Kansas Title V Maternal and Child Health Services Block Grant

2018 Application / 2016 Annual Report
Executive Summary

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KANSAS MATERNAL & CHILD HEALTH

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Vision: Title V envisions a nation where all mothers, children and youth, including CSHCN, and their families are healthy and thriving.

Mission: To improve the health and well-being of the nation's mothers, infants, children and youth, including children and youth with special health care needs, and their families.

Letter from Kansas Title V Director

Dear Partner:

As Director of the Kansas Title V Program, it is my pleasure to provide this Executive Summary of the Kansas Title V Maternal and Child Health (MCH) Services Block Grant 2018 Application/2016 Annual Report. The purpose of this summary is to orient the reader to the Title V MCH Block Grant, highlight key programmatic themes and data points, provide specific examples of MCH program impact/reach, and encourage input and comment on the Block Grant program itself.

Title V legislation directs states to conduct a statewide MCH Needs Assessment every five years to identify the need for preventive and primary care services for pregnant women, infants, children, adolescents, and individuals with special health care needs. From this assessment, states select Priorities, National Performance Measures, and State Performance Measures for focused programmatic efforts over the five-year reporting cycle. The most recent needs assessment, referred to as *MCH 2020*, resulted in a meaningful, responsive action plan for the period 2016-2020. The Title V State Plan truly reflects priorities and needs of MCH populations statewide and demands commitment and "shared" responsibility among the state Title V program, partnering state agencies, families/consumers, and other valued state and local program partners. The Kansas Maternal & Child Health Council serves a critical role related to monitoring the state action plan in partnership with the Kansas Title V Program. Additionally, local MCH partners across the state assure access to needed services.

More detailed information about the MCH Services Block Grant Application/Annual Report and *MCH 2020* Five-Year Needs Assessment can be viewed on the KDHE Bureau of Family Health website www.kdheks.gov/bfh or KDHE Title V MCH Block Grant website http://www.kdheks.gov/c-f/mch.htm. The Title V program also supports a website (www.kansasmch.org) and Facebook page (www.facebook.com/kansasmch) to promote and increase awareness of the Kansas Title V MCH programming. This has provided the opportunity to share relevant information and provide ongoing updates related to the needs assessment and release of the final plan.

The MCH Program values its partnerships and collaborations. Success with advancing the plan during the next year and beyond lies in the strength of partnerships and willingness to align efforts and collectively impact outcomes. Together, we can achieve the common goal of improving the health of mothers, children, and families in Kansas. Thank you for the great work we were able to accomplish in 2017!

Rachel Sisson, Director
KDHE Bureau of Family Health
Kansas Title V Maternal & Child Health Program

Title V MCH Block Grant Background

What is Title V?
Title V of the Social Security Act is the longest-standing public health legislation in American history. Enacted in 1935, Title V is a federal-state partnership that promotes and improves maternal and child health (MCH). According to each state's unique needs, Title V supports a spectrum of services, from infrastructure-building services like quality assurance and policy development, to gap-filling direct health care for children and youth with special health care needs. Title V resources are directed towards MCH priority populations: pregnant women, mothers, infants, women of reproductive years, children and adolescents, and children and youth with special health care needs.

Why is Title V important?
Each year, all States and jurisdictions are required to submit an Application/Annual Report for Federal funds for their Title V MCH Services Block Grant to States Program to the Maternal and Child Health Bureau (MCHB) in the Health Resources and Services Administration (HRSA), U.S. Department of Human and Health Services (HHS). Without Title V, Kansas would not have dedicated funding to support core MCH public health functions. Title V is an essential mechanism to assure the health and safety of our nation's most precious resources: mothers, infants, and children.

Why is it called a Block Grant?
In 1981, seven categorical child health programs were combined into a single program known as a Block Grant. This consolidation also marked the introduction of stricter requirements for the use of funds and for state planning and reporting.

How does the MCH Title V Block Grant work?
Every year the Federal government awards MCH Block Grant dollars to each state, based on the number of children living in poverty. States provide a $3 match for every $4 in federal funding. At least 30% of funds must be used for services and programs for children and 30% for children & youth with special health care needs (CYSHCN). No more than 10% may be used for administration. Although there are no requirements regarding percentage to be spent, funding is also to be spent on preventive and primary care services for pregnant women, mothers and infants up to age one. The Kansas MCH Block Grant funds support state, regional, and local programs and staff, and are administered by the Kansas Department of Health and Environment, Division of Public Health, Bureau of Family Health.

How does the MCH Block Grant Program meet the unique needs of Kansas families?
Kansas is required to complete a statewide needs assessment every five years. This process identifies Kansas MCH program priorities and determines a plan of action to address those priorities. The most recent Kansas needs assessment, referred to as *MCH 2020*, identified eight MCH program priorities for the time period 2016-2020. KDHE continuously assesses the needs of Kansas MCH populations through an ongoing Needs Assessment. The State Action Plan is updated as needed during interim years.

With a goal to maximize the input of internal and external partners, the Kansas Title V Five Year Needs Assessment process utilizes a mixed methods approach relying on input from a diverse network of key informants, partners, and community members. Additionally, State Systems Development Initiative (SSDI) staff provide data capacity for informed decision making. This comprehensive process and broad approach assists with identifying key priorities used to develop an action plan that addresses and improves maternal and child health in Kansas while leveraging resources and partnerships across the state. Criteria are used in the final selection and categorization of priorities.

- Determination of level of impact (priority, objective, strategy)
- Ability of KDHE and Title V to advance work and impact outcomes
- Existing infrastructure, capacity, sustainability
- Role of key partners in delivering outcomes

Kansas MCH strives to engage families and consumers in a meaningful way at all levels and stages (design, planning, implementation, evaluation) in an ongoing, continuous manner through the Kansas Special Health Services Family Advisory Council (SHS-FAC), Kansas Maternal and Child Health Council, and special projects. Opportunities are provided to support growth and participation as council members, professionals, and experts.

The following table provides a snapshot of the priorities, and associated National Performance Measures (NPMs), State Performance Measures (SPMs) and Evidence-based or evidence-informed Strategy Measures (ESMs).

MCH 2020 (2016-2020) Kansas MCH Program Priorities

Priority 1: Women have access to and receive coordinated, comprehensive services before, during and after pregnancy.

Domain(s): Women/Maternal Health

Performance Measure(s)

- NPM 1: Well-woman visit (Percent of women with a past year preventive 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
- SPM 1: Percent of preterm birth (<37 weeks gestation)

Priority 2: Services and supports promote healthy family functioning.

Domain(s): Cross-Cutting/Life Course

Performance Measure(s)

- SPM 2: Percent of children living with parents who have emotional help with parenthood

Priority 3: Developmentally appropriate care and services are provided across the lifespan.

Domain(s): Child Health

Performance Measure(s)

- 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 and adolescents ages 10 through 19)
    - ESM: Number of free car seat safety inspections completed by certified child passenger safety technicians
- SPM 3: Percent of children, ages 6 through 11, and adolescents, ages 12 through 17, who are physically active at least 60 minutes per day

Priority 4: Families are empowered to make educated choices about infant health and well-being.

Domain(s): Perinatal/Infant Health

Performance Measure(s)

- NPM 4: Breastfeeding (Percent of infants who are 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
- SPM 4: Number of safe sleep [sudden infant death syndrome (SIDS)/ sudden unexpected infant death (SUID)] trainings provided to professionals

Priority 5: Communities and providers support physical, social and emotional health.

Domain(s): Adolescent Health

Performance Measure(s)

- NPM 9: Bullying (Percent of adolescents, ages 12 through 17, who are bullied or who bully others)
    - ESM: Number of schools implementing evidence-based or informed anti-bullying practices and/or programs
- NPM 10: Adolescent well-visit (Percent of adolescents, ages 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

Priority 6: Professionals have the knowledge and skills to address the needs of maternal and child health populations.

Domain(s): Cross-Cutting/Life Course

Performance Measure(s)

- 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

Priority 7: Services are comprehensive and coordinated across systems and providers.

Domain(s): Children and Youth with Special Health Care Needs

Performance Measure(s)

- 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

Priority 8: Information is available to support informed health decisions and choices.

Domain(s): Cross-Cutting/Life Course

Performance Measure(s)

- SPM 5: Percent of adults who report that it is somewhat difficult or very difficult to understand information that doctors, nurses and other health professionals tell them

NPM: National performance measures; **SPM**: State Performance Measures; **ESM**: Evidence-based or evidence-informed Strategy Measures

How does the MCH Block Grant maximize its reach?

There are many more maternal and child health-related programs and activities beyond those funded by the MCH Block Grant. The MCH Program relies on collaborative efforts and partnerships to maximize reach and promote efficiency. For example, by working closely with the Immunization Program; the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV); Healthy Start Program; Early Childhood Comprehensive Systems (ECCS) Initiative; and others, we can help assure that the diverse needs of Kansas families are met, without duplicating efforts.

How is Kansas held accountable?

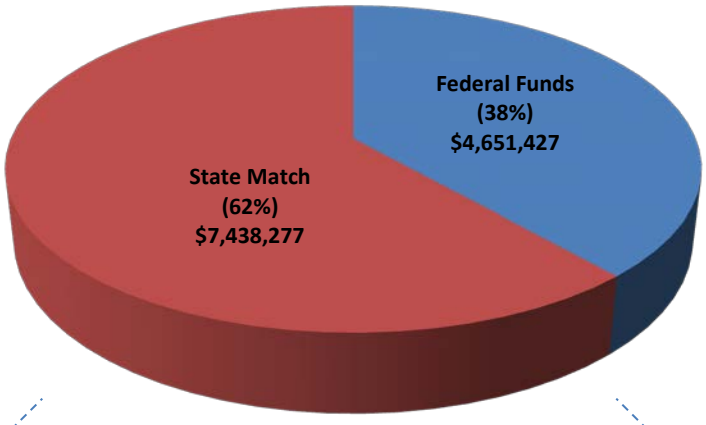
Each year the MCH Program reports on over 80 indicators and performance measures. Some measures are determined by the Federal government and others by Kansas. Kansas also writes an application and annual report, which includes a description of state capacity, collaborations/partners, and Title V-funded/supported activities. This document is reviewed and discussed with the Federal Maternal and Child Health Bureau (MCHB).

Where do I fit into the Title V Block Grant?

Whether you are a parent, government official, advocate, service provider, or member of the general public, the MCH Block Grant likely touches your life. Its success lies in the strength of partnerships and collaborations. The program collects input related to existing services, population needs, and emerging issues throughout the year. Your input is needed to assure that the MCH Program is guided by the needs of Kansas families. Review the full-length MCH Block Grant at: http://www.kdheks.gov/c-f/mch.htm. To provide feedback, please refer to the "Public Input" section. Learn more through the Federal Title V Information System (TVIS) website which allows you to compare Kansas to other states: https://mchb.tvisdata.hrsa.gov/.

Kansas Title V MCH Block Grant Budget Overview

The Federal-State Title V partnership budget totals $12,089,704 for FY2018 (federal funds $4,651,427; state funds $3,531,773; local funds $3,906,504). Federal and State MCH funds totaling $4,839,019 is allocated for FY2018 to support local agencies in providing community-based, family centered MCH services, including services for individuals with special health care needs.



$12.1 Million*

Federal-State Title V Block Grant Partnership

State Match
$3,531,773

Local Match
$3,906,504

For every $4 of Federal funds, at least $3 must be matched by state and local funds.

Aid to Local
$4,839,019

Grants to local health departments, contracts, special health services

*Source: Title V Block Grant 2018 Application/2016 Annual Report, Forms 2, 3a, 3b

Kansas MCH Population

Kansas, spanning 81,759 sq. miles, is divided into 105 counties with 628 cities. The U.S. Census Bureau estimates there are approximately 2,911,641 residents living in the state (2015). Kansas has a unique geographic layout that ranges from urban to frontier counties. In 2015, there were an estimated 38,972 infants living in Kansas (1.3%); 851,797 children and adolescents aged 1-21 years (29.3%); and 560,142 (19.2%) women of reproductive age 15-44 years. The race and ethnicity composition for this MCH group was estimated at 71.2% non-Hispanic white, 8.0% non-Hispanic black, 1.1% non-Hispanic Native American or Alaska Native, 3.7% non-Hispanic Asian and Pacific Islander, and 15.9% Hispanic (any race).

Total of Individuals Served Under Title V*, 2015

Types of Individuals Served	
Pregnant Women	5,237
Infants < 1 Year	9,574
Children 1 to 22 Years	55,892
Children with Special Health Care Needs	2,060
Other	4,735
Total	77,498

Source: KDHE Bureau of Family Health, 2015
*More details are available on Block Grant Form 5a.

Key Kansas Characteristics, 2015

Number of Births[a]	39,126
Ratio of the black non-Hispanic to white non-Hispanic infant mortality[a]	2.2
Number of children <20 years old[b]	800,610
% of children <18 years old with special health care needs[c]	19.4%
% of births covered by Medicaid[a,*]	32.2%
% of children <18 years old without health insurance[d]	5.1%
% of children <20 years old living in densely-settled rural, rural and frontier areas[b]	27.8%

Sources:
[a] KDHE Bureau of Epidemiology and Public Health Informatics, 2015
[b] U.S. Census Bureau, Bridged Race Population, 2015
[c] National Survey of Children's Health, 2011/12
[d] U.S. Census Bureau, American Community Survey, 2015 (B27001)
*Based on the "principal source of payment for this delivery" as reported on the birth certificate.

How Do Medicaid Births Compare to Non-Medicaid Births? Kansas, 2015

Indicators	Medicaid*	Non-Medicaid*	All
Infant mortality rate (per 1,000 live births)	7.9	4.8	5.9
Percent low birthweight (<2,500 grams)	8.7%	6.0%	6.9%
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	72.7%	86.2%	81.7%
Percent of pregnant women with adequate prenatal care	76.6%	87.2%	83.6%
Percent of women who smoke during pregnancy	24.9%	4.4%	11.0%
Percent of all births	**32.2%**	**67.8%**	**100.0%**

Source: KDHE Bureau of Epidemiology and Public Health Informatics, 2015
*Based on the "principal source of payment for this delivery" as reported on the birth certificate

How Does Kansas Compare to Other States?

Compared to other states, Kansas ranks 15th overall in 2017.

KIDS COUNT Key Indicators

Indicators	Kansas	United States	Rank
Economic Well-Being Indicators			***7***
Percent of children in poverty (2015)	17	21	
Percent of children living in families where no parent has full-time, year-round employment (2015)	23	29	
Percent of children living in households with a high housing cost burden (2015)	24	33	
Percent of teens (ages 16-19) not attending school and not working (2015)	5	7	
Education Indicators			***26***
Percent of children (ages 3-4) not attending preschool (2013-2015)	56	53	
Percent of fourth graders in public school not proficient in reading (2015)	65	65	
Percent of eighth graders in public school not proficient in math (2015)	67	68	
Percent of high school students not graduating on time (2014/15)	14	17	
Health Indicators			***20***
Percent low birthweight babies (2015)	6.8	8.1	

Percent of children without health insurance (2015)	5	5	
Child and teen death rate (per 100,000 children ages 1-19) (2015)	26	25	
Percent of teens (ages 12-17) who abuse alcohol or drugs (2013-2014)	5	5	
Family and Community Indicators			***23***
Percent of children in single-parent families (2015)	30	35	
Percent of children in families where the household head lacks a high school diploma (2015)	11	14	
Percent of children living in high-poverty areas (2011-2015)	9	14	
Teen birth rate (per 1,000 females ages 15-19) (2015)	25	22	

Source: Annie E. Casey Foundation, 2017 KIDS COUNT Data Book, http://www.aecf.org/m/resourcedoc/aecf-2017kidscountdatabook.pdf

Selected Key Block Grant Indicators by MCH Population and Priority Area

	2011	2012	2013	2014	2015	Trend	HP2020	Sources
Women/Maternal Health								
Women have access to and receive coordinated, comprehensive services before, during and after pregnancy.								
• Percent of women with a past year preventive medical visit	66.7%	66.4%	68.2%	63.7%	65.1%	↓	-	1
• Percent of preterm births (<37 weeks gestation)	9.1%	9.0%	8.9%	8.7%	8.8%	↓*	**11.4%**	2
Perinatal/Infant Health								
Families are empowered to make educated choices about infant health and well-being.								
• Percent of infants who are ever breastfed	79.5%	81.7%	84.2%	86.1%	87.4%	↑*	**81.9%**	2
• Percent of infants breastfed exclusively through 6 months	11.4%	24.5%	23.4%	-		↑	**25.5%**	3
• Number of Safe Sleep [sudden infant death syndrome (SIDS)/sudden unexpected infant death (SUID)] trainings provided to professionals; annual/cumulative	2,611	2,913	4,015	2,893	2,588		-	4
	2,611	5,524	9,539	12,432	15,020	↑		
Child Health								
Developmental appropriate care and services are provided across the lifespan.								
• Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool	-	37.0%	-	-	-	●	-	5
• Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9	88.4	93.5	88.8	80.8	-	↓	-	6,7
• Percent of children 6 through 11 who are physically active at least 60 minutes per day	-	36.0%	-	-	-	●	-	5
Adolescent Health								
Communities and providers support physical, social and emotional health.								
• Percent of adolescents, 12 through 17, who are bullied or who bully others	-	11.0%	-	-	-	●	**17.9%**	5
• Percent of adolescents, 12 through 17, with a preventive medical visit in the past year	-	83.4%	-	-	-	●	**75.6%**	5
• Rate of hospitalization for non-fatal injury per 100,000 children ages 10 through 19	212.7	226.2	199.4	203.1	-	↓	-	6,7

• Percent of children 12 through 17 who are physically active at least 60 minutes per day	-	19.9%	-	-	-	●	**20.2%**	5
Children and Youth with Special Health Care Needs								
Services are comprehensive and coordinated across systems and providers.								
• Percent of children with special health care needs having a medical home	-	53.8%	-	-	-	●	**54.8%**	5
• Percent of children without special health care needs having a medical home	-	60.4%	-	-	-	●	**63.3%**	5
Cross-Cutting or Life Course								
Services and supports promote healthy family functioning.								
• Percent of children living with parents who have emotional help with parenthood	-	91.5%	-	-	-	●	-	5
Professionals have the knowledge and skills to address the needs of maternal and child health populations.								
• Percent of women who smoke during pregnancy	14.5%	13.7%	12.5%	12.0%	11.0%	↓*	**1.4%**	2
• Percent of children who live in households where someone smokes	-	25.3%	-	-	-	●	**47.0%**	5
Information is available to support informed health decisions and choices.								
• Percent of adults who report that it is somewhat difficult or very difficult to understand information that doctors, nurses and other health professionals tell them	-	-	-	-	-	-	-	1

*Statistically significant trend ($p<0.05$)
An "-" indicates the data were not available at the time of reporting.

HP2020: Healthy People 2020 Goal; Green Arrow: Positive; Red Arrow: Negative; Yellow Dot: No Trend

Sources:
1. Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System (BRFSS)
2. Kansas Department of Health and Environment (KDHE), Bureau of Epidemiology and Public Health Informatics. Kansas birth data (resident)
3. Centers for Disease Control and Prevention (CDC). National Immunization Survey (NIS)
4. Kansas Infant Death and SIDS Network, Inc.
5. Health Resources and Services Administration (HRSA). National Survey of Children's Health (NSCH), 2011/12
6. Agency for Healthcare Research and Quality (AHRQ). Healthcare Cost and Utilization Project (HCUP) - State Inpatient Database (SID)
7. U.S. Census Bureau. Population Estimate, Bridged-Race Vintage data set

Kansas Title V Activities & Program Highlights

KDHE is developing an integrated system of care coordination and outcome assessment for community level maternal and child health initiatives. The Title V plan coordinates MCH activities across funding sources, state agencies, and local providers. It relies on partnerships, high quality shared measurement, and data to track the impact and effectiveness of services, activities, and strategies. Review the full Block Grant Application to learn more: http://www.kdheks.gov/c-f/mch.htm.

Women/Maternal & Perinatal/Infant Health

Maternal & Pregnancy-Associated Mortality: The Title V program is facilitating discussions among KDHE, American Congress of Obstetricians and Gynecologists (ACOG) Kansas Section,

March of Dimes, the Kansas Maternal & Child Health Council, and other partners representing public health and primary care to implement maternal mortality review in Kansas. Technical assistance and resources have been provided by CDC and AMCHP, including the Review to Action staff and website (www.reviewtoaction.org) to support launch and use of existing resources.

Pregnancy Risk Assessment & Monitoring System (PRAMS): Funded in 2016, Kansas PRAMS (www.kdheks.gov/prams) is a collaborative project with the CDC. The Bureau of Epidemiology and Public Health Informatics administers the grant, while Title V MCH provides input/support, promotes the project/survey, and will use data to inform planning and programming to improve outcomes. The PRAMS steering committee includes members from 2 Maternal & Child Health Council subcommittees, Women/Maternal and Perinatal/Infant. Data collection began in April 2017.

Opioid Crisis & Neonatal Abstinence Syndrome: The Title V program is leading planning and implementation of a state-level response to address Neonatal Abstinence Syndrome (NAS) in Kansas. Recent progress involved convening policy makers to define NAS within the context of the opioid epidemic and develop a path for Kansas. Short-term plans involve utilizing the Vermont Oxford Network (VON) NAS Universal Training Program as a tool. We are planning a comprehensive approach involving several levels of intervention (surveillance to clinical practice improvements) as well as points of intervention to prevent exposure and reduce the impact when exposure occurs (lifespan approach with emphasis on the preconception, pregnancy, and infant health periods).

Birth Defects Surveillance & Zika Virus: Short-term support from CDC enabled Kansas to enhance the current passive birth defects surveillance system by hiring a Program Coordinator and officially launching the Birth Defects Surveillance Program. Protocols to be developed include case verification, improved surveillance methodology, new partnerships and data sources (hospital discharge), the ability to rapidly identify cases of microcephaly and other defects potentially linked to Zika, and an effective referral process into early intervention and other services.

Early Elective Delivery – Celebrating Success: The Kansas MCH Program, March of Dimes, Kansas Hospital Association, and the Kansas Healthcare Collaborative joined together to launch the 39+ Weeks Hospital Banner Recognition Program to encourage continued progress towards eliminating early elective deliveries (EED) in our state. The collaborative efforts and hard work of hospitals have resulted in a rapid and significant reduction in the statewide EED rate from 8% to 2% between 2013 and 2015. Eligible hospitals with rates less than 5% can apply for and receive a customized banner for commitment to improving the quality of care for moms and babies.

Perinatal Community Collaboratives/Birth Disparities Programs: The Kansas MCH Program, in collaboration with local communities and the broader network of local health care and community service providers are involved in an on-going process of developing perinatal

collaboratives utilizing March of Dimes Becoming A Mom/Comenzando Bien® as a consistent and proven prenatal care education curriculum. The model brings prenatal education and care together. Birth outcome data reveals improvements in preterm delivery, low birth weight, and breastfeeding initiation. Most notable is the Infant Mortality Rate (IMR) from pre-to post-program implementation in the longest running programs (5 years): Saline County 8.5 to 4.2 and Geary County 10.4 to 6.4 (deaths/1000 live births).*
*Source: Kansas Vital Statistics 2006-2010 and 2011-2015

Communities Supporting Breastfeeding (CSB): The long-term goal of the CSB project is to improve exclusive breastfeeding rates for infants aged 3 and 6 months by assisting communities achieve the Kansas Breastfeeding Coalition (KBC) CSB designation. Seventeen communities have achieved the designation since 2015, when the program began with support from KDHE BFH, the KBC, and the Kansas Health Foundation.

Baby-Friendly® Hospitals: Kansas MCH and the United Methodist Health Ministry Fund (UMHMF) have teamed up to provide financial and technical assistance to support five hospitals to move toward Baby-Friendly designation (implementing the 10 steps to support breastfeeding). The goal is to receive ongoing technical assistance through the Carolina Global Breastfeeding Institute (CGBI).

Safe Sleep Expansion Initiative: Kansas MCH program is partnering with the Kansas Infant Death & SIDS (KIDS) Network to reduce infant mortality through expanded safe sleep efforts. The KIDS Network previously trained 24 Safe Sleep Instructors in the six public health regions (home visitors, nurses, health department staff). In order to facilitate a safe sleep culture in Kansas and reduce the number of infant deaths related to unsafe sleep, we must leverage trained instructors to their maximum potential. Increasing the number of instructors and expanding reach and scope of existing community models will build statewide infrastructure to promote consistent infant safe sleep messages with consideration for cross-cutting issues that impact sudden infant death such as smoking and breastfeeding. The three-year project aims to enhance the Safe Sleep Instructor (SSI) program by building capacity to roll out safe sleep promotion programs developed for specific venues, including the community, hospitals and outpatient maternal and infant clinics.

Child & Adolescent Health

State and local programs remain focused on carrying out the following objectives and strategies in the State Action Plan to address the identified needs and priorities for child and adolescent health.

- Promoting and supporting developmental screening between 10 months and six years of age, in collaboration with the Early Childhood Comprehensive Systems project team;
- Promoting annual well visits and comprehensive health screenings through adolescence in accordance with Bright Futures™, including implementation of school-based health services/centers;
- Increasing access to oral health screenings and promoting routine dental care, with

special emphasis on routines in out of home care settings;
- Developing follow-up protocols for families to be referred for behavioral health services
- Increasing awareness of options for bullying intervention and prevention; and
- Making connections among schools, families, communities and health providers through adolescent health curriculum in Family and Consumer Science classrooms, positive youth development programs, and school-based health centers.

Children & Youth with Special Health Care Needs (CYSHCN/KS-SHCN)

Kansas Law mandates health care services for CYSHCN pursuant to K.S.A. 65-5a01, based on medical and financial eligibility. The KS-SHCN program vision spans far beyond the mandate for services and aims to assess and address needs of all children, youth, and families. KS-SHCN continues to expand the focus of the program to address the needs of families through collaboration, systems integration, and increased statewide capacity. Utilizing quality improvement and evaluation, the program strives for sustainable and systemic changes for the CYSHCN population. A new care coordination model has been piloted to enhance services available and will expand implementation across the state in FY18. This model uses a holistic approach which strives to find, understand, and access services and resources within medical, school, and community systems to assure families receive the services necessary to achieve optimal child and family health outcomes.

Cross-Cutting/Life Course

Shared Measurement & Quality Improvement: The Bureau of Family Health worked with the University of Kansas Center for Public Partnerships & Research (KU-CPPR) to develop and implement a web-based, HIPAA-compliant shared measurement data system (DAISEY) across MCH service providers, with the goal of improving accountability and continuous quality improvement at the state and local levels.

Workforce Development & Strengthening Families: Kansas Title V is dedicated to providing opportunities to empower families and build strong advocates, increasing provider capacity to provide trauma-informed care, enhancing and expanding the knowledge of the maternal and child health (MCH) workforce, and assuring consumers and families are aware of available services and supports. Throughout the State Action Plan, the provision of trainings, development and promotion of educational materials, and activities to support consumer and families in all aspect of the life course are evident. A major focus is increasing the MCH workforce capacity to engage with families, understand the benefits of using trauma-informed approaches, and creating connections across Title V programs, partners, and populations. Trainings are available for families on how to: partner with medical providers, better understand how to advocate for their family's needs, and navigating cumbersome and confusing service delivery systems. New initiatives, such as the Help Me Grow resource and referral system, will enhance the State's ability to coordinate intake and referrals across all early childhood sectors, supporting more engaged families, stronger collaborative networks, and improved services.