiology and Public Health Informatics, Kansas death and birth data (resident)

NOM 9.4: Preterm-related mortality rate per 100,000 live births



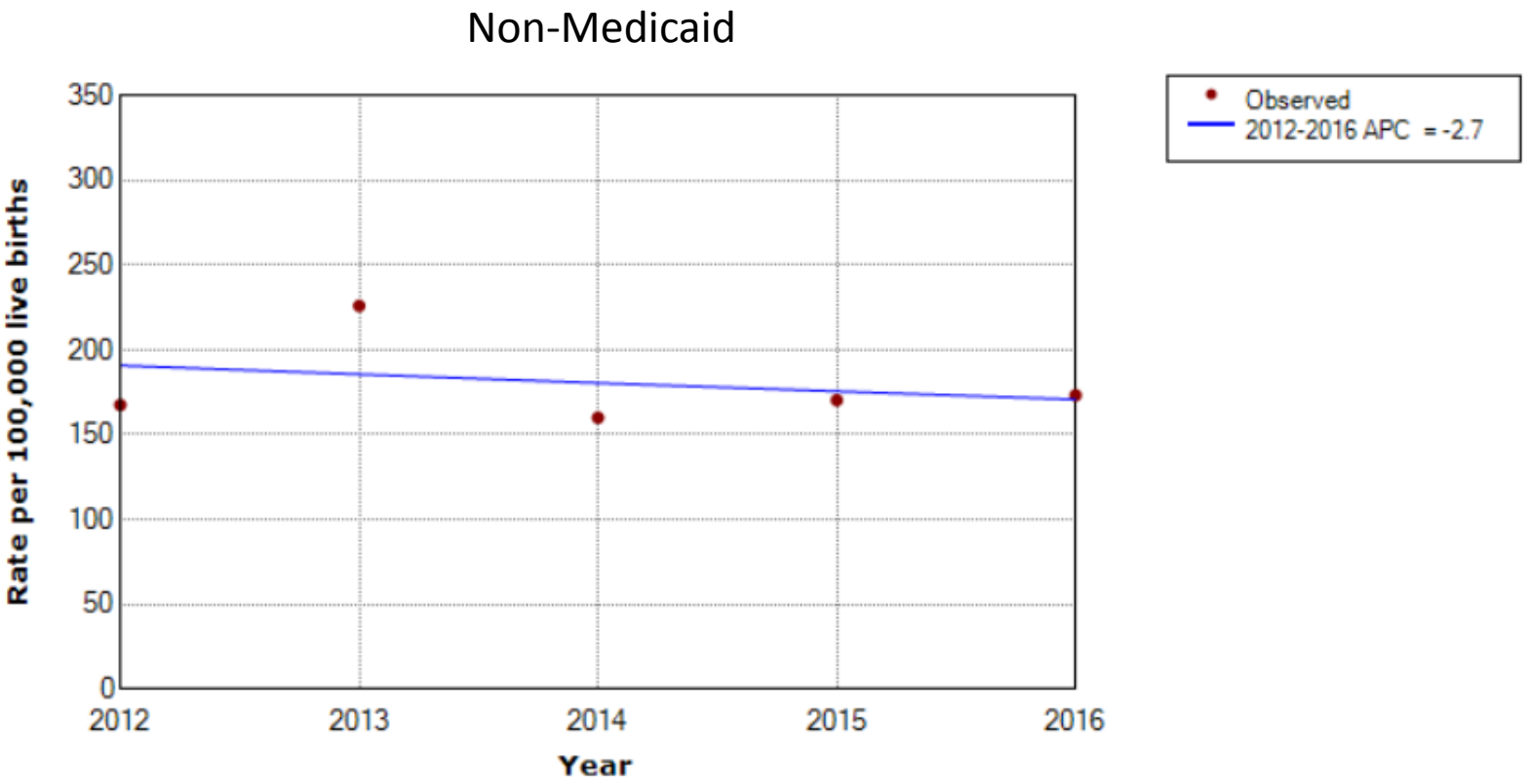
Note: Rates are plotted on a logarithmic scale.
Sources: Bureau of Epidemiology and Public Health Informatics, Kansas death and birth data (resident)

NOM 9.4: Preterm-related mortality rate per 100,000 live births



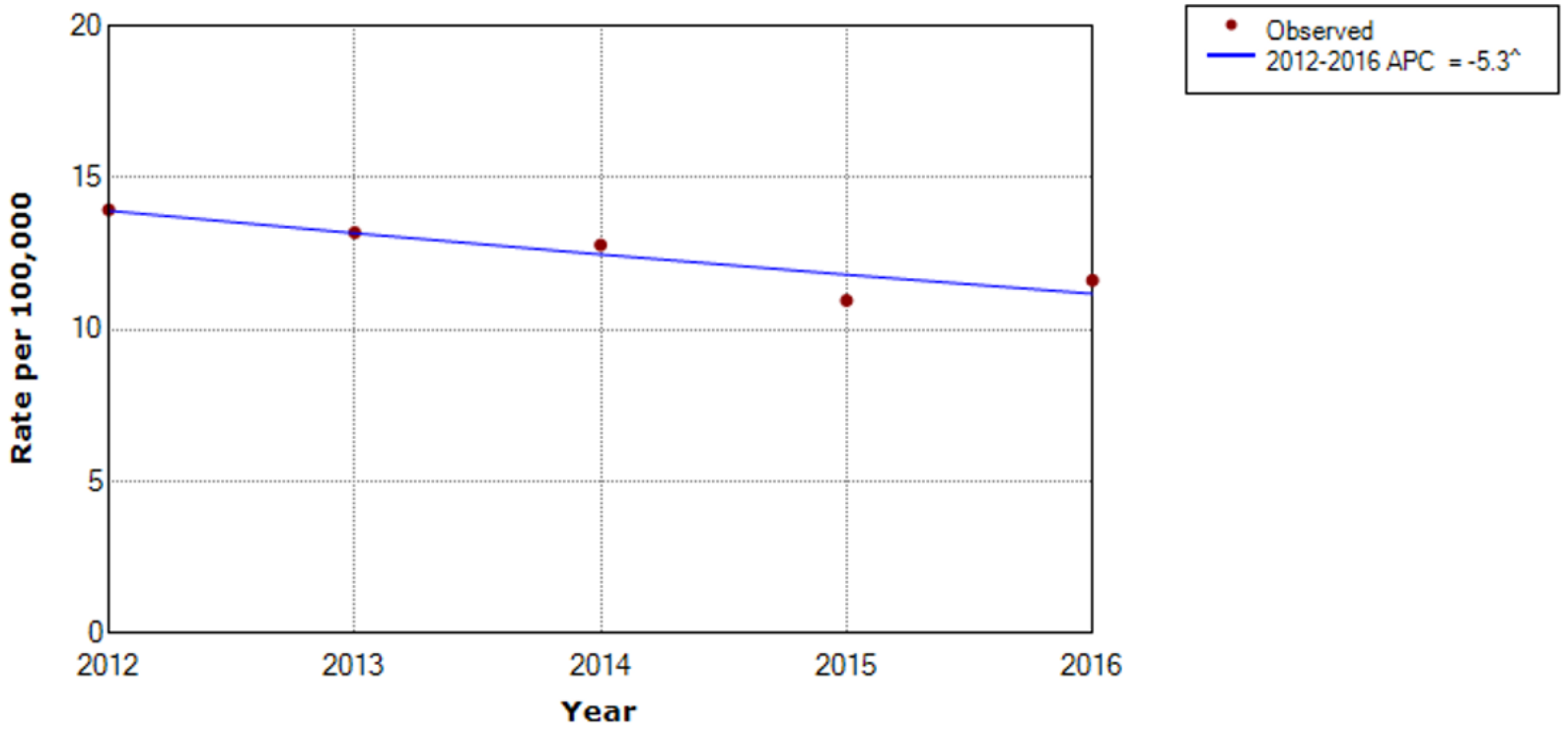
Note: Rates are plotted on a logarithmic scale.
Sources: Bureau of Epidemiology and Public Health Informatics, Kansas death and birth data (resident)

NOM 9.4: Preterm-related mortality rate per 100,000 live births



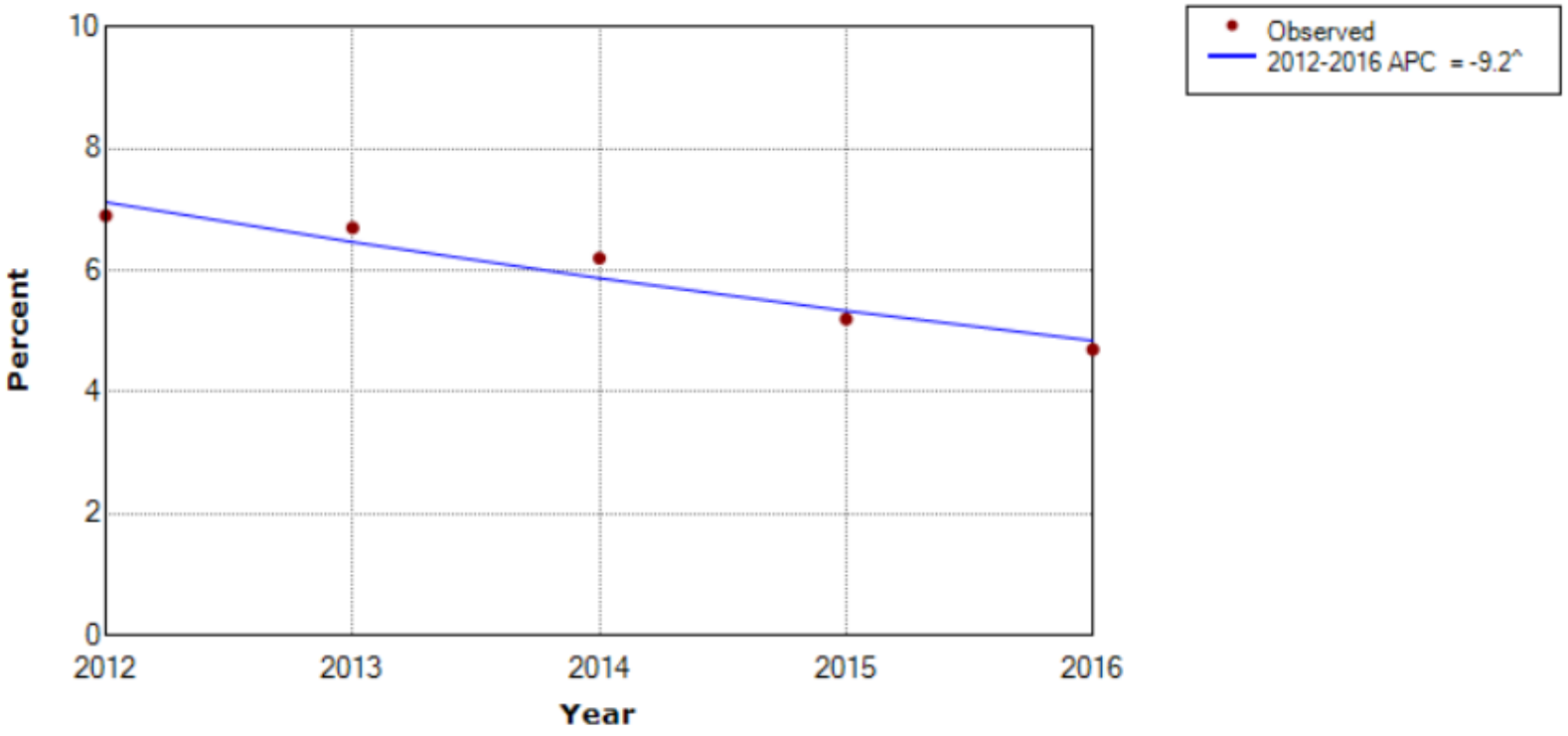
Note: Rates are plotted on a logarithmic scale.
Sources: Bureau of Epidemiology and Public Health Informatics, Kansas death and birth data (resident)

NOM 16.3: Adolescent suicide rate, ages 15 through 19, per 100,000 (3 year rolling average)



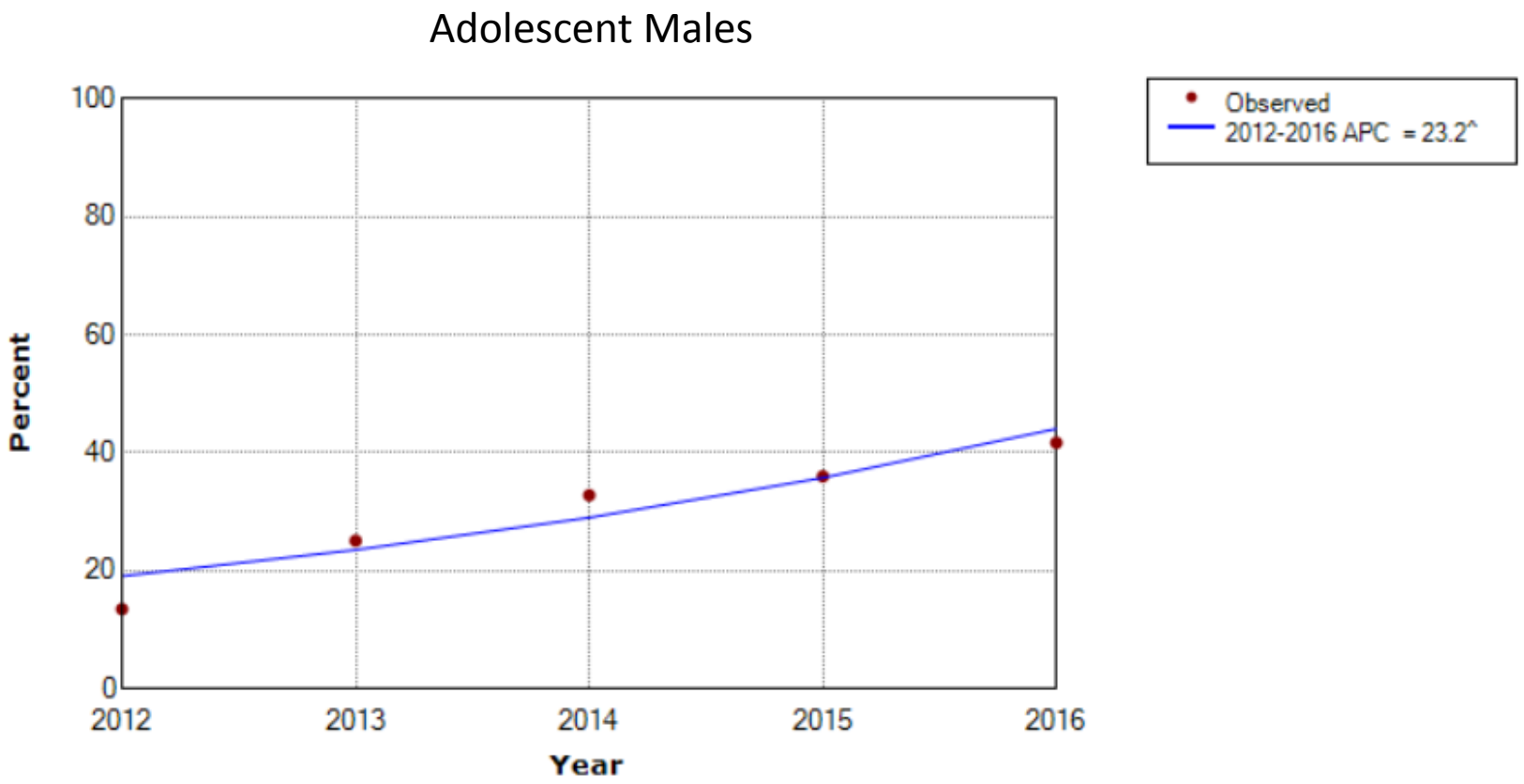
^The Annual Percent Change (APC) is significantly different from zero ($p<0.05$).
Note: Rates are plotted on a logarithmic scale.
Sources: Bureau of Epidemiology and Public Health Informatics, Kansas death data (resident); U.S. Census Bureau, Population estimate, bridged- Race Vintage data set

NOM 21: Percent of children, ages 0 through 17, without health insurance



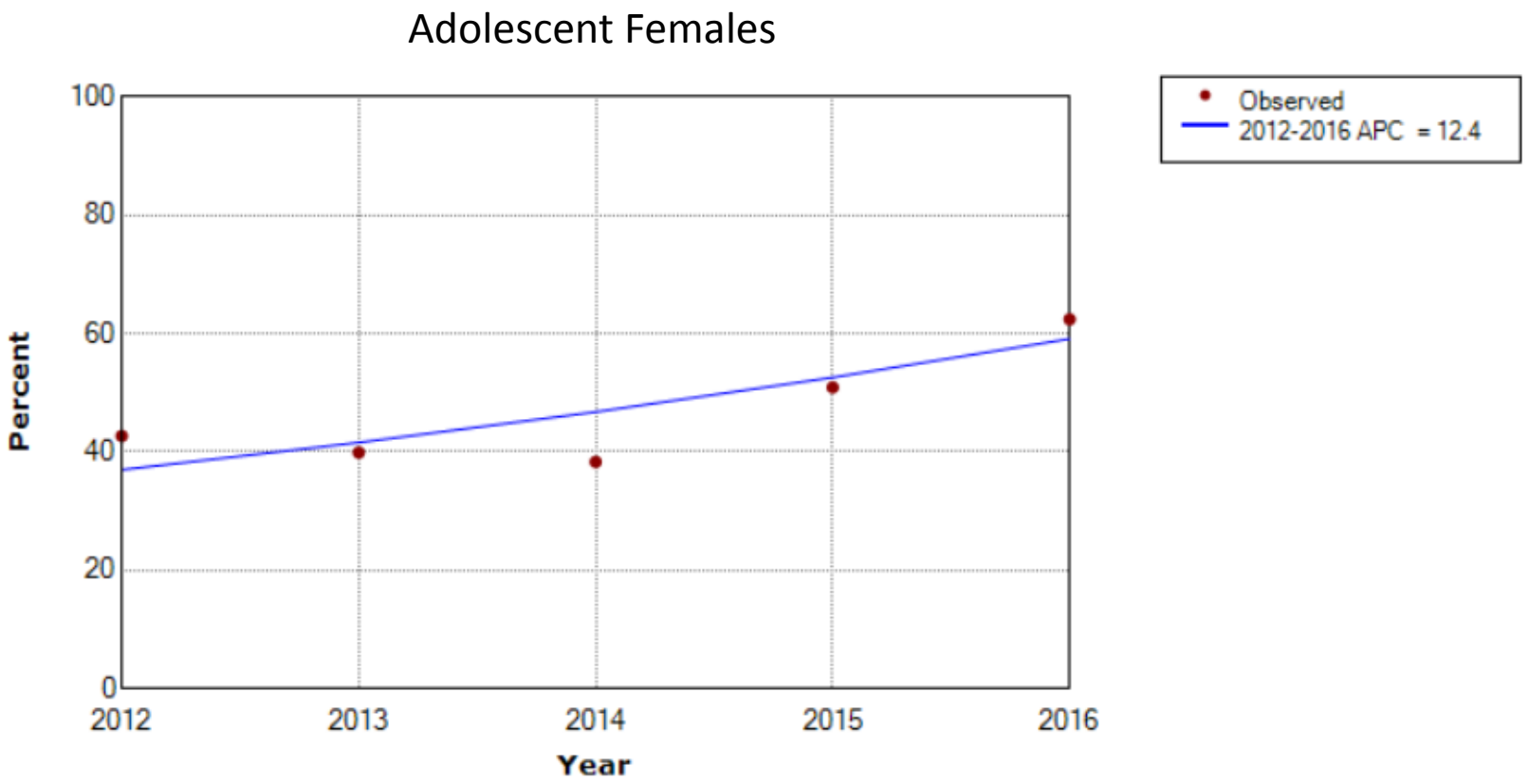
^The Annual Percent Change (APC) is significantly different from zero ($p<0.05$).
Note: Percents are plotted on a logarithmic scale.
Source: U.S. Census Bureau, American Community Survey (ACS)

NOM 22.3: Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine



^The Annual Percent Change (APC) is significantly different from zero ($p<0.05$).
Note: Percents are plotted on a logarithmic scale.
Source: Centers for Disease Control and Prevention (CDC), National Immunization Survey (NIS)

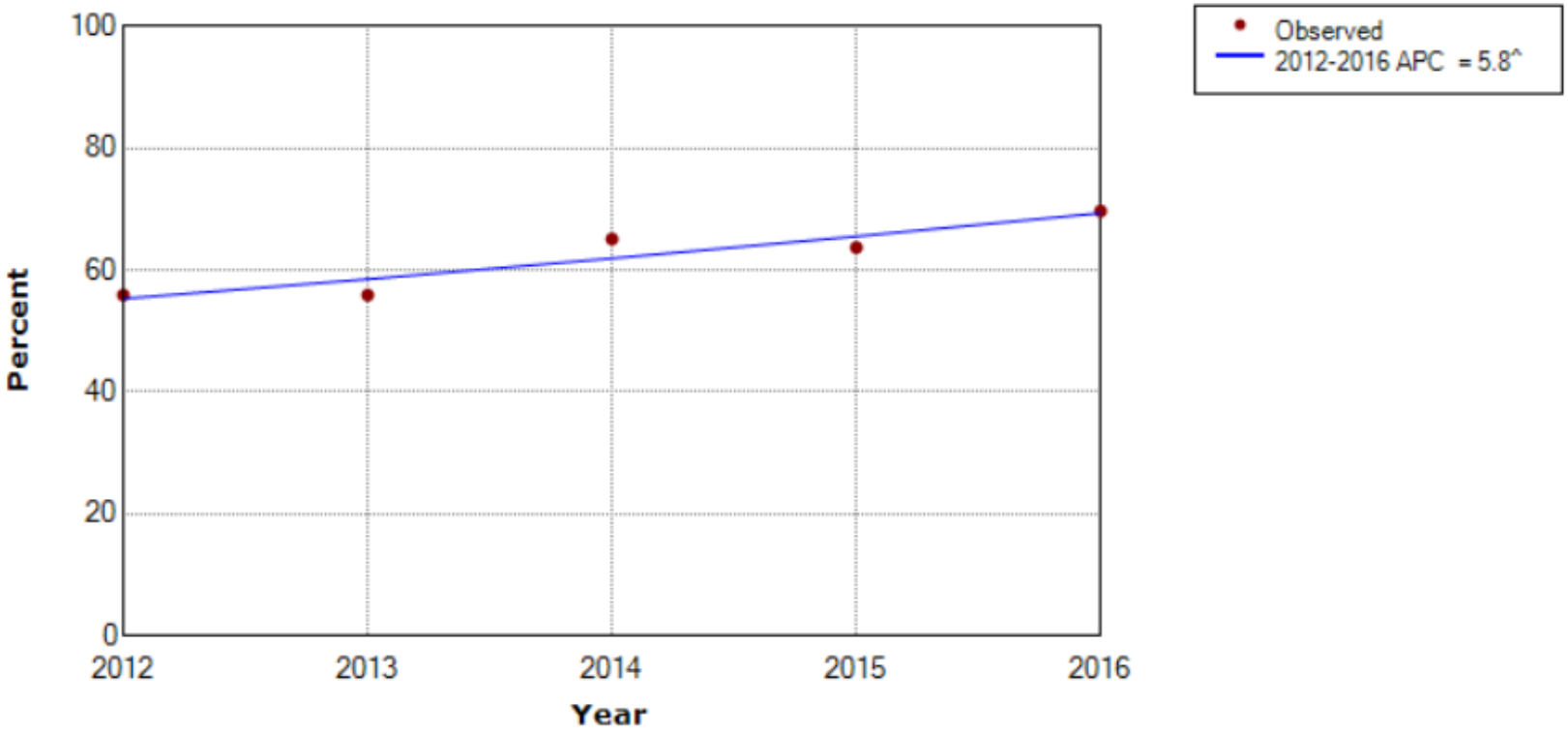
NOM 22.3: Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine



Note: Percents are plotted on a logarithmic scale.
Source: Centers for Disease Control and Prevention (CDC), National Immunization Survey (NIS)

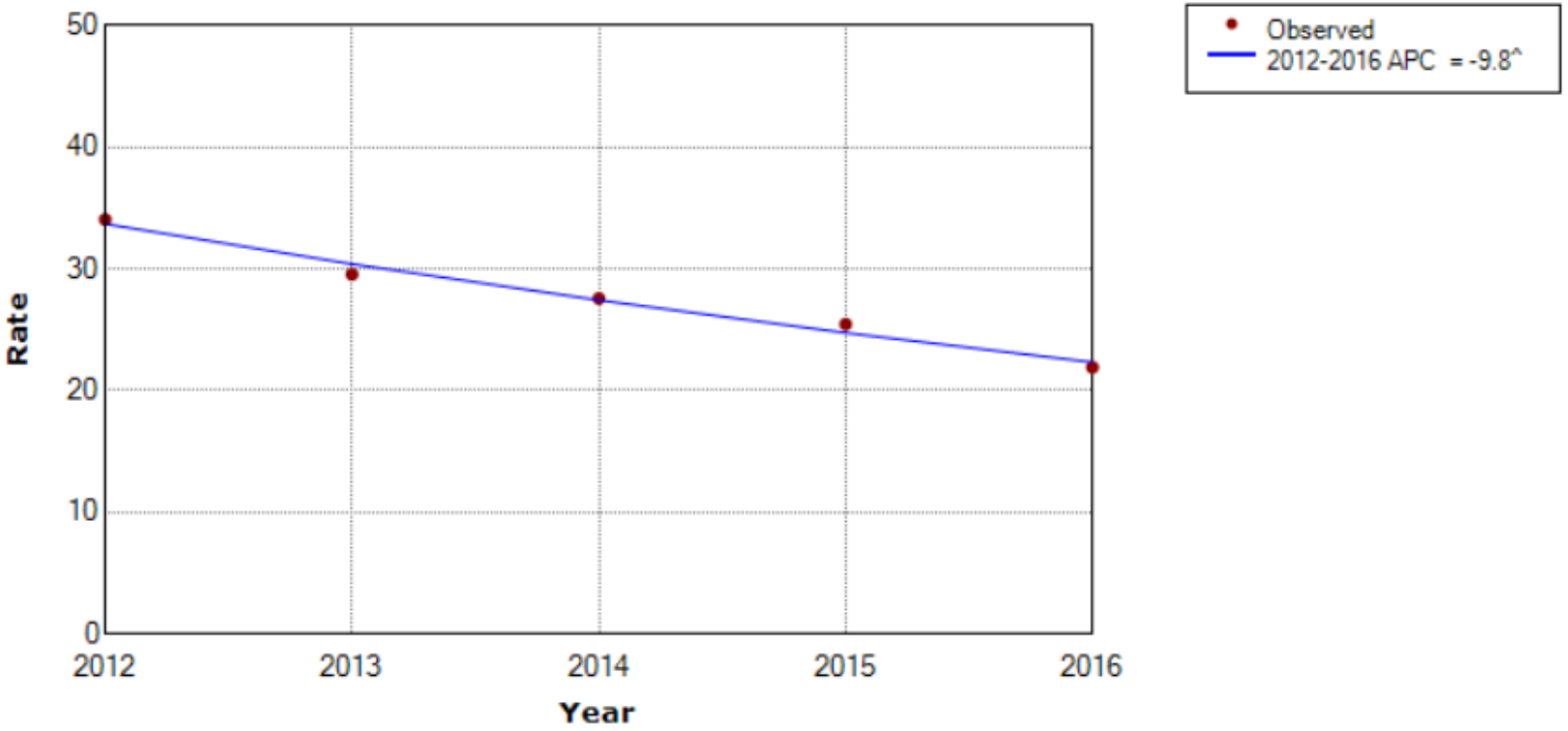
NOM 22.5: Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

KANSAS MATERNAL & CHILD HEALTH



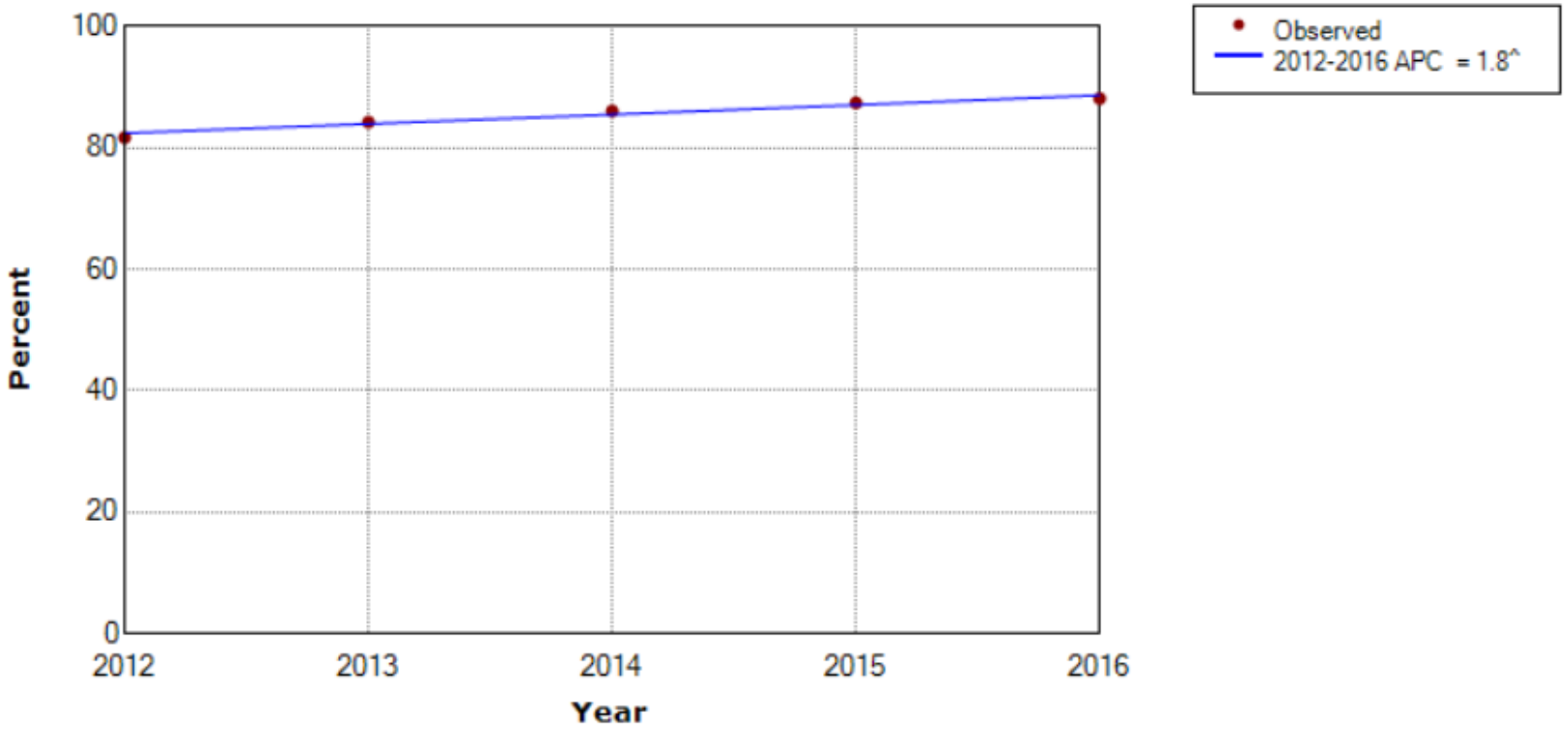
^The Annual Percent Change (APC) is significantly different from zero ($p<0.05$).
Note: Percents are plotted on a logarithmic scale.
Source: Centers for Disease Control and Prevention (CDC), National Immunization Survey (NIS)

NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females



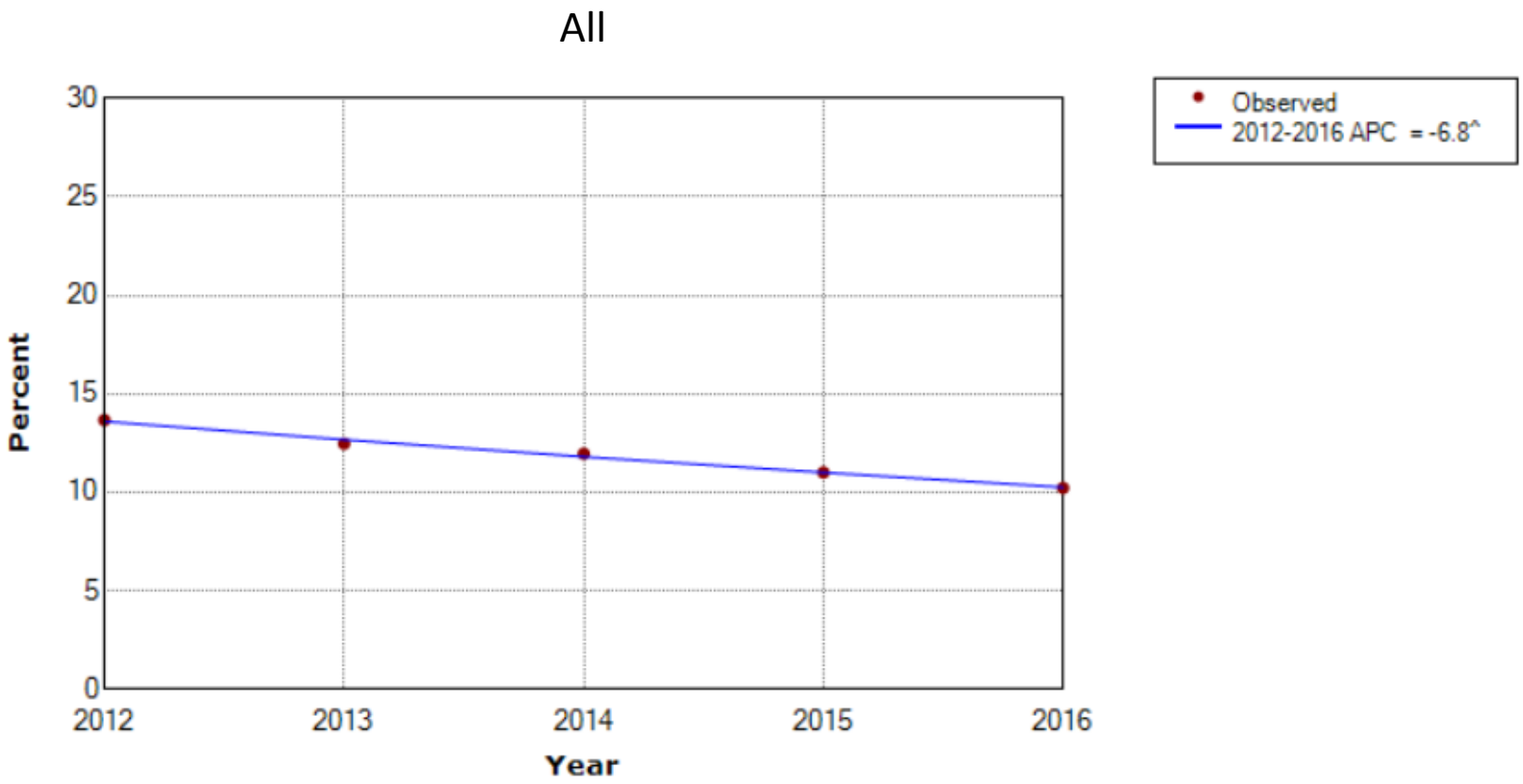
^The Annual Percent Change (APC) is significantly different from zero ($p<0.05$).
Note: Rates are plotted on a logarithmic scale.
Sources: Bureau of Epidemiology and Public Health Informatics, Kansas birth data (resident); U.S. Census Bureau, Population estimate, bridged- Race Vintage data set

NPM 4: Breastfeeding: A) Percent of infants who are ever breastfed



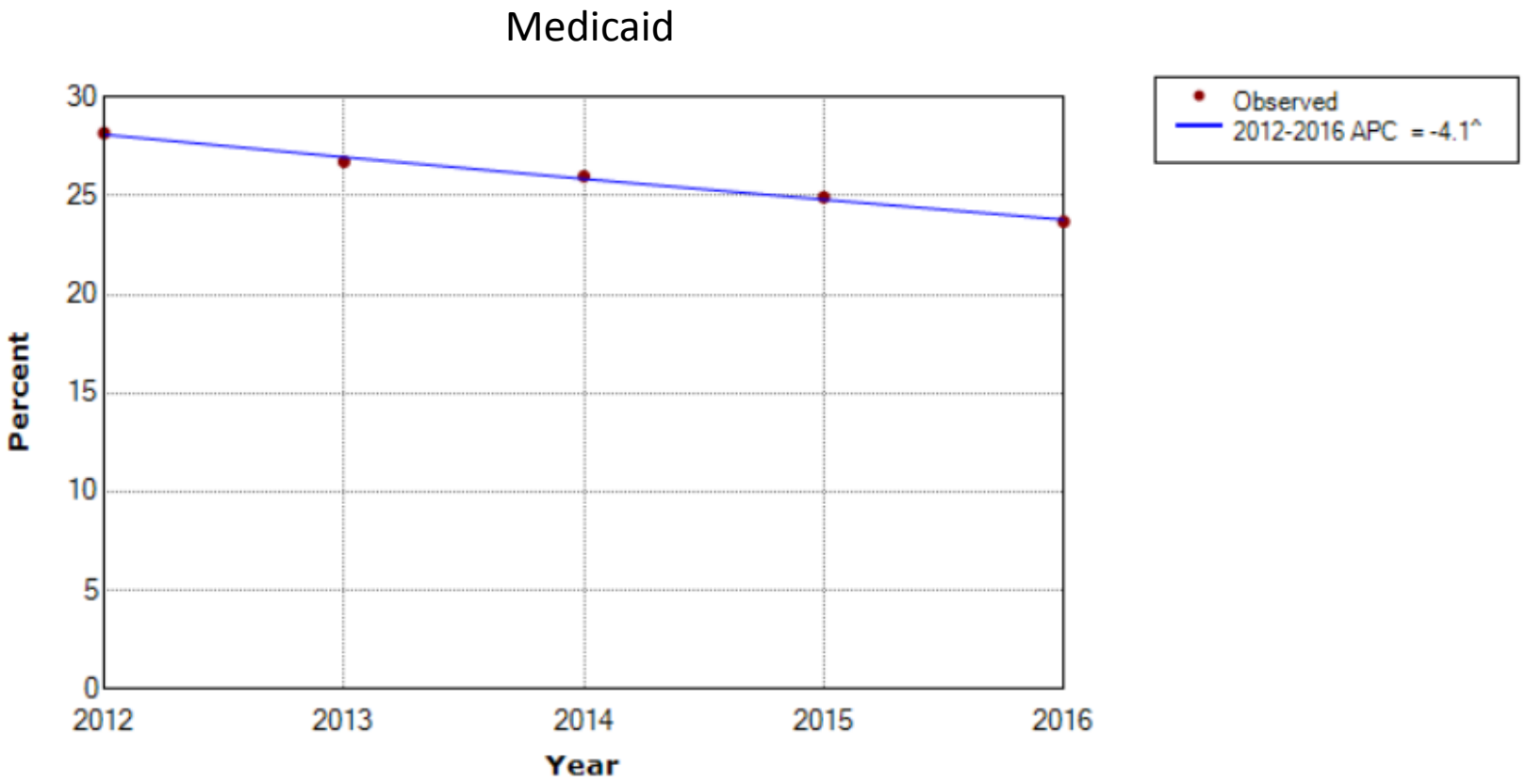
^The Annual Percent Change (APC) is significantly different from zero ($p<0.05$).
Note: Percents are plotted on a logarithmic scale.
Source: Bureau of Epidemiology and Public Health Informatics, Kansas birth data (resident)

NPM 14.1: Percent of women who smoke during pregnancy



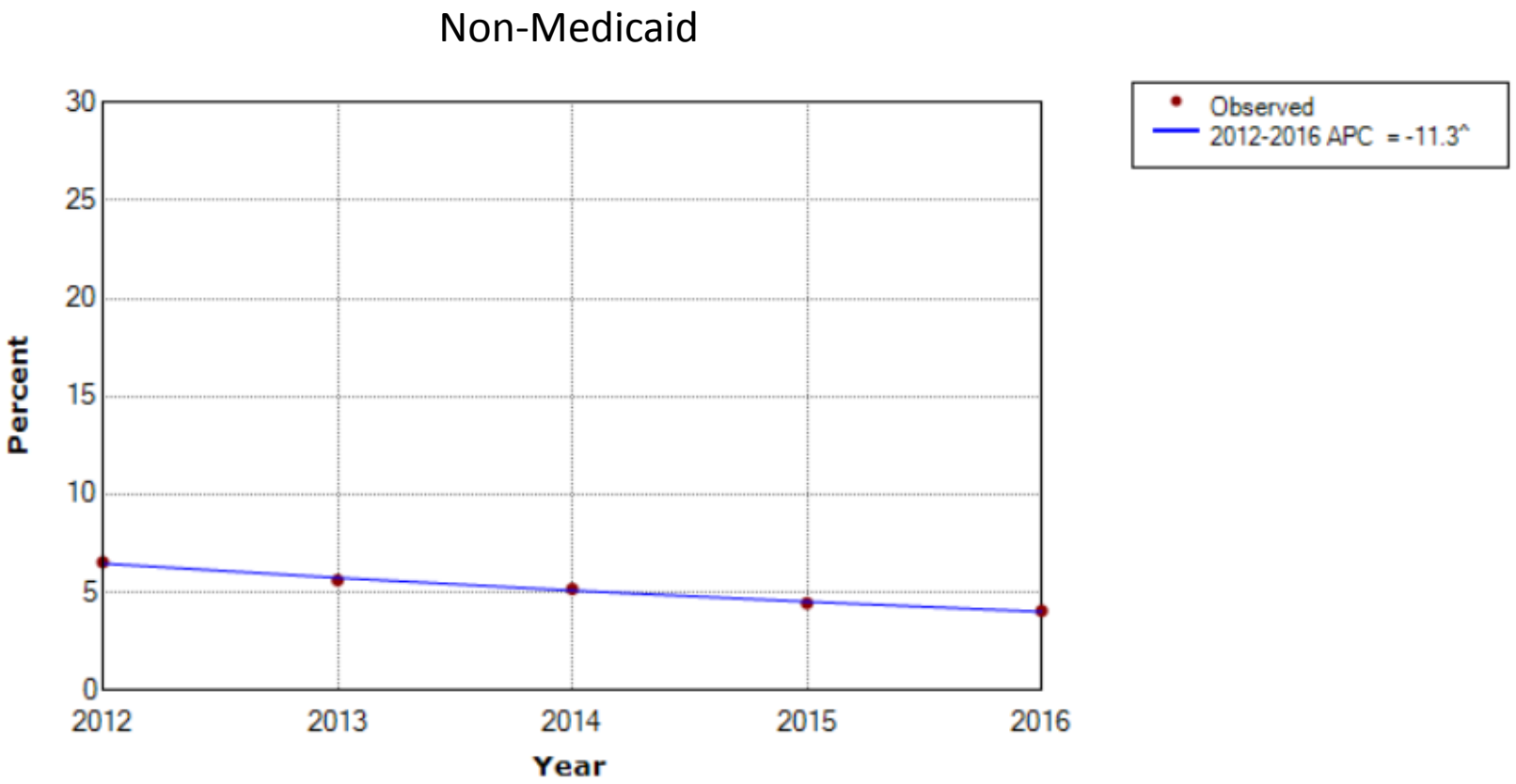
^The Annual Percent Change (APC) is significantly different from zero ($p<0.05$).
Note: Percents are plotted on a logarithmic scale.
Source: Bureau of Epidemiology and Public Health Informatics, Kansas birth data (resident)

NPM 14.1: Percent of women who smoke during pregnancy



^The Annual Percent Change (APC) is significantly different from zero ($p<0.05$).
Note: Percents are plotted on a logarithmic scale.
Source: Bureau of Epidemiology and Public Health Informatics, Kansas birth data (resident)

NPM 14.1: Percent of women who smoke during pregnancy

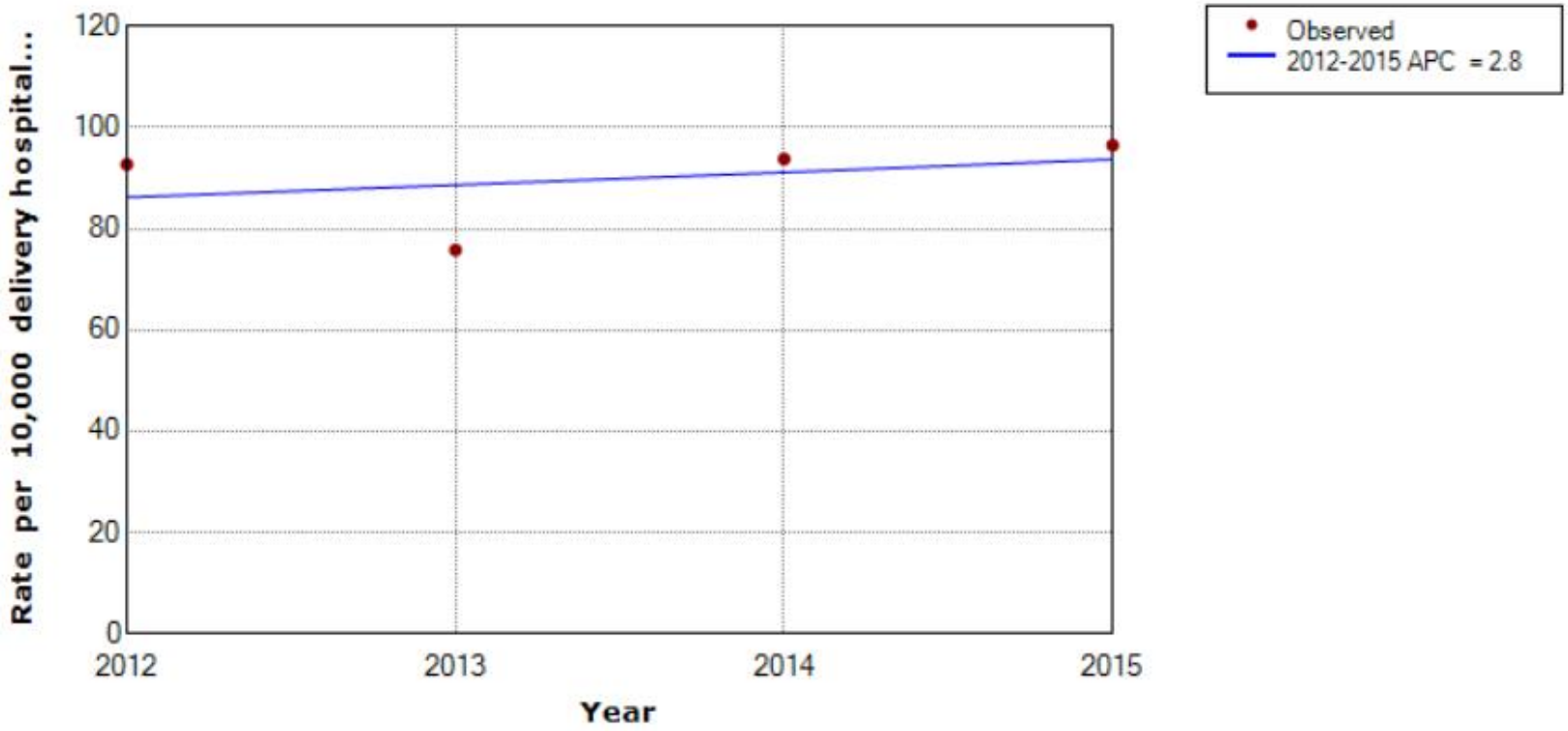


^The Annual Percent Change (APC) is significantly different from zero ($p<0.05$).
Note: Percents are plotted on a logarithmic scale.
Source: Bureau of Epidemiology and Public Health Informatics, Kansas birth data (resident)

KANSAS MATERNAL & CHILD HEALTH

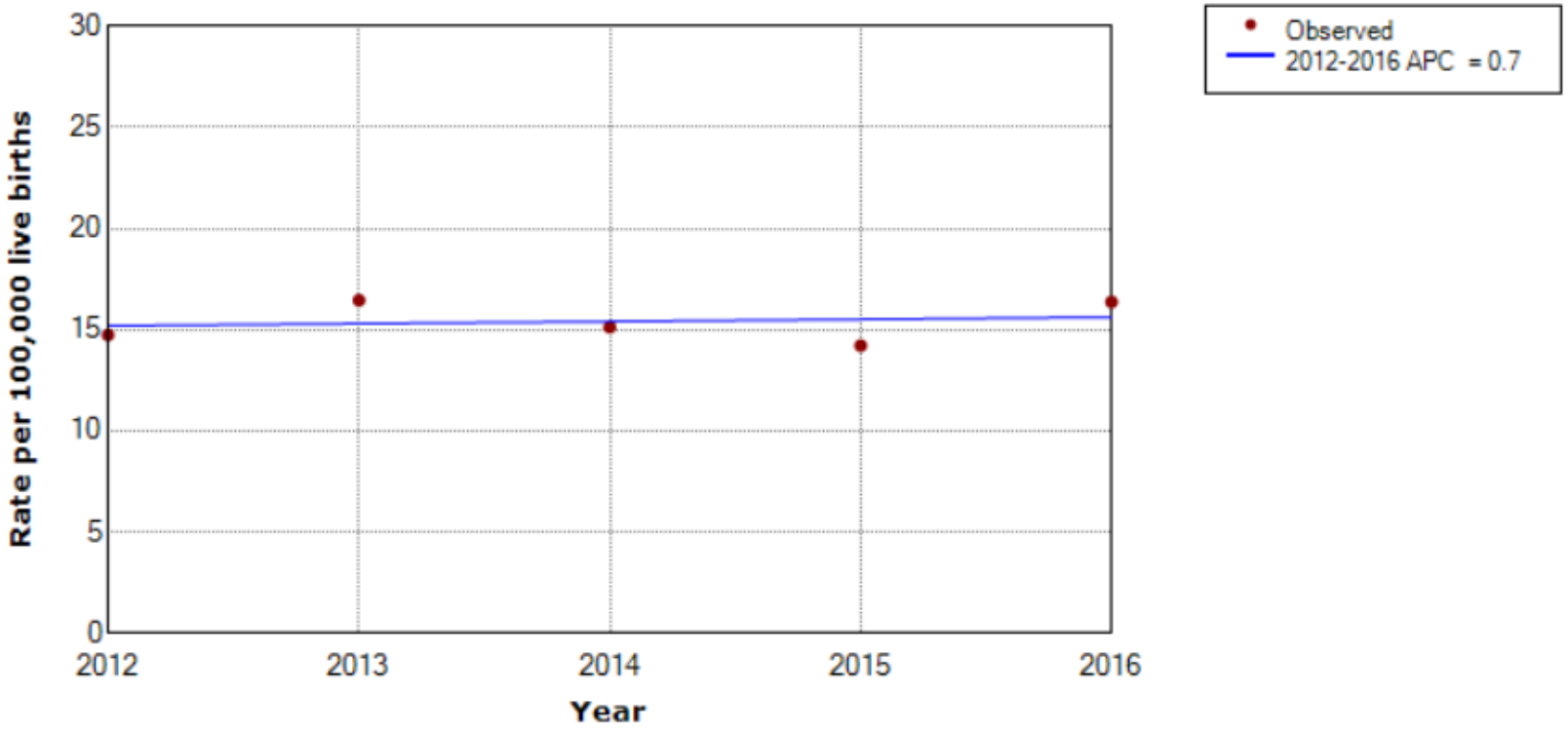
Negative Trends

NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations



Note: Rates are plotted on a logarithmic scale.
Source: Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP) – State Inpatient Database (SID)

NOM 3: Maternal mortality rate per 100,000 live births (5 year rolling average)

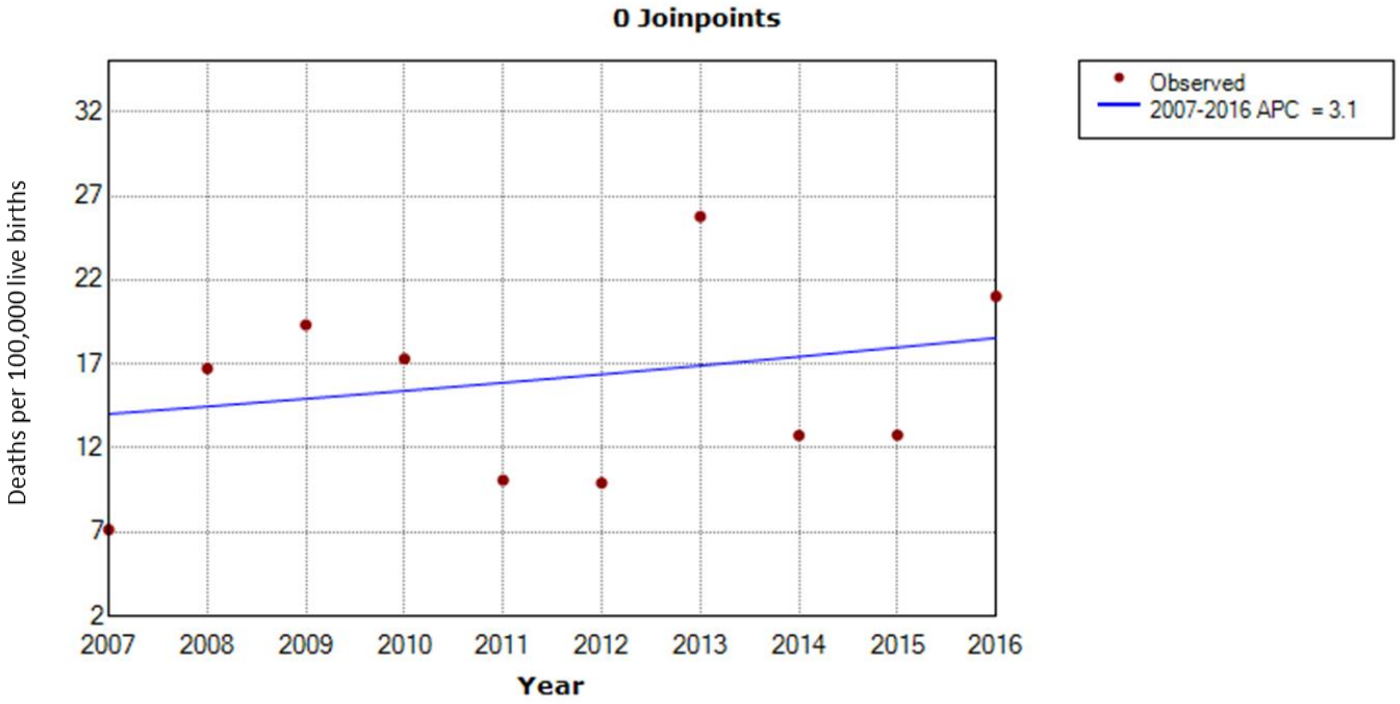


Note: Rates are plotted on a logarithmic scale.
Sources: Bureau of Epidemiology and Public Health Informatics, Kansas death and birth data (resident)

Kansas Maternal Mortality Rates (MMR)*, 2007-2016

KANSAS MATERNAL & CHILD HEALTH

Trend: Although not statistically significant, the Kansas maternal mortality rate ***increased by 3.1% per year*** [95% Confidence Intervals (CI): -6.4, 13.7] during the period 2007-2016.



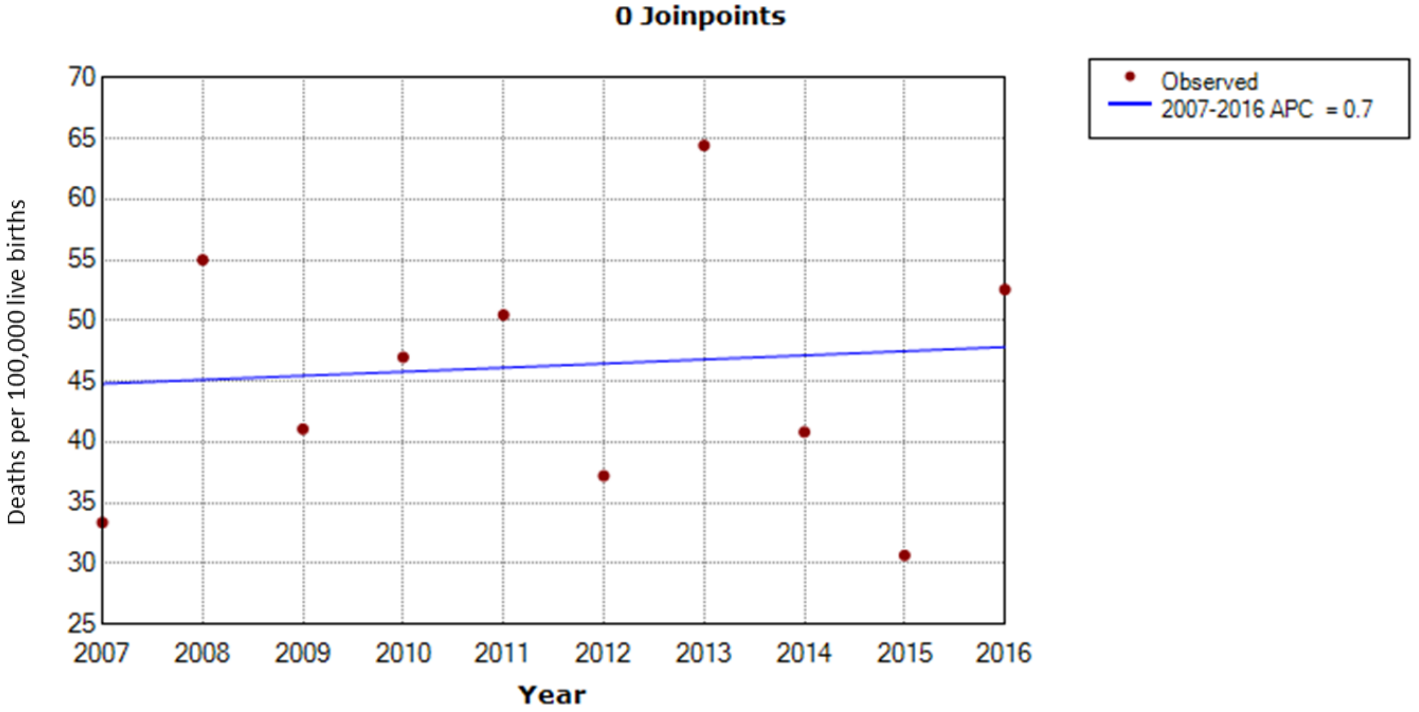
*Rate: Deaths per 100,000 live births

Source: 2007-2016 Kansas Vital Statistics, Bureau of Epidemiology and Public Health Informatics, KDHE

Kansas Pregnancy Associated Mortality Rates (PAMR)*, 2007-2016

KANSAS MATERNAL & CHILD HEALTH

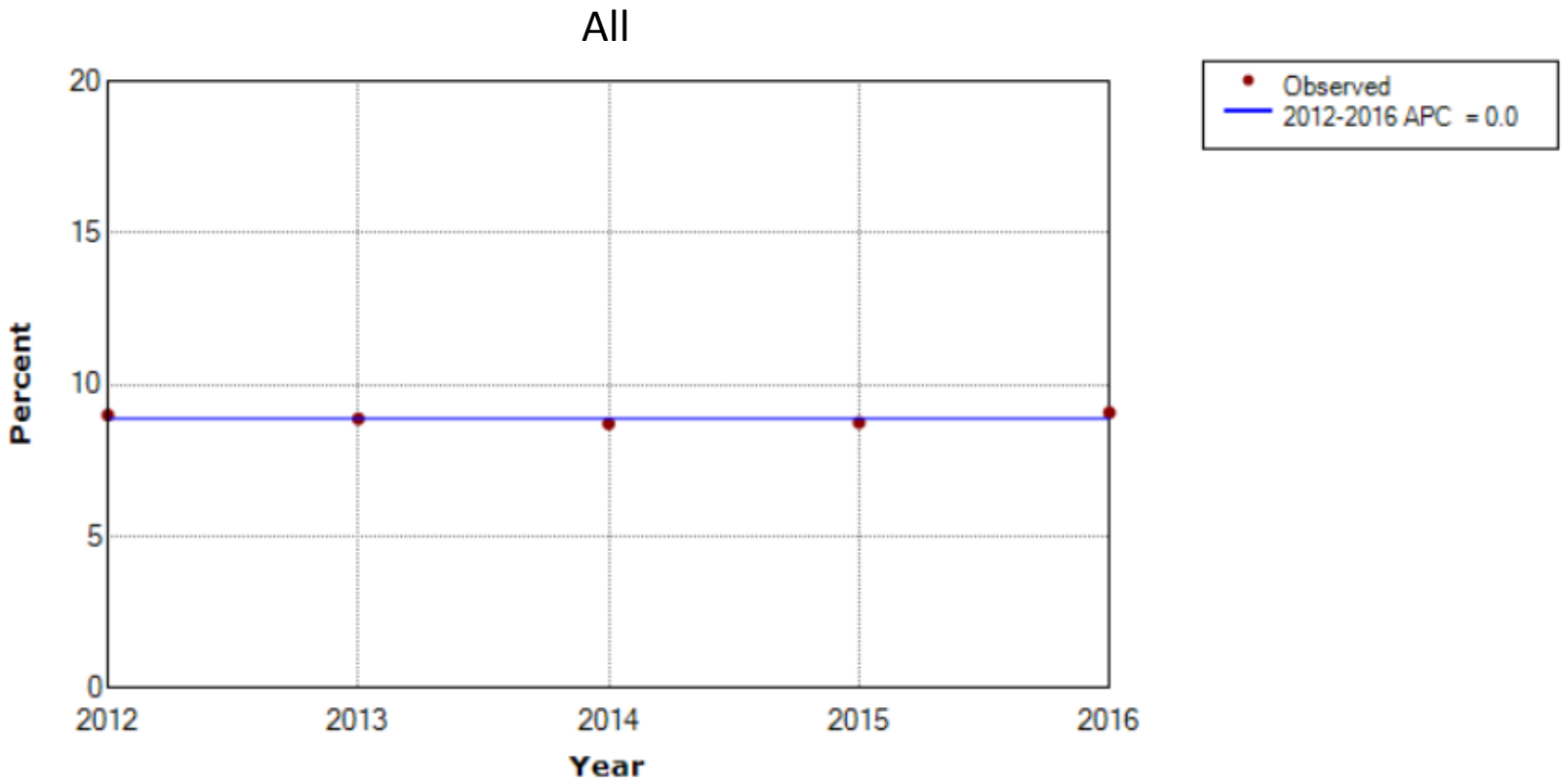
Trend: Although not statistically significant, the Kansas pregnancy associated mortality rate increased by 0.7% per year [95% Confidence Intervals (CI): -5.4, 7.3] during the period 2007-2016.



*Rate: Deaths per 100,000 live births

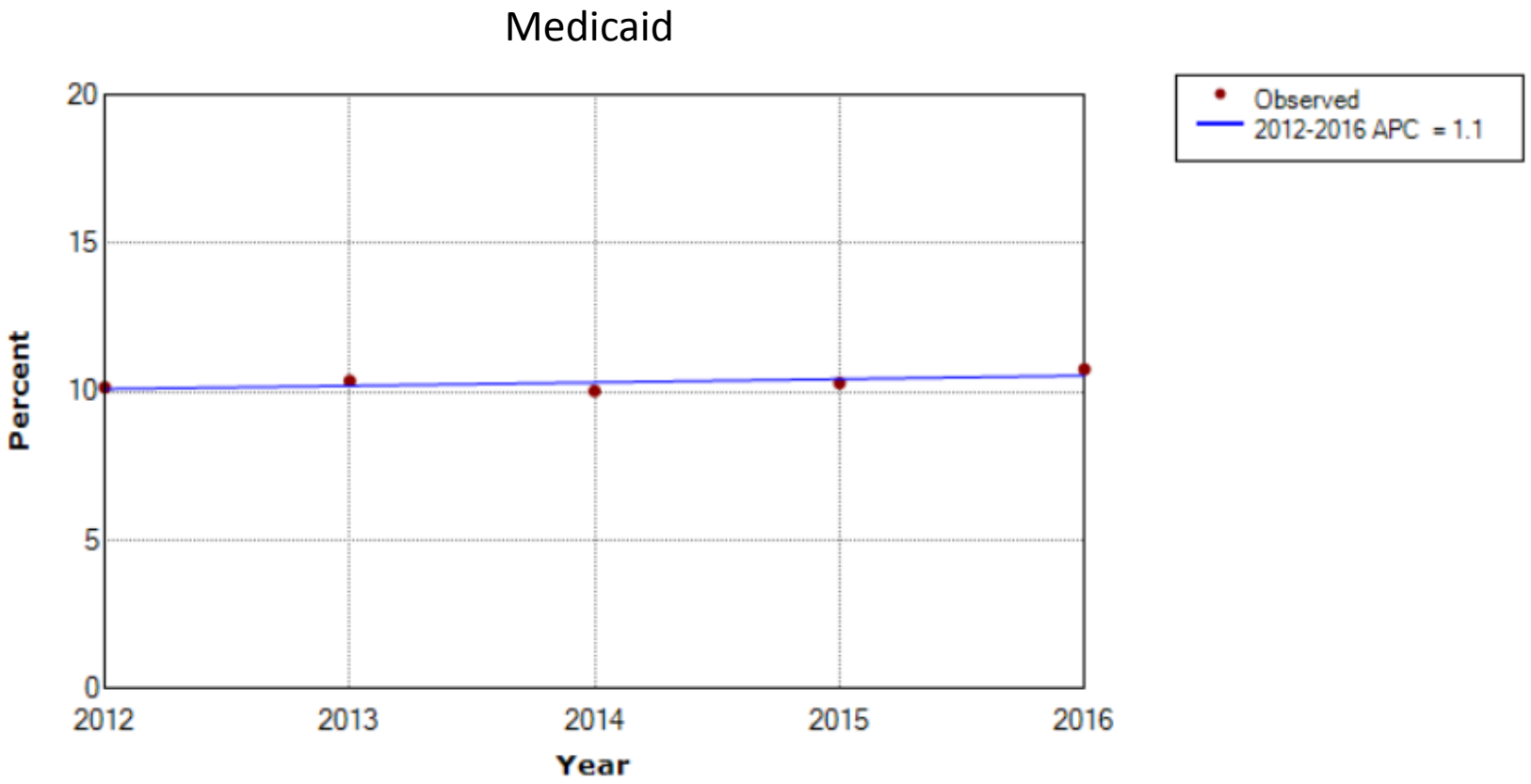
Source: 2007-2016 Kansas Vital Statistics, Bureau of Epidemiology and Public Health Informatics, KDHE

NOM 5/SPM 1: Percent of preterm births (<37 weeks gestation)



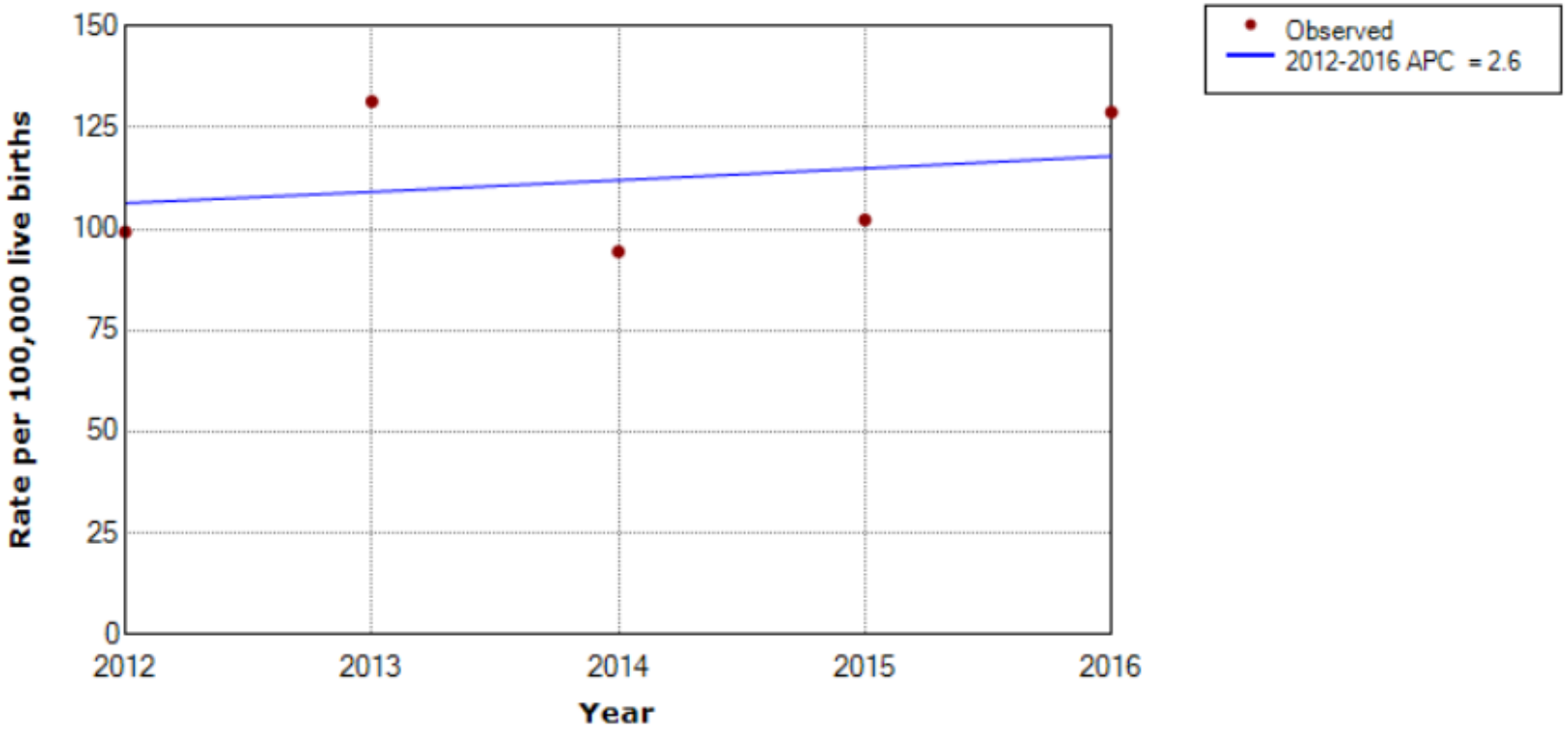
Note: Percents are plotted on a logarithmic scale.
Source: Bureau of Epidemiology and Public Health Informatics, Kansas birth data (resident)

NOM 5/SPM 1: Percent of preterm births (<37 weeks gestation)



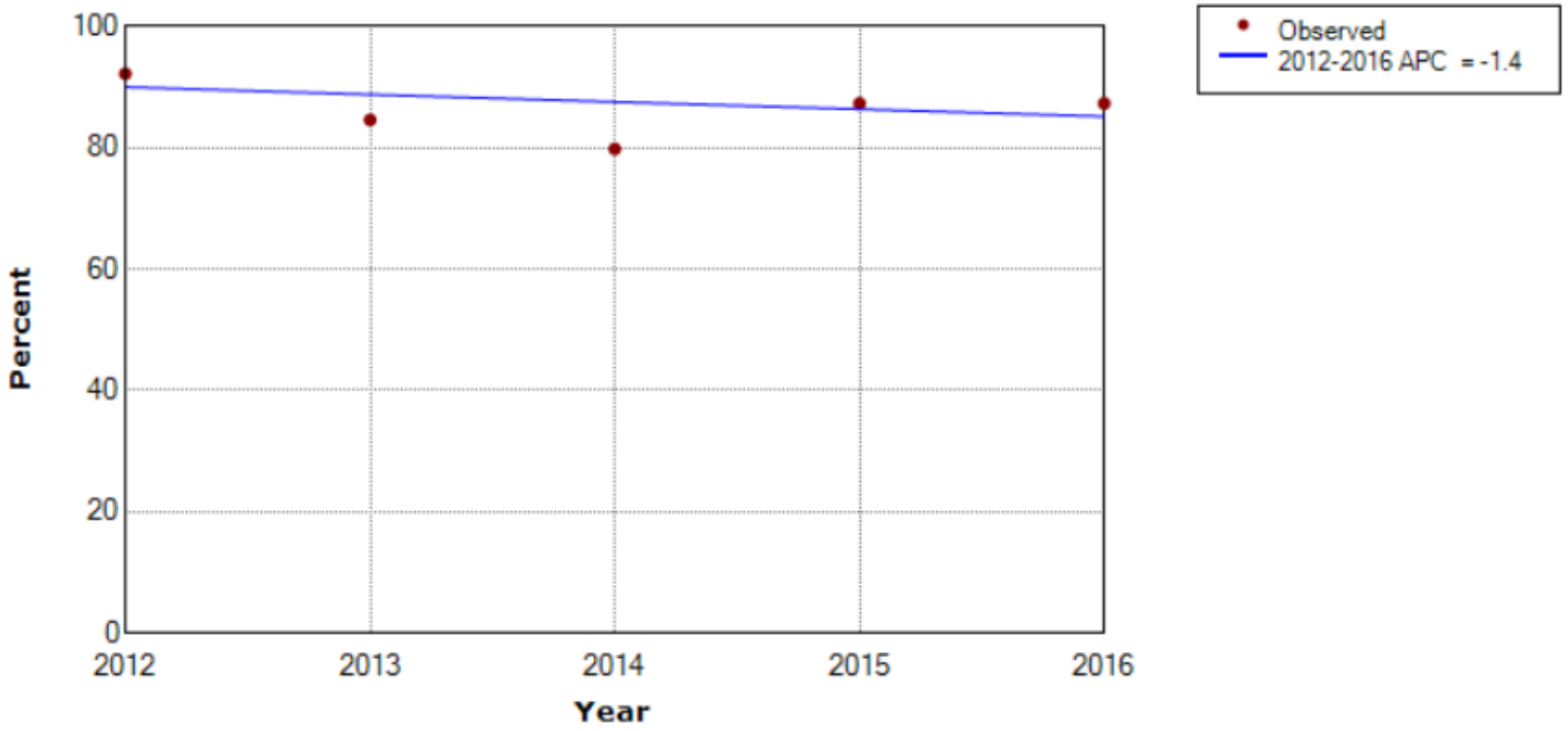
Note: Percents are plotted on a logarithmic scale.
Source: Bureau of Epidemiology and Public Health Informatics, Kansas birth data (resident)

NOM 9.5: Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (R95, R99, W75)



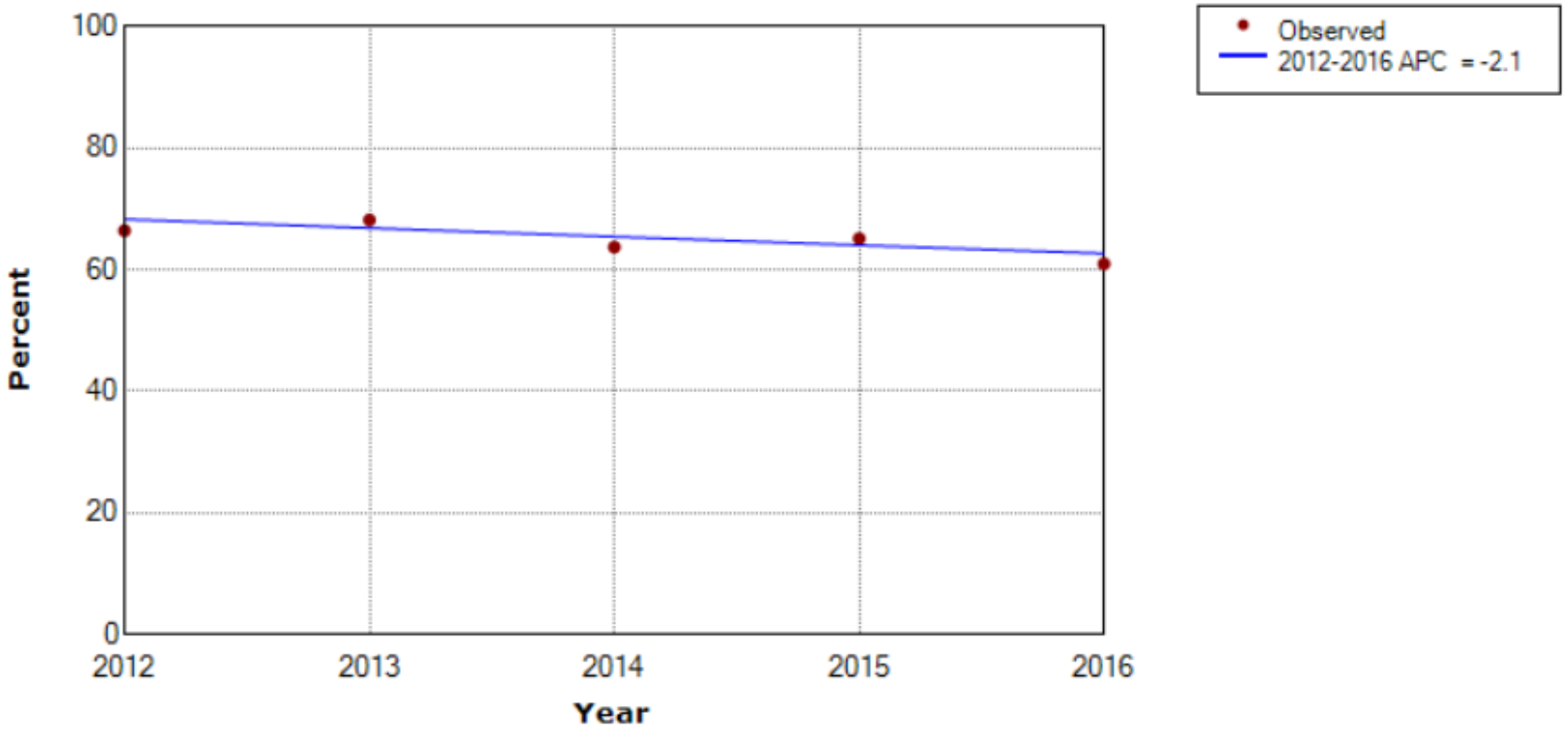
Note: Rates are plotted on a logarithmic scale.
Sources: Bureau of Epidemiology and Public Health Informatics, Kansas death and birth data (resident)

NOM 22.4: Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine



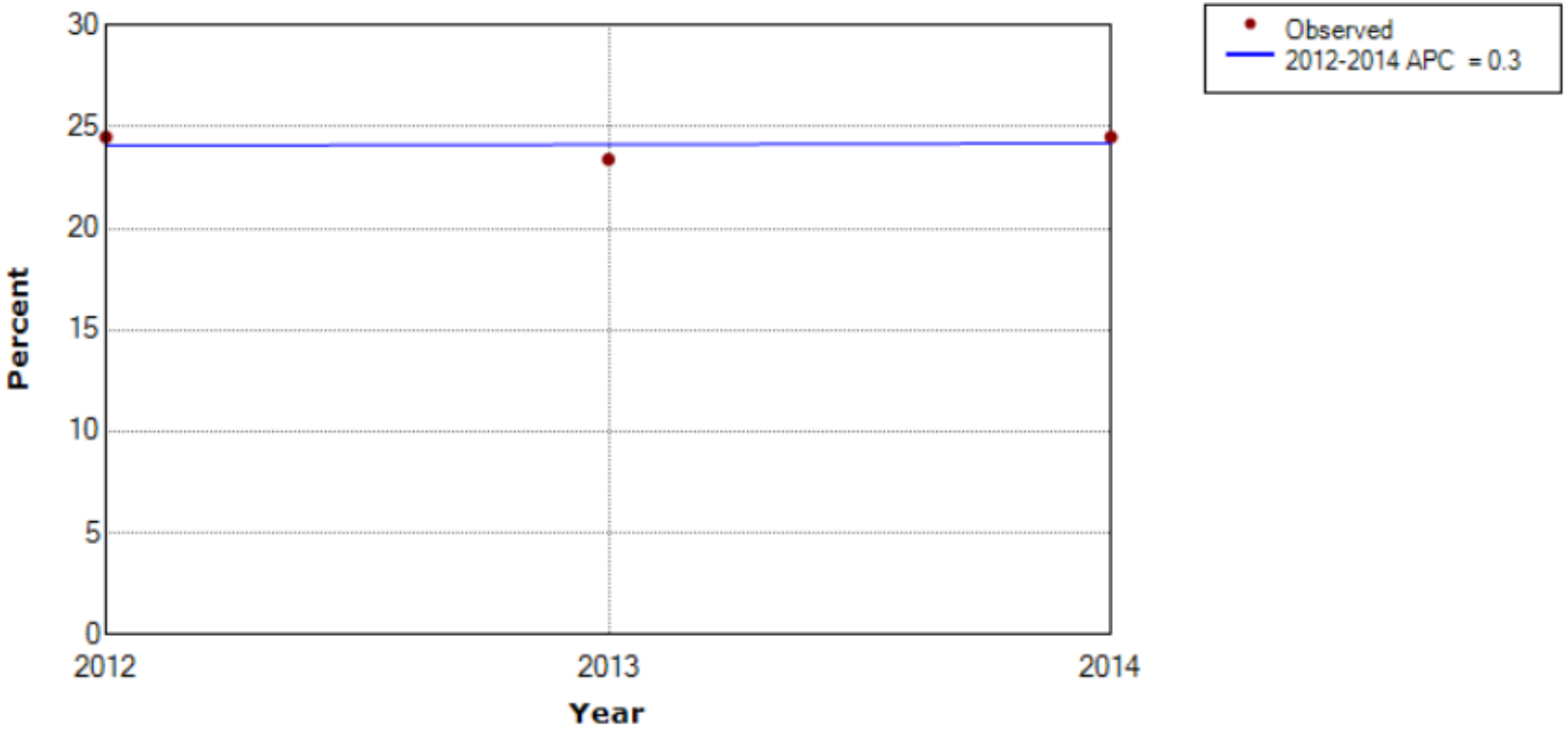
Note: Percents are plotted on a logarithmic scale.
Source: Centers for Disease Control and Prevention (CDC), National Immunization Survey (NIS)

NPM1: Well-Women Visit: The percent of women with a past year preventive medical visit



Note: Percents are plotted on a logarithmic scale.
Source: Kansas Behavioral Risk Factor Surveillance System (BRFSS)

NPM 4: Breastfeeding: B) Percent of infants breastfed exclusively through 6 months



Note: Percents are plotted on a logarithmic scale.
Source: CDC, National Immunization Survey (Children born in 2012 - 2014)

KANSAS
MATERNAL &
CHILD HEALTH

Lunch & Networking

KANSAS MATERNAL & CHILD HEALTH

Domain Group Work

TASK 1: REVIEW DRAFT STATE ACTION PLAN

TASK 2: DISCUSS DOMAIN ISSUE - UNIQUE

Domain Group Assignments

STAFF SUPPORT BY DOMAIN GROUP

Women/Maternal: Stephanie Wolf, Diane Daldrup, & Sarah Fischer

Perinatal/Infant: Carrie Akin & Jenny Taylor

Child: Kayzy Bigler & Tammy Broadbent

Adolescent: Elisa Nehrbass & Tamara Jones

Domain Group Work

Task 1 (30-45 min): Review Draft State Action Plan

- Handout: Feedback on group input from April
- Reference: State Action Plan (2 copies)

Task 2 (30-45 min): Discuss Selected Domain "Issue/Problem"

- Women/Maternal: Women's Health—increasing awareness and access to the preventive medical visit; developing content and tools/resources for local agencies
- Perinatal/Infant: Home Visiting and Breastfeeding Peer Counselor—expansion through planning and innovative staffing models
- Child: Developmental Screening—maximizing resources available/developed through ECCS/KIDOS
- Adolescent: Adolescent Health—focusing beyond the school based health center cohort project to increase awareness and access to the preventive medical visit (multiple strategies)

Ground Rules

1. Stay present (phones on silent/vibrate, limit side conversations).
2. Invite everyone into the conversation. Take turns talking.
3. ALL feedback is valid. There are no right or wrong answers.
4. Value and respect different perspectives (providers, families, agencies, etc.)
5. Be relevant. Stay on topic.
6. Allow facilitator to move through priority topics.
7. Avoid repeating previous remarks.
8. Disagree with ideas, not people. Build on each other's ideas.
9. Capture "side" topics and concerns; set aside for discussion and resolution at a later time.
10. Reach closure on each item and summarize conclusions or action steps.

KANSAS MATERNAL & CHILD HEALTH

Small Group Reports

W/M, P/I, C, A

KANSAS MATERNAL & CHILD HEALTH

Child Health Group

MCO PARTNERSHIP RECOMMENDATION

CHILD GROUP MEMBERS

KANSAS MATERNAL & CHILD HEALTH

Announcements October Agenda

KDHE & KMCHC MEMBERS

KANSAS MATERNAL & CHILD HEALTH

COUNT THE KICKS® INTERGRATION WEBINAR

Count the Kicks

Why is Count the Kicks® Important?

According to the Centers for Disease Control & Prevention (CDC) each year in the United States approximately 24,000 babies are stillborn. That equates in the US to a baby being born still every 22 minutes! Stillbirth claims more lives than drunk driving, childhood cancer, or HIV/AIDS each year!

The costs of stillbirth are staggering. Direct costs are higher because a stillbirth requires more resources than a live birth. Indirect costs include funeral expenses, loss of income from reduced or delayed employment on the part of parents, and the continuing costs of counselling and medical care in subsequent pregnancies. Healthy Birth Day Inc. also reports that families who have experienced a stillbirth have higher divorce rates and increased mental health issues.

In 2016, the perinatal period III death rate in Kansas was 9.8[1] (per 1,000 live births + stillbirths). The perinatal period III includes stillbirths and hebdomadal deaths (deaths that occur prior to the 7th day of life). This rate is much higher than the US rate which has hovered between 6.2 and 6.9 since the year 2000 (most recent data available is 2013 rate of 6.2 per 1,000 live births + stillbirths[2]). To fight this alarming statistic, The Kansas Department of Health and Environment is partnering with Healthy Birth Day, Inc. to launch the Count the Kicks® initiative in Kansas.

Count the Kicks is a stillbirth prevention campaign that teaches pregnant moms how to count their baby's movements daily in the third trimester. The campaign educates moms about contacting their provider right away if they notice a change in her baby's normal movement pattern.

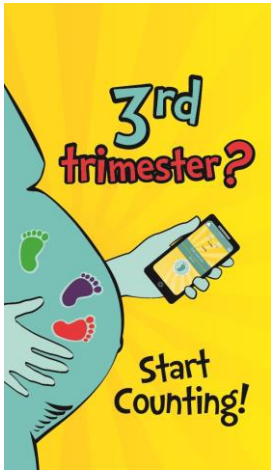
https://youtu.be/TOLyWXPWYmM

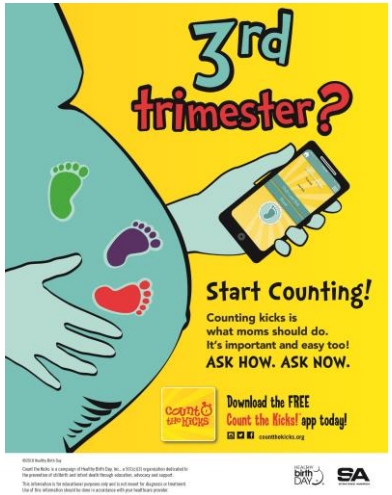
[1]Kansas Department of Health and Environment Bureau of Epidemiology and Public Health Informatics. Annual Summary of Vital Statistics, 2016.

[2]Marian MacDorman, Elizabeth Gregory. Fetal and Perinatal Mortality: United States, 2013. National Vital Statistics Reports, v64, 8.

Launching the Kansas Campaign!

The Count the Kicks® launch will begin with a mail campaign to Kansas providers and other stakeholders, including all MCH grantees! The mail campaign will include a letter outlining Count the Kicks® and a sample of the educational materials that organizations can order for free (up to 12 months)! The materials include brochures and posters in Spanish and English and appointment cards that include information on the free Count the Kicks® app.





The MCH program will continue to support the launch of Count the Kicks® in Kansas with an email campaign providing links to digital tools that will help providers implement the program. Tools include how-to videos, downloadable kick counting charts and easy-to-use lesson plans for childbirth educators. The MCH program will also release Count the Kicks® PSA announcements via social media for your organization to post and share!

KANSAS MATERNAL & CHILD HEALTH

Next Meeting Date

OCTOBER 10, 2018

KANSAS MATERNAL & CHILD HEALTH

Closing Remarks

DENNIS COOLEY, MD, CHAIR