

**Maternal and Child  
Health Services Title V  
Block Grant**

**Kansas**

**FY 2018 Application/  
FY 2016 Annual Report**

Created on 9/25/2017  
at 10:26 PM

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## I. General Requirements

### I.A. Letter of Transmittal

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Curtis State Office Building  
1000 SW Jackson, Suite 220  
Topeka, KS 66612



Phone: 785-291-3368  
Fax: 785-296-6553  
[www.kdheks.gov/bfh](http://www.kdheks.gov/bfh)

Susan Mosier, MD, Secretary

Department of Health & Environment

Sam Brownback, Governor

July 15, 2017

HRSA Grants Application Center  
ATTN: MCH Block Grant  
901 Russell Avenue, Suite 450  
Gaithersburg, MD 20879

Dear Sirs:

Attached to this letter of transmittal is a signed Application for Federal Assistance Standard Form 424 for Kansas' electronic submission of the FFY 2018 Maternal and Child Health Services Block Grant Application and FFY 2016 Annual Report. Kansas is not requesting a waiver to the 30 percent allotment requirement.

If you have questions concerning this application, please contact Rachel Sisson, Kansas Title V Director, at 785-296-1310 or [rachel.sisson@ks.gov](mailto:rachel.sisson@ks.gov).

Sincerely,

A handwritten signature in cursive script that reads "Susan K. Mosier".

Susan Mosier, MD, MBA, FACS  
Secretary and State Health Officer  
Kansas Department of Health and Environment

Enclosures

## **I.B. Face Sheet**

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

## **I.C. Assurances and Certifications**

The State certifies assurances and certifications, as specified in Appendix C of the 2015 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

## **I.D. Table of Contents**

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

## I.E. Application/Annual Report Executive Summary

### Kansas Title V Maternal & Child Health Services Block Grant Program

[www.kdheks.gov/bfh](http://www.kdheks.gov/bfh)

[www.kansasmch.org](http://www.kansasmch.org)

[www.facebook.com/kansasmch](https://www.facebook.com/kansasmch)

The Kansas Department of Health and Environment (KDHE) is responsible for the administration of programs carried out with allotments under Title V. The Title V Maternal and Child Health (MCH) Services Block Grant program is administered by the Bureau of Family Health (BFH) in the Division of Public Health. The mission of the Bureau is to “provide leadership to enhance the health of Kansas women and children through partnerships with families and communities.”

#### 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\* (Reporting Year 2016)

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

*\*More details are available on Block Grant Form 5a.*

#### Assessing State Needs

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.

#### Title V MCH Priorities (2016-2020)\*

Kansas selected eight priorities with the Title V mission, purpose, legislation, and measurement framework in mind.

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

#### **Title V National Performance Measures (FFY 2018)**

Kansas selected eight National Performance Measures (NPMs) that most closely align with the priorities.

- NPM1: Well-woman visit
- NPM4: Breastfeeding
- NPM6: Developmental screening
- NPM7: Child injury
- NPM9: Bullying
- NPM10: Adolescent well-visit
- NPM11: Medical home
- NPM14: Smoking during pregnancy and household smoking

#### **Title V State Performance Measures (FFY 2018)**

Kansas identified five State Performance Measures to monitor progress with state priority needs not addressed by NPMs.

- SPM: Preterm births (<37 weeks gestation)
- SPM2: Parenthood supports
- SPM3: Physical activity (children and adolescents)
- SPM4: Safe Sleep (SIDS/SUID) training
- SPM5: Health literacy

#### **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 Mortality:* The Title V program is facilitating discussions among KDHE, American Congress of Obstetricians and Gynecologists (ACOG) Kansas Section, March of Dimes, and the Kansas Maternal & Child Health Council 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](http://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](http://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.

*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. The short-term goal is to convene policy makers to define NAS within the context of the opioid epidemic, introduce the [Vermont Oxford Network \(VON\) NAS Universal Training Program](#) as a tool, and discuss a path for Kansas. 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*<sup>®</sup> 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<sup>®</sup> 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).

#### 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<sup>™</sup>, 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
- 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 (KUCPPR) to develop and implement a web-based shared measurement data system (DAISEY) across MCH service providers, with a 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.

#### **Kansas Title V Block Grant Budget**

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.

## II. Components of the Application/Annual Report

### II.A. Overview of the State

This section puts into context the Title V Maternal and Child Health (MCH) program within the State's health care delivery environment. The overview provides an understanding of the State Health Agency's current priorities/initiatives and the Title V role.

#### Overview & Authority

The Kansas Department of Health and Environment (KDHE) is responsible for administration of programs carried out with allotments under Title V. The Title V MCH Services Block Grant program is administered by the Bureau of Family Health (BFH) in the Division of Public Health. The mission of the Bureau is to "provide leadership to enhance the health of Kansas women and children through partnerships with families and communities." KDHE convenes the Kansas Maternal and Child Health Council and contracts with local public health departments (independent entities) across the state to ensure provision of MCH services within a coordinated, family-centered system. Kansas statutes do not mandate comprehensive services for MCH populations except for Children and Youth with Special Health Care Needs (CYSHCN). Pursuant to K.S.A. 65-5a01, a "child with special health care needs" means a person under 21 years of age who has a disease, defect or condition which may hinder normal physical growth and development." Statutes and regulations detail program requirements related to direct health services, in which individuals ages 0-21 with eligible medical conditions and all ages with conditions diagnosed through the state's newborn screening program are served. Kansas provides direct services for state mandated conditions, and the program provides non-direct services through community partnerships to the broader CYSHCN population, as defined by MCHB/HRSA.

#### Geography/Demography

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. Within each of its regions there are few populous cities intermixed with multiple rural areas. For example, the South Central region includes Wichita with a population of 384,445. Within that same region also lays Pratt with a population of 6,850. This is a good example of Kansas' diversity where rural communities are influenced by mid-sized cities and mid-sized cities are influenced by rural communities. This diversity provides challenges to service delivery, but also an opportunity for sharing resources.<sup>1</sup>

#### Population Density & Peer Groups (Urban, Semi-Urban, Densely-Settled Rural, Rural, and Frontier)

The population density of Kansas was 35.6 inhabitants per square mile in 2015, a 13.4% increase from 31.4 persons per square mile in 1996. For comparison, the population density of the U.S. increased from 71.1 to 91.0 persons per square mile from 1996 to 2015, a 28.0% increase. In 2015, 36 of the state's 105 counties had population densities of less than 6.0 persons per square mile. The most sparsely populated county was Wallace, with a density of 1.7 persons per square mile. The most densely populated county was Johnson, with 1,225.6 persons per square mile. Several Kansas counties were re-categorized from one population-density peer group to another, to reflect population shifts indicated by the 2010 U.S. Census. During the 2011-2015 period, the population of the urban and semi-urban peer groups increased by 3.2% and 0.4%, respectively, while the frontier, rural, and densely-settled rural peer groups decreased by 2.8%, 1.7%, and 1.0%, respectively.<sup>1</sup>

#### Population Growth/Change

The percent increase in the Kansas total population from 1996-2015 was 13.2%, including a 14.8% increase for Kansas males and an 11.6% increase for Kansas females. Kansas increased in population from 2,904,021 residents in 2014 to 2,911,641 residents in 2015, a 0.3% increase. Pottawatomie, Greeley, and Douglas Counties had the largest relative increases in population from 2011 to 2015 with percent changes of 6.3, 5.7, and 5.2 respectively. Stanton, Elk, and Hamilton Counties had the largest relative decreases in population, with changes of 7.9%, 7.3% and 7.2% respectively.<sup>1</sup> In 2015, there were an estimated 38,972 infants living in Kansas or about 1.3% of the total Kansas population (2,911,641). Women of reproductive age 15-44 accounted for 19.2% (560,142) of the Kansas population. In 2015, there were 851,797 children and adolescents aged 1-21 years living in Kansas, which represents 29.3% of the Kansas population. Among families with children under 18, 29.6% are single-parent families versus married-couple families (70.4%). According to the 2011/12 National Survey of

Children's Health, 19.4% of Kansas children aged 0 to 17 (est. 139,623 children) had special health care needs. These rates represent an increase from the percentage reported in 2009/10 (17.3%) for Kansas. The reasons for this increase are not fully understood. While it is possible that the number of children and youth with special health care needs (CYSHCN) is actually increasing, it is also possible that children's conditions are more likely to be diagnosed, due to increased access to medical care or growing awareness of these conditions on the part of parents and physicians.<sup>2</sup>

### **Age**

The median age of Kansans in 2015 was 36.1 years, a 4.0% increase from the median age of 34.7 in 1996. The median ages of Kansas males and females in 2015 were 34.9 and 37.6 respectively. Shifts in the Kansas population distribution by age from 1996 to 2015 included a decrease in the 35-44 age group of 17.0%. An increase of 19.5% in residents 45-54 years of age and 80.8% in residents 55-64 reflected the aging of the baby boomers. Furthermore, there were 9.4%, 3.9%, 15.8%, 6.3%, and 12.4% increases in the 0-4, 5-14, 15-24, 25-34, and 75 and over age-groups respectively.<sup>1</sup> The prevalence of special health care needs within the child population increases with age. Older children in Kansas were twice as likely as younger children to have a special health care need. In Kansas, preschool children (aged 0-5 years) have the lowest prevalence of special health care needs (10.2%), followed by children aged 6-11 years (23.9%). Adolescents (aged 12-17 years) have the highest prevalence of special health care needs (24.3%). The higher prevalence of special health care needs among older children is likely attributable to conditions that are not diagnosed or that do not develop until later in childhood.<sup>2</sup>

### **Race/Ethnicity**

According to the 2015 Census Bureau estimates, 76.4% of Kansans were non-Hispanic white and 5.9% were non-Hispanic black. Hispanics made up 11.6% of Kansas' population.<sup>1</sup> The race and ethnicity composition of women aged 15-44 (i.e., of childbearing age) was estimated at 72.7% non-Hispanic white, 6.3% non-Hispanic black, 0.9% non-Hispanic Native American or Alaska Native, 4.0% non-Hispanic Asian and Pacific Islander, 2.6% non-Hispanic multiple race, and 13.4% Hispanic (any race). The Kansas population, like that of the nation, is becoming more racially and ethnically diverse. About three-in-ten (30.4%) Kansas children and adolescents (1-21 years) belong to a racial or ethnic minority. Across the age groups, one-in-three (31.7%) young children (1-5 years) are part of a racial/ethnic minority versus about one-in-four (28.9%) young adults (20-21 years). About 15.3% of Kansans age 15-21 are Hispanic, compared to 18.8% of young children. The prevalence of special health care needs varies by the child's race and ethnicity. Kansas Hispanic children (15.2%) were least likely to have a special health care need compared to non-Hispanic white children (19.6%) and non-Hispanic black children (22.3%).<sup>2</sup>

### **Diversity/Languages**

According to the 2011-2015 American Community Survey, in Kansas, 2.4% of the households met the definition of being limited English speaking compared to 4.5% of U.S. households. In Kansas, the prevalence of limited English speaking in households varies by language spoken at home. Limited English speaking among households speaking Spanish was 22.7%, other Indo-European languages 9.7%, Asian and Pacific Island languages 26.6%, and other languages 15.6%.<sup>3</sup> Ninety-three percent (93.1%) of the people living in Kansas in 2011-2015 were native residents of the United States. About 59.0% of these residents were living in the state in which they were born. About 6.9% of the people living in Kansas in 2011-2015 were foreign born. Of the foreign born population, 35.9% were naturalized U.S. citizens, and 90.7% entered the country before the year 2010. About 13.0% of the foreign born entered the country in 2010 or later. Foreign born residents of Kansas come from different parts of the world.<sup>4</sup> Among people at least five years old living in Kansas in 2011-2015, 11.3% spoke a language other than English at home. Of those speaking a language other than English at home, 66.3% spoke Spanish and 33.7% spoke some other language; 39.7% reported that they did not speak English "very well." Notable is a change in Spanish speaking population in Kansas, which has been steadily increasing. The increase mirrors similar trends at the national level.<sup>4</sup>

### **Education**

Kansas compares favorably with the U.S. average in terms of educational attainment with a 90.0% high school graduation rate compared with 86.7% for the U.S. Thirty-one percent (31.0%) of Kansans have a bachelor's degree or higher compared with 29.8% for the U.S.<sup>4</sup>

### **Income/Poverty**

For 2015, the federal poverty level was \$24,250 for a family of four. Children living in families with incomes below the federal poverty level are referred to as poor.<sup>5</sup> Research suggests that, on average, families need an income of about twice the federal

poverty level to meet their basic needs.<sup>6</sup> In 2015, based on the Small Area Income and Poverty Estimates (SAIPE), compared to the U.S. population, a lower percentage of Kansans lived in households with incomes below the federal poverty level (12.9% vs. 14.7% for the U.S.) and also a lower percentage of children under age 18 lived in households with incomes below the federal poverty level (16.9% vs. 20.7% for the U.S.). During the past 10 years (2006-2015), Kansas experienced a significant increase in the poverty rate for children under age 18. Similar trends were seen in the United States.<sup>7</sup> In 2015, 119,994 Kansas children under 18 years of age were living in poverty. Most of these children live within four population centers: Sedgwick County (Wichita), Wyandotte and Johnson Counties (Kansas City metropolitan area), Shawnee County (Topeka), and Douglas County (Lawrence). Five counties accounted for over half of all Kansas children (62,824 children; 52.4%) in poverty: Sedgwick (27,528), Wyandotte (14,546), Johnson (9,403), Shawnee (8,447), and Douglas (2,900). However, the rural southeastern portion of the state has many counties with high concentrations of children in poverty as well.<sup>7</sup> In 2015, the percent of Kansas' families living at or below the federal poverty level (8.4%) was lower than the U.S. (10.6%). Poverty was more common in Kansas families headed by single females and those with children in the household, regardless of race or ethnicity. In 2015, the Kansas percent of female headed households with related children under 18 years living below 100% federal poverty level (36.5%) was slightly below the U.S. percent (39.2%). The prevalence of special health care needs varies by income group in Kansas. CYSHCN prevalence among low income families, 0-99% of the federal poverty level (FPL), was the highest group (26.4%).<sup>2</sup>

### **Health Insurance Coverage**

Data from the Small Area Health Insurance Estimates (SAHIE) show that the percentage of Kansas children under 19 years old without health insurance decreased from 6.7% in 2011 to 5.1% in 2015, a 23.9% decrease.<sup>8</sup> Part of the reason for this finding is an increase in public coverage of Kansas children.<sup>9</sup> This increase suggests factors such as the weakness in the economy and the state's active outreach efforts to enroll children who need coverage may be responsible.<sup>9</sup> The U.S. percentage also decreased from 7.9% in 2011 to 5.0% in 2015. In 2015, about half (49.8%) of all uninsured Kansas children under age 19 live in the four largest population centers: Sedgwick County (Wichita), Johnson and Wyandotte counties (Kansas City metropolitan area), Shawnee County (Topeka), and Douglas County (Lawrence). However, the southwestern part of the state, a largely Hispanic populated area and presumably, many are not KanCare (Medicaid or CHIP) eligible, has many counties with high concentrations of uninsured children under age 19. The southeastern portion of the state (Kansas Ozarks), on the other hand, has a cluster of counties with high concentrations of children in poverty, as stated above, but the children are less likely to be uninsured than those in the southwestern part of the state. According to the 2011/12 National Survey of Children's Health, in Kansas, 89.3% of CYSHCN were reported to have been insured for all of the previous 12 months, while the remaining 10.7% were uninsured for all or some part of the year. Overall, almost 96% of CYSHCN were reported to have some type of insurance at the time of the interview: about two-thirds (64.2%) had private coverage, 25.1% had public coverage, 6.2% had both, and 4.6% had no insurance.<sup>2</sup>

### **Primary Care Access & Workforce**

In 2012 (most recent data available), the supply of primary care physicians per 100,000 population (42.5) was not significantly different in Kansas, compared to the national average (46.1).<sup>10</sup> However, in Kansas, the percentage of physicians having physician assistants or nurse practitioners in their practices (74.2%) exceeded the national average (53.0%).<sup>10</sup> KDHE recognizes that while there are needs across the state, there are also unique needs in different areas of the state. Access to care has been recognized as a challenge for the maternal and child health population living in both geographic domains for different reasons. For example, women in rural areas face barriers accessing transportation and getting to providers who may be unavailable in their area. Whereas, women in more densely populated areas, have a wider availability of services yet may not have time off work or the insurance needed to receive services. The CYSHCN population often experiences reduced access due to the lack of pediatric specialists in the state, in addition to the other barriers mentioned. In fact, 14.5% of CYSHCN families reported that they had trouble getting specialist care versus 3.1% of non-CYSHCN families.<sup>2</sup> Overall, KDHE has recognized that programs and providers are an important part of the landscape and the unique needs of the Kansas MCH population are being addressed throughout the state. The Bureau has been and will continue to be committed to working with local partners to address those unique needs, and to build on the successes at the local and regional levels in improving maternal and child health.

### **Health Equity and Social Determinants of Health (SDoH)/Disparities**

According to the 2017 KIDS COUNT Data Book, Kansas ranked 15<sup>th</sup> for overall child well-being, 7<sup>th</sup> in economic well-being, 20<sup>th</sup>

in health, 23<sup>rd</sup> in the family and community, and 26<sup>th</sup> in education. The annual KIDS Count Data Book uses 16 indicators to rank each state across four domains – health, education, economic well-being and family and community – that represent what children need the most to thrive. Comparing 2015 and 2009, Kansas saw no improvement in the percentage of fourth graders not proficient in reading and experienced a six percent rise in eighth graders not proficient in math. In addition, Kansas saw a rise in the percentage of 3- to 4-year-olds not attending school, from 53% to 56%, over a five-year period. Kansas saw improvement in all four economic well-being measures. The number of children living in families where no parent has a full-time, year-round job declined nearly 2% between 2014 and 2015 to 167,000. This decline marks a five-year low for Kansas and a 4% drop since 2010. However, the percentage of children living in high-poverty areas jumped, from 8% to 9% (est. 63,000 children), over a five-year period.

When looking at outcomes such as infant mortality, preterm birth and smoking during pregnancy rates, we see consistent trends based on race/ethnicity (particularly black-white) and socioeconomic factors (particularly Medicaid vs. non-Medicaid) in Kansas. Factors include:

- Race/Ethnicity
- Insurance Type
- Education Level
- Federal Poverty Level
- Special Health Care Needs

These variables are all tied together. For example, people with lower education levels are more likely to live in poverty.

To address disparities, we have taken the following action steps to improve health equity and eliminate disparities:

- Using data to determine where to pilot/target programming, based on disparities (e.g., Smoking Cessation pilot sites chosen from the counties with the highest smoking rates)
- Increasing access to prenatal education and service access in communities with demonstrated disparities (Perinatal Collaboratives/Becoming a Mom®)
- Providing culturally appropriate prenatal education (bi-lingual curriculum and instructors)
  - Currently accommodate for the Hispanic population (curriculum in Spanish and program forms also translated)
  - In conversation with the March of Dimes to launch *The Coming of the Blessing* ([comingoftheblessing.com](http://comingoftheblessing.com)) by late fall to target the Native American population.
- Assessing the need for health care coverage, transportation, housing, food, education, etc.
- Implementing nontraditional community-level outreach (minority and at-risk)
- Assuring gap-filling services for those without insurance/access
- Expediting Medicaid eligibility for prenatal care coverage
- Expanding the Optum/Alere Health partnership to increase availability of 17P for Medicaid-covered pregnant women in the service area (KC)
  - Need Medicaid reimbursement for non-Optum beneficiaries
  - Need Wichita facility inspection for launch
- Screening for social determinants through local MCH programs
  - Need tool or screening questions to integrate into existing programs/services
- Working with the agency-appointed staff person to coordinate/advance minority health and health equity strategies (utilizing the CollN SDoH network framework and resources)
- Expanding the Community Baby Shower model focused on safe sleep to integrate smoking cessation and breastfeeding education and referral to services on site; partnering with managed care organizations (MCOs) to align efforts
- Implemented a centralized, web-based data sharing system (DAISEY) that allows for monitoring outcomes and quality improvement along MCH programs

### **State Health Agency Priorities & Initiatives - Title V Roles & Responsibilities**

Kansas is a state that values young children and families. Over the past decade, significant investments have been made in building a collaborative environment and in supporting at-risk communities to improve child and family health and well-being. The Kansas Department of Health and Environment, Bureau of Family Health has been a leader in these efforts. The Bureau/Title V Program plays a key role with the following:

Infant Mortality Collaborative Improvement and Innovation Network (IM CollIN): Kansas' selections for the IM CollIN (national-state-local partnership) are Smoking cessation (before, during, after pregnancy) and Early/preterm birth. This work has resulted in implementation of the BABY & ME - Tobacco Free evidence-based program and screening for previous preterm birth resulting in utilization of progesterone. A partnership between Title V and Optum (Alere Health) is underway to ensure eligible women are prescribed progesterone and then referred to a case manager for follow up. Sustainability is the key to improved outcomes and long-term success. From concept to reality, the state has worked to integrate CollIN activities into existing systems (MCH, Tobacco, WIC) and programs (Becoming a Mom--prenatal education and care, screening, referral; Healthy Start; Safe Sleep; Communities Supporting Breastfeeding) to provide the mechanism to achieve current success and future expansion of successful programs. This integration extends to the inclusion of all CollIN efforts in the Title V Needs Assessment. Due in part to the CollIN exposure, Kansas is currently seen as a maternal and child health leader on the national stage recognized by NICHQ, AMCHP and the March of Dimes.

Communities Supporting Breastfeeding: The Bureau of Family Health (BFH) and the Kansas Breastfeeding Coalition, Inc. (KBC) continue to work on several projects that support breastfeeding families and build community support. These organizations have partnered on the [Communities Supporting Breastfeeding](#) project with funding for continuation of this project into 2017 from the Kansas Health Foundation. Five communities were designated as a Community Supporting Breastfeeding (CSB) in 2015. An additional 12 communities reached the designation by 2017 with support from the Kansas Health Foundation.

Perinatal Community Collaboratives/Birth Disparities Programs: The Title V Program and March of Dimes in collaboration with local communities and the broader network of health care and community service providers are involved in an on-going process of developing grassroots perinatal care collaboratives using March of Dimes *Becoming A Mom/Comenzando Bien*® (BAM) as a consistent and proven prenatal care education curriculum. The model brings together prenatal education and clinical care. The first program was launched and piloted in Salina (Saline County) in 2010. This innovative model was replicated in Junction City (Geary County) in 2012 (Healthy Start community aka Delivering Change) with preliminary successes similar to that of the Saline pilot program. In 2015, the Bureau of Family Health/Title V committed to partner with the March of Dimes for further expansion of the model across the state, as well as securing long-term sustainability of the program by integrating the model into MCH services at the local level. Additionally, the Universal Home Visiting model implemented by Delivering Change was documented and informed redesign of the MCH home visiting program, with intent of making sure all women and infants receive and least one visit and referred to additional services as needed.

Pregnancy Risk Assessment Monitoring System (PRAMS): Kansas PRAMS was funded in 2016 and is a collaborative project with the Centers for Disease Control and Prevention (CDC). Kansas began collecting data in April 2017 to understand the risk factors as well as the experiences and behaviors before, during, and after pregnancy that contribute to poor pregnancy outcomes. The Bureau of Epidemiology and Public Health Informatics oversees the grant while the Bureau of Family Health (Title V) promotes the project/survey and utilizes data to inform MCH programming to improve outcomes. The PRAMS steering committee is a joint group including members from two of the four standing Kansas Maternal & Child Health Council subcommittees, Women/Maternal and Perinatal/Infant.

Birth Defects Surveillance & Zika Virus: KDHE applied for the CDC's *Surveillance, Intervention, and Referral Services for Infants with Microcephaly and other Adverse Outcomes Linked with the Zika Virus* grant in June 2016. Through the most recent opportunity, Kansas proposes to enhance the current passive birth defects surveillance system by including case verification and improving surveillance methodology to include additional data sources (hospital discharge data) to rapidly identify cases of microcephaly and other defects potentially linked to Zika. The Bureau of Epidemiology and Public Health Informatics will oversee the grant and manage Zika Pregnancy Registry reporting while the Bureau of Family Health (Title V) will manage the Birth Defects Program (surveillance, coordination, Registry).

Special Health Care Needs Program (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. In response to the Special Health Care Needs Strategic Plan, Kansas implemented a new financial assistance structure to support families around greatest areas of financial need. Additionally, there is a new care coordination model being piloted to enhance services available to the CYSHCN population. 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. Further development of an existing innovative web-based communication tool (IRIS), now used in MIECHV communities and slated for Help Me Grow communities, will also allow families to initiate services or referrals and be empowered with the right information and warm hand-offs among MCH providers and community partners.

State Systems Development Initiative (SSDI): The SSDI project aims to 1) develop, enhance and expand MCH data capacity, allowing for informed decision making and resource allocation to support effective, efficient and quality programming; 2) support the Kansas Infant Mortality CollN Team through improved availability and reporting of timely data to inform efforts and track outcomes that drive quality improvement and collaborative learning; and 3) advance the utilization of the Minimum/National Dataset (M/NDS), Core/National Dataset (C/NDS), and Core/State Dataset (C/SDS) for the Kansas Title V MCH program.

Kansas Tribes: KDHE has been working over the last four years to develop a working relationship with the four Kansas tribes (Iowa Tribe of Kansas and Nebraska, Prairie Band Potawatomi Nation, Sac & Fox Tribe, and Kickapoo Tribe) (1.0% of the Kansas population). As a result of improved communication and established trust with KDHE, the first Kansas Tribal Health Summit was held in 2013. The purpose of the annual Summit has been to bring together Kansas Tribes and leadership from KDHE. The partnership grew in 2015 when the Summit involved more KDHE programs and staff including MCH (represented by the Title V Director) and focused on the status/future plans of each of the tribes' community health assessments (following the Healthy Kansans 2020 model/process). As stated in the disparities section, the MCH program is planning to partner with the March of Dimes to launch *The Coming of the Blessing* ([comingoftheblessing.com](http://comingoftheblessing.com)) in late 2017 or early 2018, starting with the Kickapoo Tribe in response to their request for support and initiatives to improve access to prenatal care and birth outcomes.

Early Childhood Comprehensive Systems: Building on previous work that made tools and resources for screening available across the state, current work focuses on increasing cross-sector collaboration. The purpose of the work is to increase developmental screenings and related referral for children birth to age five (early detection and assessment), maternal depression screening, and ensuring children's developmental needs are identified so families are connected to the right services in an appropriate and timely manner. Plans to enhance systems involve building capacity and functionality to support electronic referral through IRIS among partners statewide.

Adolescent Health: Title V partners with Kansas State University, the Kansas State Department of Education, the KDHE Bureau of Health Promotion, and Kansas School Nurse Organization, health providers, and community-based organizations to advance Adolescent Health. A model is under development for school-based health centers to improve adolescents' access to health services and increase understanding of the importance of annual well visits.

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## II.B. Five Year Needs Assessment Summary and Updates

### FY 2018 Application/FY 2016 Annual Report Update

#### Promoting the Needs Assessment & Population Domain Action Plans

As reported in previous updates, the final state action plan was transformed into a final "design" document for release and dissemination. The final document is available on websites and routinely shared with partners in the course of our work and conversations. Presentations to key stakeholder groups are ongoing.

Along with MCH branding to connect/tie all activities and materials together, the Title V team developed a "profile" for each domain which provides information about the needs assessment including: state priority(ies), measure(s), objectives, and strategies/change ideas for each population domain in an easy to read and understand 1-page snapshot.



*Domain Profile EXAMPLES (all profiles are available in the supplement documents section)*

### MCH 2020: Perinatal & Infant Health

#### State Priority

Families are empowered to make educated choices about infant health and well-being

#### Performance Measures

- Percent of infants who are ever breastfed
- Percent of infants breastfed exclusively through 6 months
- Percent of Women, Infants, and Children (WIC) infants breastfed exclusively through six months in designated "Communities Supporting Breastfeeding"
- Number of Safe Sleep (SIDS/SUID\*) trainings provided to professionals

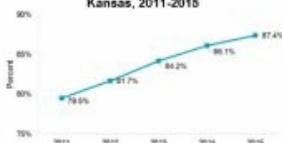
\*Sudden Infant Death Syndrome and Sudden Unexpected Infant Death

#### Data Highlights

- In 2015, 87.4% of Kansas infants were breastfed,<sup>1</sup> higher than the *Healthy People 2020* goal of 81.9%.
- Breastfeeding exclusively for six months supports optimal growth. In 2013, 23.4% of Kansas infants were breastfed exclusively for 6 months,<sup>2</sup> lower than the *Healthy People 2020* goal of 25.5%.
- Sudden Unexplained Infant Death (SUID) is the third leading cause of death for Kansas infants. The Kansas Infant Death & SIDS Network provides safe sleep training to more than 4,500 parents and providers annually.<sup>3</sup>
- Opportunity for Improvement: Disparities persist in perinatal/infant health based on racial, ethnic, socioeconomic and geographic factors.

#### Spotlight on Improvement

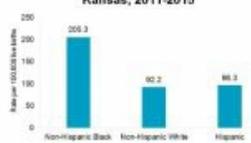
Percent of Infants Ever Breastfed  
Kansas, 2011-2015



Source: KDHE Bureau of Epidemiology and Public Health Informatics

#### Example of Health Disparity

SUID Rate by Race/Ethnicity  
Kansas, 2011-2015



Source: KDHE Bureau of Epidemiology and Public Health Informatics

#### Next Steps

- Increase the number of communities that provide breastfeeding support across community sectors (i.e. hospitals, businesses, physician clinics, health departments, child care facilities).
- Increase the number of Baby-Friendly<sup>®</sup> hospitals participating in the Baby Friendly Hospital Initiative.
- Develop standardized education content on the importance of prenatal and postpartum nutrition and exercise for optimal infant feeding to support existing programs, including perinatal community collaboratives utilizing the March of Dimes Becoming a Mom<sup>®</sup> curriculum; home visiting; and Women, Infants, and Children (WIC).
- Implement a multi-sector safe sleep initiative to include safe sleep instructor training, expanded community baby shower (safe sleep, breastfeeding, smoking cessation), hospital bundle, and physician's toolkit.



This fact sheet, created by the Kansas Department of Health & Environment Bureau of Epidemiology and Public Health Informatics and Family Health, highlights the priorities and measures identified as part of the Title V MCH Services Block Grant Program five year needs assessment (MCH 2020). The Title V Block Grant was authorized in 1936 as part of the Social Security Act. Title V's mission is 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.



Data Sources: 1. KDHE Bureau of Epidemiology & Public Health Informatics, Kansas by its state (Accessed); 2. Centers for Disease Control & Prevention, National Immunization Survey; 3. KDHE Network 2015 Annual Report.



## MCH 2020: Women & Maternal Health

### State Priority

Women (ages 15-44 years) have access to and receive coordinated, comprehensive services before, during and after pregnancy

### Performance Measures

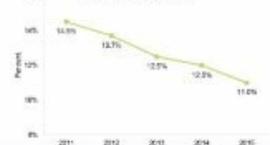
- Percent of women with a past year preventive medical visit
- Percent of women served by a Title V program that received education on the importance of a preventive medical visit in the past year
- Percent of preterm births (<37 weeks gestation)
- Percent of women who smoke during pregnancy

### Data Highlights

- In 2014, 63.7% of Kansas women (18-44 years) had a preventive medical visit.<sup>1</sup>
- In 2015, the Kansas preterm birth rate (8.8%) was higher than the March of Dimes goal: 8.1% by 2020.<sup>2</sup>
- Kansas mothers who smoked anytime during pregnancy were almost two times more likely to have a baby die than mothers who did not smoke. In 2015, 11.0% (4,294 out of 39,050) of mothers reported smoking during pregnancy.<sup>3</sup>
- **Opportunity for Improvement:** Disparities persist in women/maternal health based on racial, ethnic, socioeconomic and geographic factors.

### Spotlight on Improvement

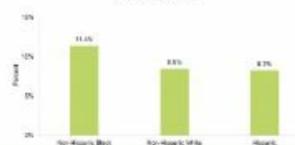
Women Reporting Smoking During Pregnancy  
Kansas, 2011-2015



Source: KDHE Bureau of Epidemiology and Public Health Informatics

### Example of Health Disparity

Preterm Birth (<37 Weeks Gestation) by Race/Ethnicity  
Kansas, 2015



Source: KDHE Bureau of Epidemiology and Public Health Informatics

### Next Steps

- Increase the number of women receiving a preventive medical visit (well woman visit) annually.
- Implement a standard prenatal/postnatal risk screening protocol, including screening for trauma, depression, and prior spontaneous preterm birth. Promote the appropriate use of progesterone therapy among pregnant women.
- Increase the number of established perinatal community collaboratives. The Kansas Perinatal Community Collaborative Model utilizes the March of Dimes Becoming a Mom<sup>®</sup> prenatal education curriculum. This public/private partnership brings together prenatal education and clinical care.
- Increase the proportion of smoking women referred to evidence-based cessation services and increase abstinence from cigarette smoking among pregnant women.
- Increase the number of women/families receiving home visiting services through improved coordination and referral.



This fact sheet, created by the Kansas Department of Health & Environment Bureau of Epidemiology and Public Health Informatics and Family Health, highlights the priorities and measures identified as part of the Title V MCH Services Block Grant Program five year needs assessment (MCH 2020). The Title V Block Grant was authorized in 1995 as part of the Social Security Act. Title V's mission is 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.



Data Sources: 1. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2014. 2. KDHE Bureau of Epidemiology and Public Health Informatics, Kansas birth data (prebirth)

The MCH website ([www.kansasmch.org](http://www.kansasmch.org)) and Facebook page ([www.facebook.com/kansasmch](https://www.facebook.com/kansasmch)) previously reported on are gaining popularity. The Kansas MCH website analytics reveal a general increasing trend in terms of page visitors and visits for the website since January 2016. The increasing trends for traffic and “likes” could be attributed to the fact that the website and Facebook page are shared and promoted at every Kansas MCH Council meeting, state conference, committee meeting, and any other meeting/venue when the opportunity presents itself. The website and Facebook page are also shared during partner meetings and have been added to the signature for emails to support promotion and outreach. It appears that local partners and Council members are “inviting” partners to “like” the page, and the posts are receiving more traffic which results in more “sharing” and “liking” of the Kansas MCH Facebook page posts. This in turn results in more “likes” for the page itself. We are pleased to provide this resource for local MCH partners and grantees across the state. Many local agencies are unable to host their own Facebook or other social media sites, so this provides them with the opportunity to access information and resources.

*MCH Facebook Page: Unique Visitors and Visits & Pages Visited (January 2016-May 2017)*



The MCH Facebook page analytics reveal a trend of increased likes since launch.

*MCH Facebook Page "Likes"*



## Ongoing Review & Assessment of State Needs

The Kansas Title V team continued work related to the Title V Needs Assessment and State Action Plan in partnership with the Kansas Maternal & Child Health Council and Special Health Services Family Advisory Council. The primary focus since last year's application involved refining the objectives, strategies, and Evidence- Based or Informed Strategy Measures (ESMs) for each of the eight National Performance Measures (NPM) Kansas selected. Additionally, discussions related to timely tracking and reviewing progress on measures (performance and strategy measures) was ongoing. A system for tracking and monitoring was determined and established. Data sources were reviewed to assure validity.

Team meetings were held monthly and more often as needed to review objectives and strategies within each priority—this was to assure they were on target with priority work and relevant efforts. Concentrated effort has continued to be focused on aligning objectives to the priorities of other Kansas Department of Health and Environment (KDHE) and partner programs to ensure they are not repetitive or duplicative but are collaborative. Strengths of this approach include the ability to ensure the individuals whose input was most important to a priority attended the meeting for that priority. Internal and external partners and subject matter experts from other areas of KDHE and partnering organizations were invited to select meetings when they could contribute to the discussion (e.g., Oral Health, Injury Prevention, WIC, Tobacco Cessation). Any and all updates to the state action plan were reviewed with and/or informed by the Kansas Maternal and Child Health Council. The Council actively participates in monitoring of the plan and assists with prioritization and assessment of progress on a regular basis.

Interim Year Changes to the State Action Plan: Based on ongoing work, progress, challenges, changing needs, and input, the following noteworthy revisions/updates were made and/or are being discussed as they relate to the state action plan for the period 2016-2020.

- Updated ESM for Cross-cutting domain NPM # 14 (smoking)
- Updated ESM for Adolescent domain NPM # 9 (bullying)
- Merged objectives and strategies that were very similar in nature within the Child and Adolescent health domains to streamline and increase clarity and focus
- Possibly develop an objective or strategy to lead and implement a coordinated state-level response to Neonatal Abstinence Syndrome
- Possibly develop an objective or strategy to lead discussions and facilitate launch of a Kansas Maternal Mortality Review Committee
- Possibly develop a strategy to further integrate systems and improve coordination of services at the state and community levels through affiliation as a Help Me Grow state
- Possibly develop a strategy to increase access to mental health first aid training (youth and adult) for MCH local program staff including home visitors, schools, and other MCH community network partners

Children & Youth with Special Health Care Needs Update: KS-SHCN completed a strategic plan in FY15 which reflects the integrated and cross-systems approach to the Kansas work. As part of the strategic planning, an analysis of service provision led to significant changes.

The Direct Assistance Programs (DAPs) were implemented in July 2015 and have been monitored and reviewed to identify any gaps or barriers so adjustments could be made. A tracking form was developed to track client concerns/issues with DAPs and a review process was put into place to evaluate if changes were needed. This has led to a few changes in DAP policies and to some of the protocols. In 2017, a Legislative Post Audit (LPA) was conducted regarding the PKU Program, as related to the Metabolic Products DAP (above). The LPA resulted in recommendations on how to better support families, however ultimately validated the shift to this DAP model. These programs will continue to be monitored, promoted, and policies adjusted to best support the families and clients served through the program.

A direct result of the DAP program includes stronger partnerships with families. An unintended result of the DAP program includes significant cost-savings. It is believed the top contributing factor to these savings is better care coordination efforts such as fighting for insurance coverage or payment of eligible services to assure KS-SHCN funds are truly the payor of last resort. This has resulted in better accountability for providers to bill all insurances prior to submitting to KS-SHCN for payment. The process supported partners and providers with opportunities and an avenue for recommending systems change, or advocating for additional support to promote higher quality services. In addition to programmatic cost-savings and increased care coordination opportunities, we have experienced greater support for families and are seeing improved outcomes as families are more equipped and educated about taking care of their health needs.

The Title V Needs Assessment and new KS-SHCN priorities provided a foundation for the development of the "Kansas State Plan for Systems of Care for Children and Youth with Special Health Care Needs" as part of the D-70 Integrated Community Systems for CYSHCN grant. One of the goals under the grant was to develop a "multi-system state plan that supports system standards and enhanced services for CYSHCN." The plan is attached to the grant application and is based upon the [Standards for Systems of Care for CYSHCN](#).

## FY 2017 Application/FY 2015 Annual Report Update

### Finalizing the Title V State Action Plan for the Period 2016-2020

The Kansas Title V team partnered with the University of Kansas Center for Public Partnerships & Research (KU-CPPR) to continue the work related to the Title V Needs Assessment and State Action Plan. The primary work since last year's application was to reorganize and refine the priorities and objectives, identify State Performance Measures, and develop/identify an Evidence-Based or Informed Strategy Measure (ESM) for each of the eight National Performance Measures (NPM) Kansas selected.

To finalize the plan and ensure changes going forward did not compromise the original needs identified based on input and data, the team created a crosswalk linking goals and objectives in the original needs assessment to the most recent copy of the Action Plan in February 2016 to confirm fidelity to the original assessment. The action plan focuses on eight priority areas.

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

Team meetings were held weekly to review objectives within each priority and revise them as necessary to ensure each was SMART. In addition, data sources were identified for each objective to ensure it could be measured and a rank assigned based on how difficult it would be to obtain and analyze the associated data. The KU-CPPR facilitator maintained a running draft of changes proposed during meetings and maintained a single draft version of the working document. The facilitator reviewed rankings, to ensure the team knew the level of difficulty associated with measuring all of the objectives outlined within each priority. The facilitator also followed up with members of the team to ensure outstanding issues were addressed in a timely manner. Outstanding issues included identifying appropriate data sources, ensuring data from those sources would be available, and aligning objectives to the priorities of other Kansas Department of Health and Environment (KDHE) programs to ensure they were not repetitive but were collaborative. Strengths of this approach included the ability to ensure the individuals whose input was most important to a priority attended the meeting for that priority. Challenges included identifying meeting times that worked with multiple individuals' busy schedules. Outside experts from other areas of KDHE were also invited to select meetings when they could contribute to the priority being discussed that day (e.g., Injury Prevention and Tobacco Cessation Programs). When objectives were completed, they were presented to a larger group of program directors within the KDHE. Objectives were revised based on the Title V Director's feedback and presented to the Maternal and Child Health Council to assist with prioritizing the objectives within each priority. The prioritization results were used to assist in assigning dates to objectives.

State Performance Measures were selected once the objectives and strategies were finalized for each priority area/population domain. The SPMs directly relate to areas of the work plan that are not addressed by the National Performance Measures. In addition, the ESMs were selected once the strategies were finalized to ensure Kansas will be measuring processes and activities that directly relate to the NPM.

#### State Performance Measures

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

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

SPM 3: Percent of children 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes/day

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

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

Evidence-Based or Informed Strategy Measures (ESMs are still under review and may be revised as the plan is implemented and data collected):

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

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

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

ESM: Number of certified child safety seat technicians in the state  
- NPM 7: Child Injury (Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9)

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

ESM: Percent of adolescent program participants (12-22 years) that received education on the importance of a well-visit in the past year  
- NPM 10: Adolescent well-visit (Percent of adolescents, 12 through 17, with a preventive medical visit in the past year)

ESM: Percent of families who experienced a decreased need of care coordination supports  
- NPM 11: Medical home (Percent of children with and without special health care needs having a medical home)

ESM: Percent of pregnant women program participants who smoke referred to the Tobacco Quitline  
- 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)

*Children & Youth with Special Health Care Needs:* KS-SHCN completed a strategic plan in FY15, developing a 5-Year Plan with 14 objectives and 31 total strategies. The KS-SHCN five year plan five priorities, and related focus areas, are as follows: (1) Care Coordination: empowering families, improving communication among providers and systems, and stronger cross-system collaboration; (2) Family Caregiver Health: promoting health and wellness among family caregivers, increasing awareness of and access to respite services, and family leadership and peer supports; (3) Behavioral Health: collaboration to support integrated care, community education and referrals, and screening and assessments for KS-SHCN families; (4) Training and Education: advocacy, youth leadership and self-determination, and training for professional in integrated care of people with disabilities; and (5) Direct Health Services: gap-filling services such as oral health, access to adequate insurance coverage, and telehealth. These strategies are re-assessed each year by the SHS-FAC to monitor progress and make recommendation for changes, as needed.

The objectives and strategies align nicely with the Title V plan and the transformation of the Block Grant, with many of the KS-SHCN priorities and strategies integrated into the Title V state action table: not only in the priority selected for the CYSHCN domain, but in many of the overall state priorities and a variety of different objectives. This reflects the integrated and cross-systems approach to the Kansas work. While the medical home continues to be a central focus of the KS-SHCN program, the new priorities address broader needs of the child and their family and focus on stronger collaboration and integration across systems of care.

As part of the strategic planning, an analysis of service provision led to significant changes. Ultimately, the largest change resulted from the inability for KS-SHCN to monitor and track the level of funding available or authorized at any given time. The program identified a recent trend of depleting limited funds available to cover direct services, with pending service cuts if a solution was not realized. This prompted a change to a "Direct Assistance Program (DAP)" model, changing the way services were authorized rather than which services were authorized. This allowed the program to set limits per authorization and per year to better track and monitor the funds that were being spent, resulting in better accountability and an ability to identify when funds are running low and cease authorizations for that DAP until funds are made available again. Each of the DAPs have eligibility criteria and annual maximum assistance amounts. Eight DAPs were developed, as follows:

1. Co-Payments/Deductibles/Co-Insurance: For those with private insurance who have a patient responsibility through co-

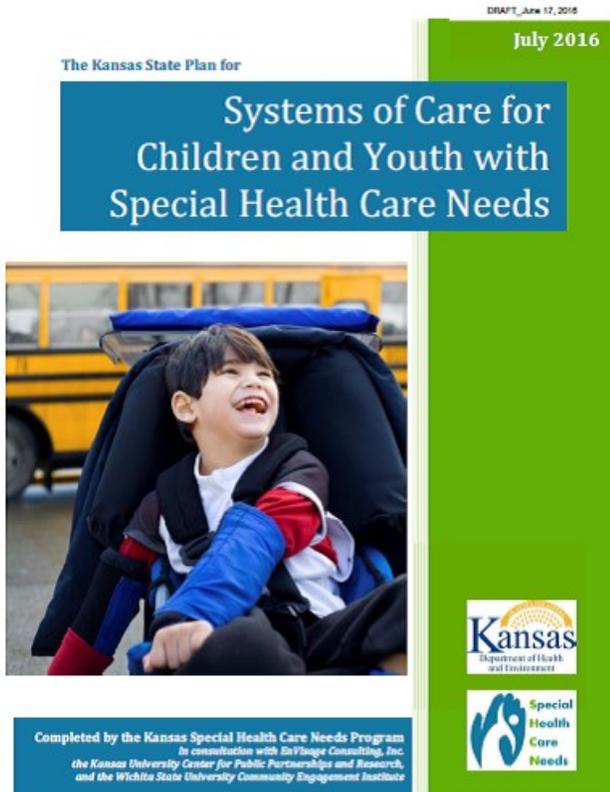
pays/deductible limits or co-insurance. This allows for up to 50% assistance towards deductible limits and/or limited support towards co-pays/co-insurance for medical specialty services.

2. Medical Services: For those with no insurance, or those who are ineligible for KanCare (Medicaid) and/or private insurance through the health insurance marketplace. This allows for direct payment for medical appointments, x-rays, specialty tests, hospitalizations, interpreter services, or other specialty care services. Some of these services require the patient to pay a small co-pay.
3. Orthodontic Treatment Services: For those with craniofacial anomalies to assist with orthodontic evaluations and comprehensive treatment plans.
4. Hemophilia: For those with hemophilia, or other bleeding disorders. This provides up to \$2,500 per factor treatment and a comprehensive hemophilia treatment center visit.
5. Metabolic Products: For those with PKU or metabolic disorders. This provides assistance for metabolic formula and low protein food items.
6. Medication: Provides assistance with medication, not covered by insurance, to eligible clients. Requires the client pay a \$5 co-pay for every \$100 per medication supported by KS-SHCN.
7. Travel: Provides travel assistance to and from the client's home to medical specialty care appointments.
8. Medical Equipment and Supplies: Provides assistance for durable medical equipment and medical supplies. Client co-pays ranging from \$25 to \$100 are applicable depending on the cost of the equipment. Medical supplies can include items such as catheters, ostomy supplies, diabetic testing equipment (CF clients only), hearing aid molds/repairs, glasses, and other items deemed medically necessary.

The DAPs were implemented in July 2015 and have been monitored and reviewed to identify any gaps or barriers so adjustments could be made. A tracking form was developed to track client concerns/issues with DAP's and a review process was put into place to evaluate if changes to the DAP(s) were needed. This has led to a few changes in DAP policies and to some of the protocols. This process has led to more program accountability, increase in client/staff communication and a better understanding of previous service gap barriers. Internal DAP tools to assist staff and clients were also developed to make the DAP structure flow smoothly.

A direct result of the DAP program includes stronger partnerships with families. An unintended or unexpected result of the DAP program includes a significant cost-savings. It is believed the top contributing factor to these savings is better care coordination efforts and assuring KS-SHCN funds are truly the payor of last resort, such fighting for insurance coverage or payment of eligible services. This also has resulted in better accountability for providers to bill all insurances prior to submitting to KS-SHCN for payment. The process supported partners and providers with opportunities and an avenue for recommending systems change, or advocating for additional support to promote higher quality services.

The Title V Needs Assessment and new KS-SHCN priorities provided a foundation for the development of the "Kansas State Plan for Systems of Care for Children and Youth with Special Health Care Needs" as part of the D-70 Integrated Community Systems for CYSHCN grant. One of the goals under the grant was to develop a "multi-system state plan that supports system standards and enhanced services for CYSHCN." A screen shot of this plan can be found below. The plan is attached to the grant application and is based upon the [Standards for Systems of Care for CYSHCN](#).



### Publishing the Title V Needs Assessment

The final needs assessment comprehensive document was released and posted on the KDHE Bureau of Family Health website in June 2016 at the time the Draft 2017 Application and 2015 Annual Report was released for public input. A screen shot of the needs assessment document cover is provided below.



## Promoting/Marketing Title V & the State Action Plan

The new Title V State Plan truly reflects priorities and needs of MCH populations statewide and is a plan that demands commitment and "shared" responsibility among the state Title V program, partnering state agencies, families/consumers, and other valued state and local programs partners. 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, so branding for the plan and program was needed. The Title V team adopted the following image that represents the focus of our work which ties to the six MCH population domains.



In addition to finalizing the state plan and developing "branding" for a plan that is reflective of MCH efforts statewide, the Title V program launched a website and Facebook page to promote and increase awareness of the Kansas Title V/MCH programming. This has provided the opportunity to announce/share ongoing updates related to the needs assessment and will provide the platform for release of the final plan.

*Kansas MCH Website ([www.kansasmch.org](http://www.kansasmch.org))*

The mission of Kansas Maternal and Child Health is to improve the health and well-being of Kansas mothers, infants, children, and youth, including children and youth with special health care needs, and their families. We envision a state where all are healthy and thriving.

For the federal Title V program, each state conducts a 5-year needs assessment to identify maternal and child health (MCH) priorities. The 2016-2020 MCH priorities for Kansas are:

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

<http://www.kansasmch.org>

*Kansas MCH Facebook Page ([www.facebook.com/kansasmch](http://www.facebook.com/kansasmch))*



An internal document has been used with the state Title V team and Kansas Maternal & Child Health Council through the revision process. At the present time, the final version of the 5-year plan is being transformed into a "design" in preparation for release and dissemination. The design document offers one-pagers highlighting the state priorities, objectives, and related national and state measures. The final document was posted on the websites and shared with partners in August 2016. Presentations to key stakeholder groups were delivered in July (Kansas School Nurse Organization) and September (Kansas Chapter AAP). A sneak peek of the document is provided below.

## Draft Action Plan Design





## **Five-Year Needs Assessment Summary (as submitted with the FY 2016 Application/FY 2014 Annual Report)**

### **II.B.1. Process**

#### **Goals, Framework, and Methodology**

With a goal to maximize the input of internal and external partners, the Kansas Title V 2020 Needs Assessment utilized a mixed methods approach relying on continuous input from a diverse team of key informants and partners, as well as broad public input. The MCH team approached the Needs Assessment as an opportunity to engage stakeholders and form partnerships through interactive regional meetings and surveys, in addition to reviews of national and state data, resulting in capturing a wide range of input and conscious decision making based on stakeholder, partner, and community knowledge. The meetings expanded beyond a listening tour model—providing a setting where community voices mattered and were heard—as the six MCH population health domain needs emerged and were defined as priorities.

The MCH Needs Assessment was led by the state's Title V Director and the Bureau of Family Health (BFH) team. This included special health care needs leaders, epidemiologists, and representatives from state maternal and child programs. The team identified and considered a range of priorities through brainstorming, statewide meetings, surveys, data analysis and stakeholder engagement.

The BFH already had an existing, strong infrastructure that prioritized ongoing evaluation and programmatic support. Even before the Needs Assessment process began, the Bureau Director, Section Directors, Epidemiologists and key partners had a solid framework to build upon. Aligning with goals of the Bureau and the Title V guidance, the team felt that it would be important to identify how: priorities would be determined; gaps would be filled; expectations of MCH staff and partners would be raised; and needs would be assessed at the community level. Additionally, current services available through KDHE were assessed.

Central to the needs assessment planning and process to identify priorities was the Kansas Maternal & Child Health Council, a "partner" identified below. The Council advises and monitors progress addressing specific MCH population needs. The council members are identified and, in consultation with KDHE, selected to serve on the Council. KDHE first worked with the Council to determine the status of Kansas MCH progress since MCH 2015 (2010 Needs Assessment). This assisted with identifying which priorities should continue.

The team outlined the process, defined its goals and examined the relationship between Title V priorities and existing initiatives in Kansas that impact the health and well-being of MCH populations. The *Alignment of Key Frameworks* document highlighted several components that were core to the Needs Assessment approach throughout the process:

1. *While serving as the lead agency for Title V, KDHE is not alone in this work.* There are many complimentary and supporting efforts across state agencies that, in conjunction with Title V, can lead to improved MCH population outcomes. Partnerships will be key to achieving the goals of the Title V work over the next 5 years.
2. *Not all populations are addressed by other initiatives at the same level of intensity.* Significant attention has been given to women, infants, and life course issues, likely as a result of infant mortality work that has been done. KDHE appears to lead in assuring that CYSHCN, child, and adolescent needs are identified and addressed.
3. *The cross-cutting/life course domain has particular significance in coordinating across initiatives and moving the needle on health across MCH domains.* Research indicates the importance of multi-generational approaches to individual and community well-being. The role of life course priorities and strategies has not fully been explored in Kansas; however, the Alignment of Key Frameworks indicated the importance of doing so through the Needs Assessment process.

#### **Stakeholder Involvement and Input**

Early on in the Needs Assessment, a broad approach was taken in order to capture input from state and local partners using in person meetings and surveys. The input came from stakeholders, local public health, WIC, healthy start and other home visiting programs, health care providers, educators, private health care providers, consumers, and other community health programs including injury prevention, safe sleep, breastfeeding, mental health, Managed Care Organizations and Medicaid.

Recognizing the complexity and comprehensiveness of the Needs Assessment, KDHE relied on partnerships to ensure all domains were adequately addressed and that priorities, objectives and strategies crossed population domains. The Title V Director coordinated and monitored the overall process and worked directly with the following key partners in conducting the comprehensive Title V Needs Assessment for the period 2016-2020:

Partner	Role	Domain(s) addressed
EnVisage Consulting, Inc. Connie Satzler	Facilitator, MCH Council & SHCN Strategic Planning Process/Meetings	Women/Maternal, Perinatal/Infant, Child, CYSHCN
Kansas State University Research & Extension Dr. Elaine Johannes	Contractor, Adolescent Health Needs Assessment & Report	Adolescent
University of Kansas Dr. Rebecca Gillam	Contractor, Overall Title V Needs Assessment Comprehensive Process & Final Report	Women/Maternal, Perinatal/Infant, Child, Cross-cutting/Life Course
Kansas Maternal & Child Health Council (variety of organizations represented; facilitated by American Academy of Pediatrics Kansas Chapter)	Advisory Council, recommendations related to existing priorities and need to continue, replace or add priorities (comparison of MCH 2015 with current status/needs)	All domains

While the Kansas Title V Priorities reflect the overall needs of the state, the Needs Assessment process incorporated a regional approach, based on the Bureau’s recognition of the unique needs of local communities. For nearly a year, the needs assessment team covered 6 regions of the state in person, conducting and facilitating MCH regional meetings, attended, facilitated, or presented at 3 MCH council meetings, the Blue Ribbon Panel on Infant Mortality, and various strategic planning meetings with MCH staff and stakeholders. The broad approach continued with three large scale surveys distributed over 9 months. The Public Input Section provides a detailed breakdown of the data collection process, input methods and level of response.

**Process Strengths/Weaknesses**

Overall, the process accomplished what it was designed to do:

1. initiate/gather broad stakeholder input; and
2. ensure that all population domains were given adequate time and attention.

The primary strength of the process was the focus on partnerships. These partnerships put Title V in a position to maximize resources. Many partnerships were in place before the Needs Assessment, with many new partnerships developing throughout, and assisted to develop effective programs and policies that address the needs of population. The mixed methods design provided opportunities for a range of input and ensured diverse representation across the state: from youth to adults; parents to providers; and urban to rural and frontier areas. Finally, the process promoted a life course approach with MCH stakeholders.

The primary weakness was the need for more time. While the process began early and generated buy-in and support from partners, more opportunity to engage in discussions with key partners, including mental/behavioral health systems and schools, may have strengthened strategies related to those issues. These conversations will occur in the coming year and will assist in the revision of state objectives and strategies.

## Guiding Principles

This process highlighted the importance of recognizing and understanding the connections between priorities across MCH population domains. Four overarching themes were identified as guiding principles that impact Title V work in Kansas. It is important to note that these guiding principles do not stand alone yet build upon and complement each other, further exemplifying the collaborative approach KDHE envisioned throughout the process. The guiding principles are:

Collaboration	Creating systems change that reduces barriers to women, infants, children, CYSHCN, and adolescents getting the services that they need—both within and across agencies
Relationships	Building collaborative relationships—at the organizational and individual levels—that provide a foundation for service delivery, continuous quality improvement, and positive community change
Health disparities/health equity	Understanding who is not being served and why. Those differences in population health that can be traced to unequal economic and social conditions and are systemic and avoidable, thus inherently unjust and unfair
Community norms	Addressing community norms that have created a stigma, causing barriers to accessing services

KDHE continuously assesses the needs of Kansas MCH populations. This is and will be an ongoing Needs Assessment that stretches beyond the 5 year vision.

### Crosswalk of Kansas MCH Priorities

2011-2015 Priorities	2016-2020 Priorities
<b>Women &amp; Infants</b>	
All women receive early and comprehensive care before, during and after pregnancy	Women have access to and receive <u>coordinated, comprehensive services</u> before, during and after pregnancy. (Women/Maternal; Cross-Cutting)
Improve mental health and behavioral health of pregnant women and new mothers	
Reduce preterm births (including low birth weight and infant mortality)	
Increase initiation, duration and exclusivity of breastfeeding	Families are empowered to make educated choices about <u>nutrition &amp; physical activity</u> . (Perinatal/Infant)
<b>Children &amp; Adolescents</b>	
All children and youth receive health care through medical homes	
	Developmentally appropriate care and services are provided across the lifespan. (Children)
Reduce child and adolescent risk behaviors relating to alcohol, tobacco and other drugs	Communities and ( <i>providers / systems of care</i> ) support <u>physical, social and emotional health</u> . (Adolescents)
All children and youth achieve and maintain healthy weight	
<b>CYSHCN</b>	
All CYSHCN receive coordinated, comprehensive care within a medical home	Services are <u>comprehensive and coordinated</u> across systems and providers. (CYSHCN)
Improve the capacity of YSHCN to achieve maximum potential in all aspects of adult life, including appropriate health care, meaningful work, and self-determined independence	
Financing for CYSHCN services minimizes financial hardship for their families	
<b>Life course/cross cutting</b>	
	Services and supports promote healthy <u>family functioning</u> . (Cross-cutting)
	Professionals have the knowledge and skills to address the needs of maternal and child health populations. (Cross-cutting)
	Information is available to support <u>informed health decisions and choices</u> . (Cross-cutting)

#### Data Sources:

- Bureau of Epidemiology & Public Health Informatics, Annual Summary of Vital Statistics
- Bureau of Epidemiology & Public Health Informatics, Kansas Hospital Discharge Data
- National Center for Health Statistics, National Vital Statistics Reports
- National Center for Health Statistics, [VitalStats](#)
- Centers for Disease Control & Prevention, WISQARS (Web-based Injury Statistics Query & Reporting System)
- U.S. Census Bureau, American Community Survey
- U.S. Census Bureau, Current Population Survey
- U.S. Census Bureau, Small Area Income and Poverty Estimates (SAIPE)
- U.S. Census Bureau, Small Area Health Insurance Estimates (SAHIE)
- Centers for Disease Control & Prevention, National Immunization Survey
- Centers for Disease Control & Prevention and Bureau of Health Promotion, Behavioral Risk Factor Surveillance System and Youth Risk Behavior Surveillance System
- National Survey of Children with Special Health Care Needs
- National Survey of Children's Health
- Kansas Medical Assistance Program Reporting System, KAN-Be-Healthy annual participation report & Well Child for HW21 report
- The Association of Community Mental Health Centers of Kansas Inc. Mental Health Consortium, Automated Information Management System (AIMS) data database.
- Bureau of Family Health, Newborn Screening Program and Newborn Hearing Screening ([SoundBeginnings](#))

## II.B.2. Findings

### II.B.2.a. MCH Population Needs

#### Women/Maternal Health

Women's health consistently was voiced as a priority. Access to care is a need that was expressed as overarching not only for the specific community, but providers, programs and families throughout the state; yet was so broad that many other priorities began to emerge as objectives that fit within the need. As stated by one of many stakeholders during community meetings, "What is really needed is a [system] where women can get all the services they need and providers work together and know what each other are doing." This exemplifies the idea there is not necessarily a need for new or additional services, but rather better coordination among existing services. This provides the foundation for the state priority for the women/maternal health domain: "*Women have access to and received coordinated, comprehensive care and services before, during and after pregnancy.*"

In 2013, more than 20% of pregnant women in Kansas did not access prenatal care in the first trimester, supporting the need for better coordination and access to care for all women. Recent NOMs data describe the health status of pregnant women in Kansas:

- 79.4% of pregnant women received prenatal care beginning in the first trimester, a 7.3% increase over the past 5 years;
- the maternal mortality rate per 100,000 live births (5 year rolling average) was 16.5, a 21.3% increase over the past 5 years; and,
- 12.5% of pregnant women smoked during pregnancy, a 17.2% decrease over the past 5 years.

Early prenatal care (i.e., care in the first trimester of a pregnancy) allows women and their health care providers to identify and, when possible, treat or correct health problems and health-compromising behaviors that can be particularly damaging during the initial stages of fetal development. Increasing the number of women who receive prenatal care, and who do so early in their pregnancies, can improve birth outcomes and lower health care costs by reducing the likelihood of

complications during pregnancy and childbirth.

KDHE has successful programs, resources and services in place to continue striving for more coordination around care and services. The message shared throughout the Needs Assessment process positions KDHE for more engagement with community partners, building on existing programs to address needs. Continuation of, or enhancements to, existing programs and partnerships are likely to impact populations through: improved Healthy Babies are Worth the Wait-HBWW/Becoming a Mom Program-BAM) outcomes; collaborative home visiting; uniform screenings; reduction of smoking in the home; increased breastfeeding; improved access to care (including well woman visits); increased health insurance coverage; better coordination; and increased access to transportation.

NPMs addressed through this domain include NPM 01: Well-woman visits and NPM 14-A: smoking during pregnancy.

### **Perinatal/Infant Health**

The perinatal mortality rate has not changed since the previous Needs Assessment, and Sudden Unexplained Infant Death (SUID) mortality has substantially decreased. The rates of deliveries of infants who were preterm or low birth rate have also remained constant, while the rate of non-medically indicated early term deliveries has significantly decreased. Therefore, the strengths and needs of the perinatal/infant population in Kansas is the same or improved from the time period during which the previous Needs Assessment occurred. The related state priority crosses many population domains, *"Families are empowered to make educated choices about nutrition and physical activity."* This is supported by NPM 04, the proportion of infants who were ever breastfed. In Kansas, a 6% increase (up to 84.2%) in the previous 5 years has been experienced in this area, however input throughout the Needs Assessment identified a continued need for the existing work around this population health need. The focus was for both infant health, and mother health - one of many priorities crossing MCH domains. Public input also outlined many other areas of focus for the perinatal/infant population, addressed through alignment with other priorities and strategies across domains.

Recent NOMs and NPMs data describe perinatal/infant health in Kansas, during the previous 5 years, has:

- remained relatively constant at 7.0% of deliveries were infants with low birth weight (<2,500 grams);
- slightly increased by 3.3% from 9.2% to 8.9% of births were preterm (<37 weeks);
- decreased by 27.1%, down to 29.3% of non-medically indicated early term deliveries (37-38 weeks) among singleton term deliveries (37-41 weeks);
- remained relatively constant with the perinatal mortality rate of 6.5 per 1,000 live birth, plus fetal deaths.

To address continued risks associated with negative outcomes for this population, strategies that will be employed include: uniformly screening and monitoring for high-risk conditions; ensuring that more than 90% of at-risk women receive 17-P; refer high-risk deliveries to facilities that provide the appropriate level of care; and expand HBWW/BAM program model, targeting areas with disparities and poor birth outcomes.

### **Child Health**

Healthy development for children was a strong theme, addressing many needs identified in each community. A strong focus was on assuring children were provided opportunities through age-appropriate services, leading to the state priority for this domain – *"Developmentally appropriate care and services are provided across the lifespan"* – directly linked to NPM 06 on developmental screening.

Many identified needs for the child health domain carried over into adolescence and were connected by a common thread: injury and safety. Injury prevention efforts, addressing safety concerns in the home and reducing risk, and selection of safe childcare settings are all areas of interest, focused on reducing non-fatal injury hospitalizations (NPM 07). Statistics indicate the number of Kansas children "excellent or very good" health is slightly higher (86.8%) than the national average (84.2%)<sup>4</sup> and Kansas children receive a preventive medical visit at a rate consistent with the national average. Data, from OSD and NOMs, related to the health status of Kansas children show:

- the rate of death in children aged 1 through 9 per 100,000 was 23.8, a 9.7% increase over the previous 5 years;

- 6.7% of children were without health insurance, a 18.3% decrease;
- 7.6% of school age children were victims of bullying<sup>2</sup>;
- 7.2% of school age children were bullies<sup>2</sup>;
- 59.1% of all children received comprehensive, coordinated care from a medical home, which was higher than the national average of 54.4%<sup>4</sup>; and
- 79.4% of children received a preventive dental visit in the previous year, which was slightly higher than the national rate of 77.2%.<sup>4</sup>

Stakeholders provided useful and innovative ideas to improve upon while expanding current initiatives, many of which are already in the scope of work for Title V. KDHE can further strengthen the guiding principle of collaboration at state and community levels, and create community change by building from existing successes of programs like Safe Kids Kansas, and increasing the number of MCH grantees that serve as a lead agency for local Safe Kids Coalitions. Other identified needs absorbed into the priority of developmentally appropriate care are focused on: safety and education opportunities; safe sleep initiatives; access to childhood immunizations; and oral health education and developmental screenings. Combined, these needs can be addressed through existing programs as well as new initiatives and contribute to the whole health of the child beginning prenatally and throughout the life course.

### **Children & Youth With Special Health Care Needs**

As with other population domains, the CYSHCN domain priority need identified was care coordination. In the regional meetings, and particularly in the “Communities for Kids” meetings, it became apparent that family support was emerging as a high need for this population, and that those supports include a need for access to care. In particular, participants mentioned a lack of transportation, particularly in rural communities, and the limited availability of specialists, again, particularly in rural areas. As the assessment progressed, family support also expanded into the need for social-emotional support and respite for caregivers. These issues lead Title V to identify a high need for more coordinated care across systems, reducing duplication of services and providing opportunity for stronger family engagement - the foundation for which led to the state priority, “*Services are comprehensive and coordinated across systems and providers,*” and will be measured through medical home indicators (NPM 12).

Data, from OSD and NPMs, related to medical home indicators for Kansas CYSHCN show:

- 49.4% receive care within a medical home, compared to 43.0% nationally,<sup>3</sup>
- 45.7% receive effective care coordination, when needed;<sup>3</sup>
- 33.1% experience difficulties or delays in getting services for their child because the services needed were not available in their area;
- 32.7% report their current insurance coverage is inadequate; and
- among families caring for CYSHCN, lack of receiving care within a medical home was associated with 1.7 times increased odds of reporting of financial burden.

Having a medical home is essential to coordinated systems of care. Families are better supported, experience less frustration when accessing services, fewer delays in services, and children tend to be healthier. Medical homes are also critical in successful transition to adult living. Kansas is above the national average of children 10 months to 5 years who received a standardized screening for developmental or behavioral problems (37% in Kansas versus 30.8% nationally).<sup>4</sup> Care coordination efforts, within a medical home or not, can assist in identifying children with potential developmental delays allowing for earlier intervention than for those without this support.

Through the KS-SHCN Strategic Planning, four additional priorities emerged: family caregiver health; behavioral health; training and education; and direct health services. Enhanced services that could be provided by KS-SHCN include increased access to family-centered medical homes through support by KDHE through existing structures, as well as through: assisting families to navigate service systems; engaging MCO’s and primary care providers; parent leadership development, increasing community and statewide partnerships, assuring children receive developmentally appropriate assessments and behavioral health screenings, implementing tele-medicine strategies, and professional development training.

### **Adolescent Health**

Central to the discussion was a holistic approach to adolescent well-being, focusing on positive youth development and providing opportunity for young people to thrive. Adolescence is an important developmental stage filled with opportunities as well as health risks, which can be magnified by transitions between systems of care, especially for CYSHCN. Regardless of geographic location, adolescents face common barriers and risks such as bullying, risk taking, poverty, boredom leading to negative choices, lack of skills, and perhaps even the responsibility of attending to other family members. Many youth cope with chronic health conditions and many live in neighborhoods and families that pose health risks. However, with positive supports and opportunities, youth can learn to build their abilities, and develop into contributing adults, leading to the state priority, *“Communities and providers support physical, social, and emotional health.”* Bullying (NPM 09) is a key focus within this domain, as is NPM 10: Adolescent well-visit.

The following data describe the health status of Kansas adolescents:

- the death rate ages 10-19 per 100,000 was 31.9, a 21.0% decrease over the past 5 years;
- the rate of suicide deaths ages 15 through 19 per 100,000 (3 year rolling average) was 13.2, a 45.1% increase over the past 5 years;
- 84.6% of adolescents, ages 13-17, have received at least one dose of the Tdap vaccine, a 33.0% increase over the past 5 years; and
- 55.9% of adolescents, ages 13-17, have received at least one dose of the meningococcal conjugate vaccine, a 46.0% increase over the past 5 years.

KDHE desires to address the needs of this population through promoting wellness and addressing serious and pervasive issues that adolescents face such as bullying, suicide, and mental/social health issues. Life skills development is an important objective under this priority. There is a need to promote positive coping mechanisms and assure youth receive annual physical and mental health screenings to promote overall health and social emotional health. Trained adults and mentors can help adolescents navigate life skills and set goals (high school completion, employment, youth development). Adolescents have a natural desire to become active in society and community, this priority will promote community partnerships and engagement, reinforce protective factors, and promote prevention of risky behaviors.

### **Cross-Cutting/Life Course**

Seeking appropriate care for the MCH population is critical to the continued support required to ensure that this populations needs are met. For quality care to be delivered, it is important that the professionals interfacing with this population are properly trained to provide this care. This priority will focus on workforce development and capacity, promoting diversity, inclusion, and integrated supports for all, and supporting providers to address the social-emotional development of children. This includes concerted efforts to support health literacy for MCH consumers. Participants stated that understanding the importance of personal health, how to find services, and how to navigate the health care system promote lifelong habits for well-being can lead to the reduction of or prevention of many of the health issues discussed throughout the process.

Participants reported that their community was in need of trained, qualified professionals to deliver services across the MCH population domains. When asked what could improve services within the community, responses included, “having trained professionals who take the time and listen to our needs.” Other responses indicated that professionals needed to be aware of the population being served so as to understand environmental stressors and the health impact that it may have on this population. In particular, children and youth with special needs was identified as a population that needed improved support from professionals. This led to a broad state priority, *“Professionals have the knowledge and skills to address the needs of the maternal and child health population.”*

Insurance coverage continuity entails continuous insurance coverage throughout the previous year. In 2011-2012, 11.3% of Kansas residents lacked continuous insurance coverage, which is congruent with the national percentage of 11.3% (The Health & Well Being of Children, 2014). Inconsistent health insurance coverage may keep children and families from receiving the necessary medical care required to maintain a good health status. If health problems go undetected, this may result in more significant health problems at a later date that require longer, intensive, and more costly health services.

### **References**

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## **II.B.2.b Title V Program Capacity**

### **II.B.2.b.i. Organizational Structure**

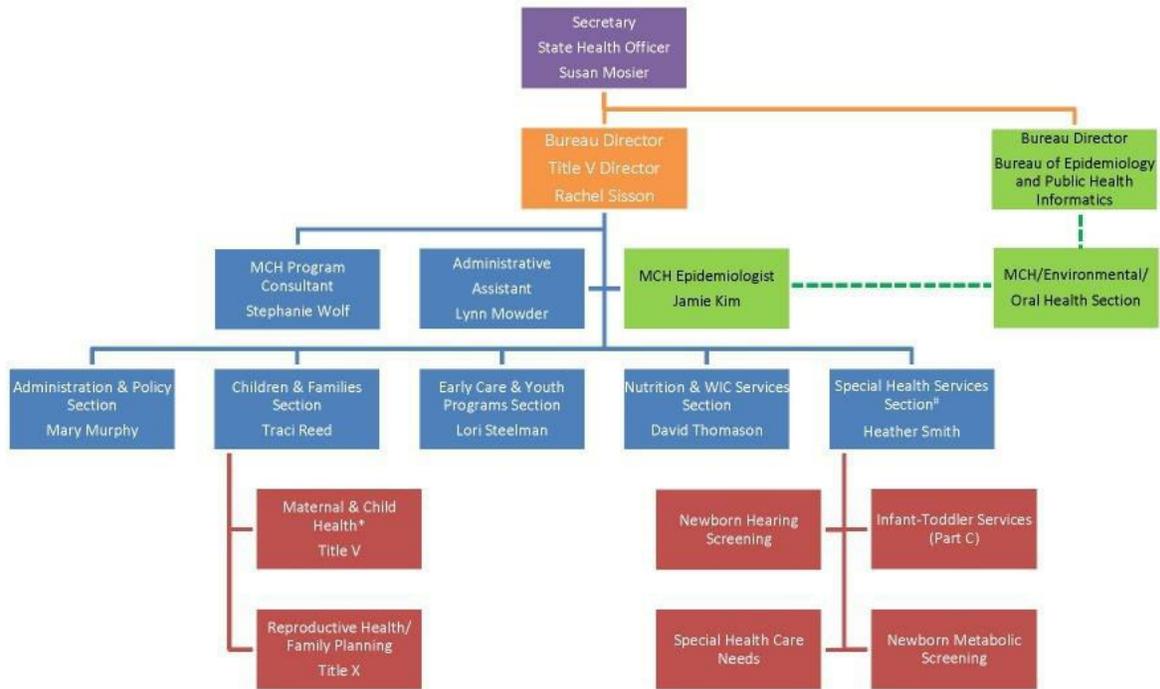
The State's public health agency, Kansas Department of Health and Environment (KDHE), is responsible for the administration (or supervision of the administration) of programs carried out with allotments under Title V [Section 509(b)]. The Secretary of KDHE is appointed by the Governor and serves on the Governor's Cabinet. The agency Secretary, State Health Officer, and Division of Public Health Director is Susan Mosier, MD. The agency is composed of three divisions: Public Health, Health Care Finance, and Environment. The Division of Public Health has six bureaus: Family Health; Disease Control and Prevention; Community Health Systems; Health Promotion; Oral Health; and Epidemiology and Public Health Informatics.

The Title V Maternal and Child Health (MCH) Services Block Grant program is administered by the Bureau of Family Health (BFH) in the Division of Public Health. The mission of the Bureau is to "provide leadership to enhance the health of Kansas women and children through partnerships with families and communities." The BFH has three goals: (1) Improve access to comprehensive health, developmental and nutritional services for women and children including children with special health care needs; (2) Improve the health of women and children in the State through prevention/wellness activities, a focus on social determinants of health, adopting a life-course perspective and addressing health equity; and (3) Strengthen Kansas' MCH infrastructure and systems to eliminate barriers to care and to reduce health disparities. The BFH has five sections\*: Children & Families; Special Health Services; Nutrition and WIC Services; Early Care & Youth Programs; and Administration & Policy. *\*Foster care was a part of the KDHE BFH until June 21, 2015, at which time the program was transferred to the Department for Children and Families as authorized by Executive Reorganization Order 43.*

The BFH programs partially funded by the federal-state Title V Block Grant include MCH, CYSHCN, and Child Care. Within the Division of Public Health, other Bureaus that receive support include the Bureau of Epidemiology and Public Health Informatics (Vital records data sharing, analysis, and reporting); the Bureau of Community Health Systems (workforce development, training, capacity building, systems development); and the Bureau of Health Promotion (PRAMS pilot telephone survey support). Budgeted and expended funds (federal, state, and local) expended are tracked through the agency's fiscal management system, SMART. Awards totaling \$4,385,468 of the \$12.6M Title V budget is allocated in FY2016 for 82 local agencies to provide community-based, family centered MCH services, including services for special health care needs. Local agencies, local public health departments and Federally Qualified Health Centers, are independent entities that apply for MCH funds annually as part of the agency's competitive Aid to Local application process.

The agency organizational charts and a local agency/grantee map are attached to this section as images.

**Kansas Department of Health & Environment  
Division of Public Health  
Bureau of Family Health**

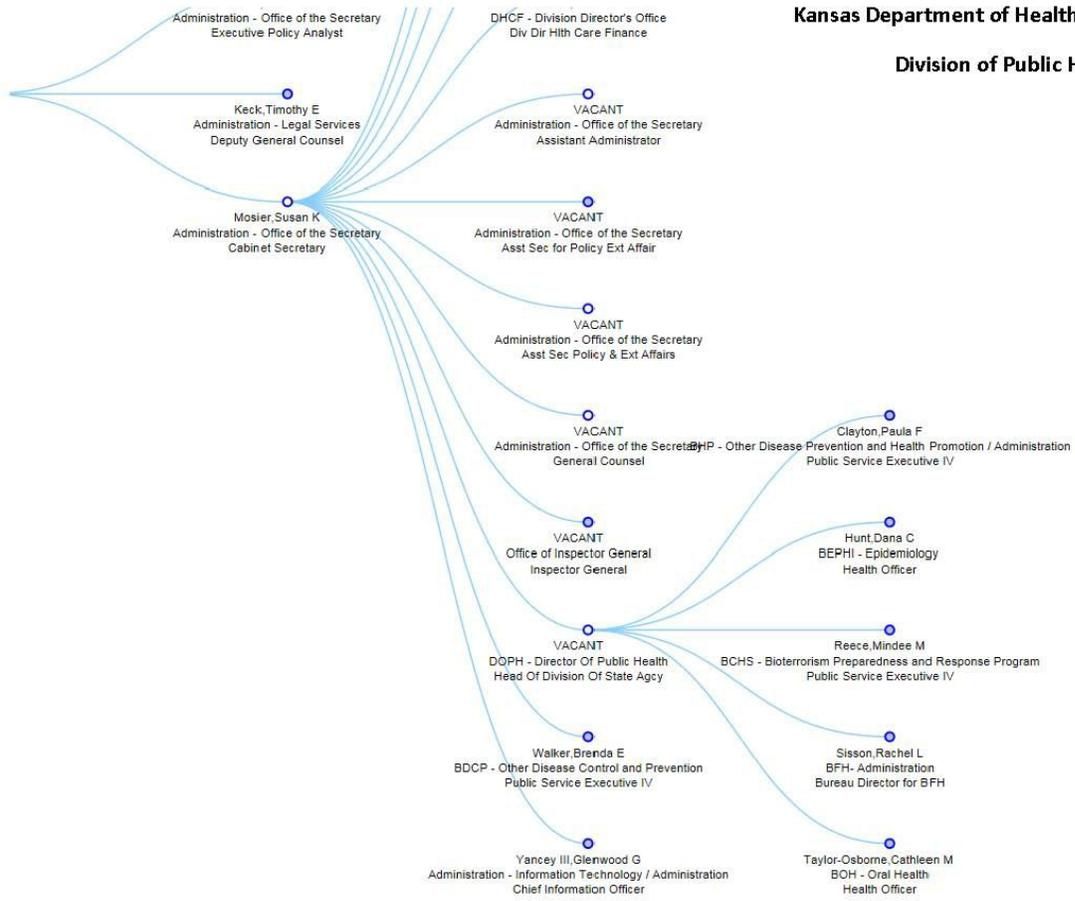


\*Includes Aid to Local Programs/Grant Projects: Title V MCH, Pregnancy Maintenance Initiative (PMI), Teen Pregnancy Targeted Case Management (TPTCM), Healthy Families, Home Visiting, MIECHV, Project LAUNCH, Early Childhood Comprehensive Systems (ECCS); Abstinence Education; Healthy Start; staffing for Woman's Right to Know (WRTK materials), Blue Ribbon Panel on Infant Mortality, and KS MCH Council

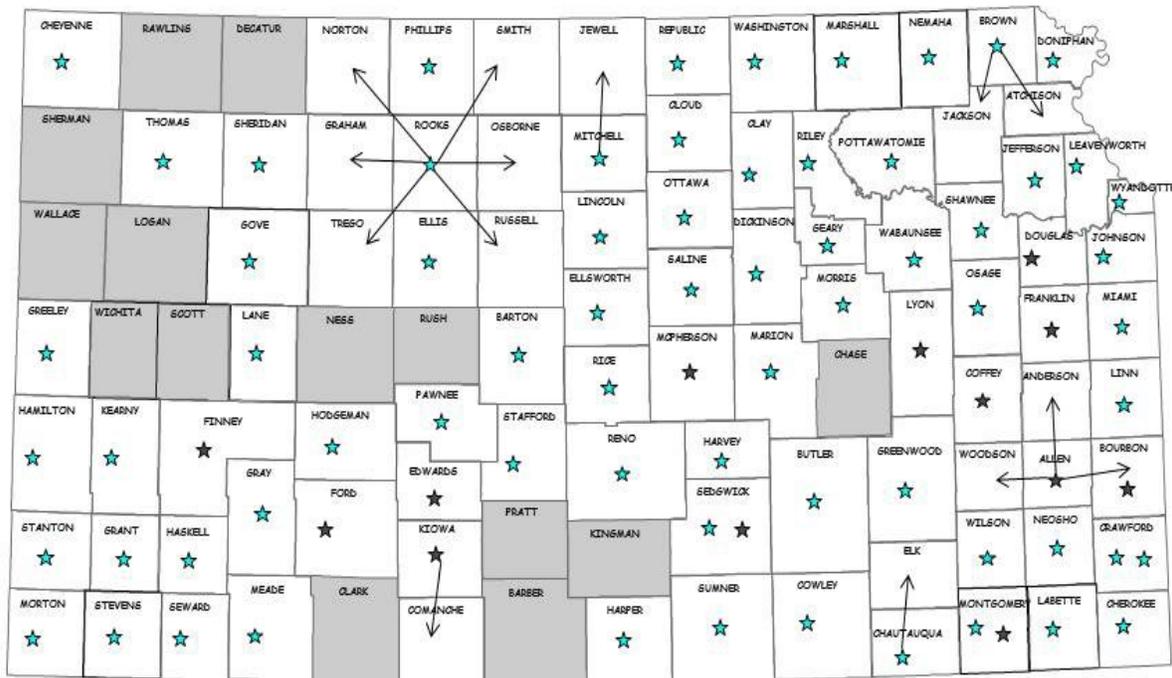
#Includes staffing for Kansas Resource Guide, Birth Defects/Registry, Newborn Screening and Hearing Screening Councils

# Kansas Department of Health & Environment

## Division of Public Health



## MCH Unit Local Program Grantees - 2016



★	Maternal Child Health (MCH)
★	Maternal Child Health (MCH) without HSHV
↔	Indicates other counties that are funding partners

### II.B.2.b.ii. Agency Capacity

**Capacity to provide services by population health domain:** The Bureau of Family Health has experienced significant vacancies and staff turnover at the state level during the past year, which has provided ongoing challenges. At the same time, it has created an opportunity to build partnerships and increase/enhance community capacity in each of the population health domains. Recognizing the staff on the MCH team are key to building partnerships at the state level and providing support at the local levels, the new structure has led to improved state-local coordination and alignment with vision. The current Title V staff (with expertise by domain) are listed below:

- Women/Maternal: Stephanie Wolf, MCH Program Consultant; Carrie Akin, MCH Administrative Consultant; Kay White, MCH Administrative Consultant
- Perinatal/Infant: Stephanie Wolf, MCH Program Consultant; Carrie Akin, MCH Administrative Consultant; Kay White, MCH Administrative Consultant
- Child: Stephanie Wolf, MCH Program Consultant; Debbie Richardson, Home Visiting Program Manager; Traci Reed, Children & Families Director; Vacant, MCH Child & Adolescent Health Consultant; Lori Steelman, Child Care Licensing Program Director; Mary Murphy, Administration & Policy Director
- CYSHCN: Heather Smith, Special Health Services Director; Kayzy Bigler, SHCN Program Manager; Jentry Sprang,

Michelle Black, Geno Fernandez, and Portia Taylor, SHCN Program Staff; Kelly Blake, SHS Payment and Contracting Specialist

- Adolescent: Traci Reed, Director, Children & Families Section; Vacant, MCH Child & Adolescent Health Consultant; Lori Steelman, Child Care Licensing Program Director; Mary Murphy, Administration & Policy Director
- Cross-cutting or Life Course: MCH team, led by Rachel Sisson, Bureau Director; Jamie Kim, MCH Epidemiologist

**State program collaboration with other state agencies and private organizations:** The table below identifies the key partnerships with other state agencies and private organizations, essential to addressing the needs and emerging issues of MCH populations.

Collaboration Partner	Type	Purpose
Kansas Department for Children & Families	Public State Agency	Coordination between child care licensing and subsidy; state level coordination of Maternal Infant and Early Childhood Home Visiting program
Kansas Department on Aging & Disability Services	Public State Agency	Access to behavioral health services
Kansas State Department of Education	Public State Agency	State level coordination of Maternal Infant & Early Childhood Home Visiting (MIECHV) program
Kansas Children's Cabinet & Trust Fund	Legislatively Created Entity	Early childhood programs and services; Children's Initiative Funds
Kansas Maternal & Child Health Council	Public-Private Collaboration	Advisory council for MCH team--serves as key advisory group re: MCH population needs/issues
March of Dimes Kansas Chapter	Private	Initiatives related to preterm/early term birth, early elective deliveries, prematurity, etc. (Ex: ASTHO Challenge); implementation and expansion of the Healthy Babies are Worth the Wait/Becoming a Mom programs
Kansas Chapter of the American Academy of Pediatrics	Private	Systems development for child, school and adolescent health care; convene and facilitates the state MCH Council
Kansas Breastfeeding Coalition, Inc.	Private	Breastfeeding education, training, and community support projects
Geary County Community Healthcare Foundation	Private	Healthy Start project/grant partner and Becoming a Mom Lead
University of Kansas Medical Center (Kansas City) and School of Medicine (Wichita)	Public	Medical specialty care and related services for children and youth with special health care needs.

**State support for communities:** The majority of programs funded by the Block Grant are delivered by health departments and safety net clinics (independent entities). These agencies are positioned to provide many core public health services in addition to MCH, so the delivery system has the advantages of convenience and comprehensive care. The programs and services delivered by local agencies are designed to address ongoing needs and those identified as part of the most recent

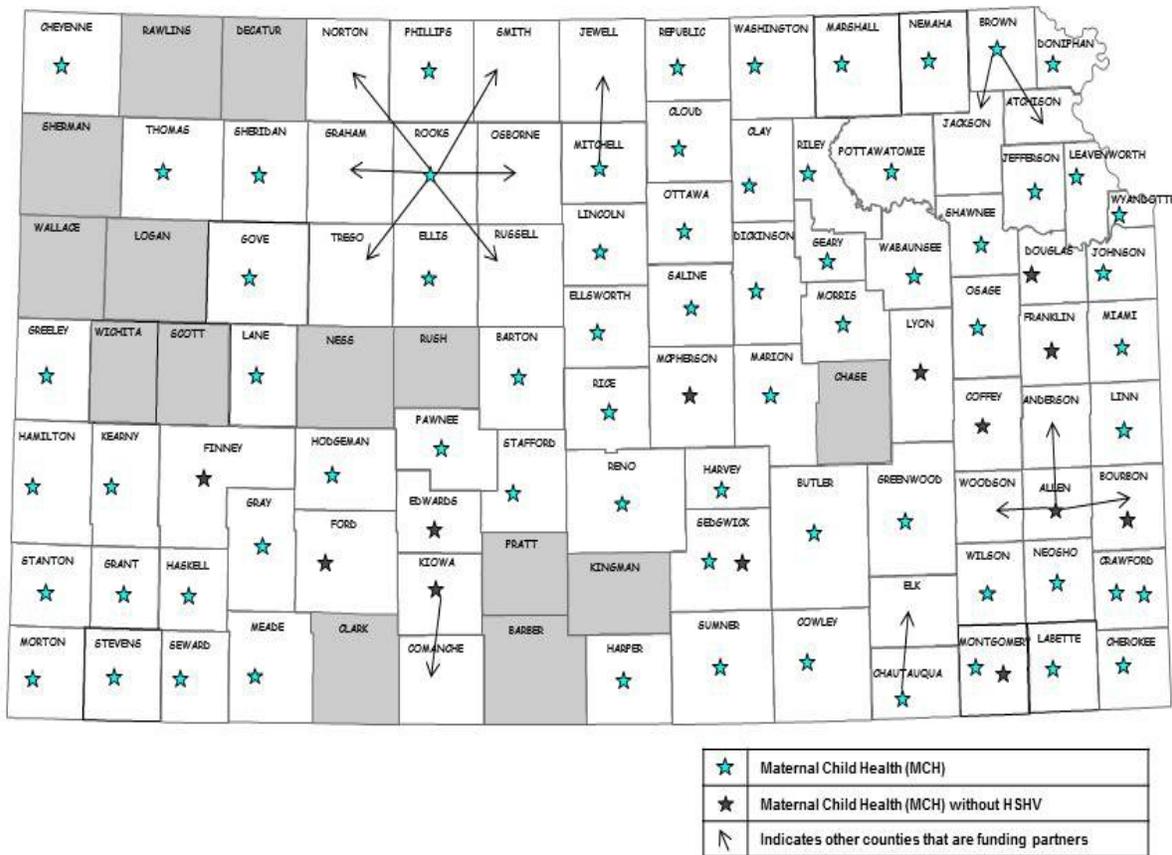
needs assessment. When funds are allocated to other programs outside the BFH, the Bureau maintains legal contracts for the use of the funds, or in the case of funds allocated to other programs within the KDHE, MOUs clarify the nature of the work that is done in support of the MCH priorities. Services are to be in compliance with Title V legislation and in accordance with the [Kansas MCH Services Manual](http://www.kdheks.gov/c-f/downloads/MCH_Manual.pdf) ([http://www.kdheks.gov/c-f/downloads/MCH\\_Manual.pdf](http://www.kdheks.gov/c-f/downloads/MCH_Manual.pdf)). The contractual process with local agencies begins with the development of Grant Application Guidance/Reporting Materials by MCH program staff annually in December. These materials are available by mid-January to local agencies currently receiving funds as well as any other eligible agency wishing to apply for Title V funding as part of the KDHE aid to local funding process. The review process which informs funding recommendations involves external reviewers applying guidance and a scoring matrix, funding formula based on poverty and population by county/target area, and willingness/ability to comply with grant requirements. Detailed client and service data is required to be collected, aggregate progress reports and affidavits of expenditures are required quarterly, and site visits are conducted to verify compliance with funding requirements and progress toward priorities, goals, objectives, and measures. More information about the [MCH Aid to Local Program](http://www.kdheks.gov/doc_lib/MaternalAndChildHealthServices.html) ([http://www.kdheks.gov/doc\\_lib/MaternalAndChildHealthServices.html](http://www.kdheks.gov/doc_lib/MaternalAndChildHealthServices.html)) including program guidance is available online. Aid to Local contract documents and the list of local 2016 MCH grantees statewide are attached as supporting documents. A map of local agencies is provided in this section.

Additionally, the BFH provides funding and technical assistance to assist local communities to improve health outcomes for pregnant women, infants, children, adolescents, and CYSHCN; systems of care and grants to communities to support the health of women in their reproductive years and the CYSHCN population; and other grants and initiatives targeted to specific populations and needs including the administration of the Early Childhood Comprehensive Systems grant, the MIECHV Program, Project LAUNCH, and SHCN regional office and multi-disciplinary specialty clinics.

**Coordination with health components of community-based systems:** The BFH has partnerships at the state and local levels to ensure coordination of health components of the MCH system. Through the MCH council, Blue Ribbon Panel on Infant Mortality, and regular communication with local agencies such as health departments and safety net clinics (FQHCs), the state MCH team provides expertise, gathers feedback, and makes connections to maximize the effectiveness of the MCH system. As an example of this work, the BFH has facilitated coordination of a Long Acting Reversible Contraceptive (LARC) program between the local Title X clinic, FQHC, and private OB/GYN practice in one rural community. The BFH acted as a convener of the conversation and drafted the partnership agreement to be modified and adopted by the local partners. This process highlights the role that the BFH has taken as not only a leader of MCH coordination, but a key partner in the process.

**Coordination of health services with other services at the community level:** The public health regional meetings at the community level are evidence of the BFH's commitment to a broad view of health and well-being that incorporates health services and other community partners. Approximately 20% of participants at the five regional meetings were representing services other than primary care at the community level. The BFH recognizes that MCH requires a systemic approach that provides health and other services to meet the needs of the community. Key partners identified through the regional meetings included schools and local elected county officials. The SHCN program has strengthened partnerships and developed new partnerships and will support a hospital to home coordination program through a state-wide home health entity and a new youth leadership program in the coming year; in addition to expansion of outreach, care coordination, supporting the University of Kansas Department of Pediatrics Medical Home, and a new initiative with the MCOs to support identification of children ages 0-5 born with Medicaid that have not received any documented follow-up care.

## MCH Unit Local Program Grantees - 2016



### II.B.2.b.iii. MCH Workforce Development and Capacity

Effective June 2015, the Bureau of Family Health (BFH) has 81.2 full-time equivalent (FTEs) positions. Two FTEs including the Title V Director and an Assistant are located in administration. Special Health Services has 20 FTEs including a Director (MPH) and program staff including: 6 Special Health Care Needs (SHCN); 3 Newborn Metabolic Screening; 6 Infant Toddler Services; 4 Newborn Hearing Screening (one audiologist). Children & Families has 12 FTEs including a Director (LMSW) and RN (4 vacancies). Nutrition & WIC has 15 FTEs including 3 nutritionists. Child Care Licensing has 20.2 FTEs including a Director and 5 Coordinator of Children's Services staff located in KDHE District Offices across the state with responsibility for supporting regulatory services at the community level. Administration & Policy has 12 FTEs including a Director, 4 Healthy Homes positions and 7 administrative and support staff. MCH Block Grant funds provide salaries for approximately 18% of the staffing in the Bureau, supporting administration, SHCN, and MCH. MCH funding also supports part-time staff in the Bureau of Community Health Systems' Local Public Health Program for (workforce development, capacity building, and training) and the Office of Vital Statistics. Additionally, funding supports two full time epidemiologists within the Bureau of Epidemiology and Public Health Informatics (one position is vacant). The epidemiologists interface with epidemiological work done in other Bureaus inside the agency and with other organizations and efforts in the state. Both

epidemiologists coordinate all data analyses for the MCH/CYSHCN needs assessment with an outside contractor. Both assist programs with assessments and evaluations, conduct research, and address epidemiologic needs of the BFH. Each of the Sections is attempting to build data capacity through staff training and education and the rewriting of job descriptions to require data skills for new hires.

Descriptions for senior level management serving in lead MCH-related positions, including staff who contribute to planning and data analysis follow.

Rachel Sisson (formerly Berroth) was appointed as the Bureau Director and Title V Director in 2012. She has 15 years of experience related to workforce development and managing statewide programs including Division of Public Health programs such as health occupations credentialing and human care regulation (hospitals and medical, child care, foster care). Prior to serving as Director of Family Health, she served as a Child Care Licensing Administrator and Director for six years and briefly served as the Program Analyst for the Newborn Hearing Screening Program. She holds a Master's degree in Early Childhood Education and Bachelor's degree in Family Studies and Human Services from Kansas State University.

Heather Smith serves as the Special Health Services and Kansas Special Health Care Needs (SHCN) Director. From 2009 to 2013, she served as a Project Coordinator for the Kansas Children and Youth with Special Health Care Needs program. Prior to that, she worked as the Director of Children's Services for Children's Miracle Network in Springfield, MO. Heather has a Master's degree in Public Health and a Bachelor's in Child and Family Development, both from Missouri State University. In 2011, she was accepted to the Kansas Public Health Leadership Institute and completed that program in 2012.

Traci Reed serves as the Children and Families Section Director. She is primarily responsible for management and oversight of the Title X Family Planning and MCH Aid to Local (ATL) programs, including Home Visiting. She also has responsibility for MIECHV and additional ATL programs: Healthy Families, Teen Pregnancy Targeted Case Management, and Pregnancy Maintenance Initiative. Prior to her current position Traci worked in State child welfare programs for 19 years, including work as an Assessment and Prevention Administrator (family services programs) with the Kansas Department of Children & Families. She has a Master of Social Work degree from Wichita State University.

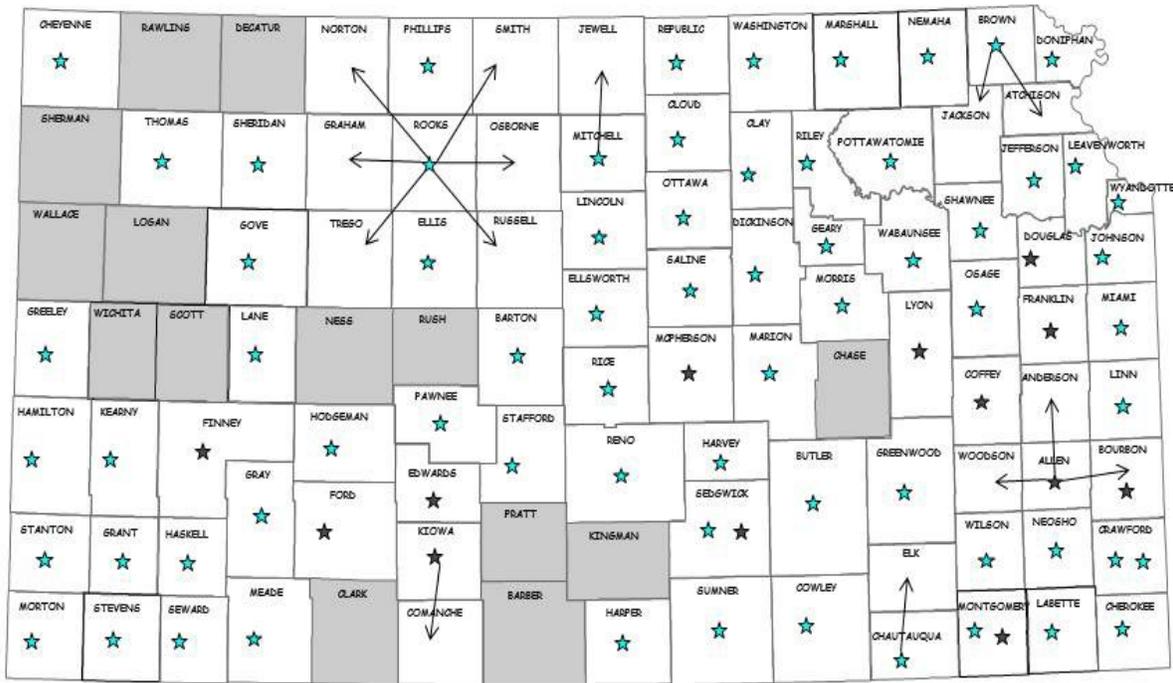
Stephanie Wolf, RN, BSN, serves as the Maternal & Child Health (MCH) Program Consultant (effective March 30, 2015). She also serves as the perinatal consultant for the Federal Healthy Start project and lead for the development and expansion of the Healthy Babies are Worth the Wait/Becoming a Mom programs across the state. Stephanie was previously the MCH Program Coordinator for the Salina-Saline County (Local) Health Department.

Kayzy Bigler is the SHCN Program Manager. She is primarily responsible for overseeing program activities, family and youth engagement opportunities within the Bureau, care coordination development and assisting with the strategic planning. Kayzy previously worked as a Parent Information Specialist and a Parent to Parent Coordinator. Past experience includes co-ownership of a private Interactive Metronome Therapy business and 15 years of experience with a local school district (Applied Behavioral Analysis (ABA) therapy, speech therapy and assisting with occupational and physical therapies and classroom education). Kayzy has an AA in Pre-Social Work from Allen County Community College. She is a Registered Interactive Metronome Certified Therapist and has obtained over 500 in-services hours through the local school district and the State of Kansas.

Jamie Kim has served as the MCH epidemiologist since 2003 and also serves as the State Systems Development Initiative (SSDI) project director. She provides epidemiological support for MCH and affiliated programming. Her priority job assignments focus on pregnant women and infants (infant mortality, Perinatal Periods of Risk approach (PPOR), maternal mortality and morbidity, teen pregnancy, family planning), CYSHCN (birth defects surveillance, newborn screening, and health disparities in children due to disability status), and WIC. She earned a Master of Public Health (in association with the University of Kansas) and Bachelor of Science in Chemistry from Wichita State University.

The Title V team has experienced significant vacancies and staff turnover at the state level during the past year (actively recruiting). However, the current team and partnerships have led to the greatest MCH advancements experienced in decades! KDHE contracts with health departments and safety net clinics (independent entities) for statewide impact.

## MCH Unit Local Program Grantees - 2016



★	Maternal Child Health (MCH)
★	Maternal Child Health (MCH) without HSHV
↗	Indicates other counties that are funding partners

### II.B.2.c. Partnerships, Collaboration, and Coordination

A major focus of all the Title V and Family Health policy and program initiatives is collaborative partnerships, so calling on partners, providers and consumers/families to be engaged in the needs assessment was highly successful. Through existing forums, Title V engaged stakeholders through the State MCH Council, State Agencies Early Learning Coordinating Council, Newborn Screening Advisory Council, Family Advisory Council, Blue Ribbon Panel on Infant Mortality, Kansas Breastfeeding Coalition, among others. The Bureau and Title V programs demonstrate strong commitment to coordinating and collaborating to address the emerging and ongoing needs of all MCH populations.

**Kansas Maternal & Child Health Council (KMCHC):** The KMCHC serves in an advisory capacity to KDHE, Bureau of Family Health, Title V Program; monitors progress; and addresses specific MCH population needs for MCH populations. The Kansas Chapter of the American Academy of Pediatrics (KAAP\*) serves as the lead agency and fiscal agent for the Council. A formal partnership exists between KAAP and KDHE to assure access to high quality MCH services in Kansas and improved outcomes. The Title V needs assessment and state action plan is the guiding document as it relates to the ongoing work of the Council. The KMCHC is chaired by Dennis Cooley, MD, FAAP, and has between 30-35 members at any given time (a roster included in this section as an image). KDHE and KAAP convene the Council at least once each quarter. The Council is comprised of a multidisciplinary team of professionals with expertise in MCH. The council members are

identified and, in consultation with KDHE, selected to serve on the Council by the KAAP. A decision was recently made (Sept. 2015) to merge the Blue Ribbon Panel on Infant Mortality with the KMCHC, resulting in greater coordination and impact. The BRPIM was established in 2009 to develop a set of recommendations to reduce infant mortality in Kansas. After the recommendations the Panel voted to continue meeting but recently voted to join the work of the KMCHC due to the strong plans to address infant mortality. \*KAAP is a professional organization comprised of pediatricians with a professional affiliation to obstetricians, gynecologists, family practice physicians and other professionals dedicated to promoting improved maternal and child health and delivery of care in Kansas, KAAP is willing to assemble individuals with professional expertise to assist and advise KDHE to achieve the best possible health outcomes for Kansas MCH populations.

**Other MCHB Investments:** BFH staff is exploring ways to better coordinate and integrate the Kansas Maternal, Infant and Early Childhood Home Visiting (MIECHV) and Early Childhood Comprehensive Systems (ECCS) program activities with other programs, and strong linkages have been identified between the MIECHV, ECCS, and Title V MCH needs assessment priorities, goals, and strategies. The Kansas MIECHV Program targets at-risk communities in Wyandotte County (urban Kansas City), Montgomery, Labette, and Cherokee counties (rural southeast Kansas). Evidence-based home visiting programs include Early Head Start, Healthy Families America, and Parents as Teachers. Wyandotte County has implemented a promising approach serving pregnant and postpartum women affected by alcohol or other drugs, the Team for Infants Endangered by Substance Abuse (TIES) Program. A state level Home Visiting Workgroup, composed of representatives from multiple state agencies, organizations, and programs including MCH, child care, and Part C, developed a strategic plan. In August 2013, KDHE BFH was awarded a new three-year ECCS grant focused on strategy two with the goal to expand and effectively coordinate, improve, and track developmental screenings and referrals for infant and toddlers across early childhood systems including home visiting and early education settings, pediatricians and medical homes, intervention services, and child care programs (now integrated into the MCH State Action Plan). The project has been named the Kansas Initiative of Developmental Ongoing Screening (KIDOS).

**Other Federal Investments and State Health Department Programs:** The WIC, Title X/Family Planning, and Abstinence Education programs are managed in the BFH, supporting joint planning, increased communication and coordination, and aligned priorities and efforts for greater impact. The Title V MCH and Title X Family Planning programs have been strategically planning and meeting as a larger team since 2014 to set priorities, goals, objectives, and identify linkages between MCH and Reproductive Health/Family Planning. Joint meetings and open communication continues, and both the Title V and Title X State Action Plans include targeted work across programs at both the state and local levels. MCH works directly with WIC on an ongoing basis and the State WIC director is part of the MCH Coordination team; joint initiatives for the next five years are related to CoIIN, home visiting, pre/early term birth, smoking cessation, breastfeeding, and oral health. Title V engaged the Injury Prevention program throughout the needs assessment process and received direct input related to the state's injury prevention plan and state bullying prevention efforts; the MCH action plan reflects shared priorities and strategies in these areas. The MCH Perinatal Consultant and MCH epidemiologist work directly and in partnership with the Director of Vital Statistics Data Analysis and maintain an on-going collaboration with health departments to assist with data needs, Perinatal Periods of Risk (PPOR) Analysis, Fetal and Infant Mortality Review (FIMR), local public health system assessment, Pregnancy Risk Assessment Monitoring System (PRAMS) pilot, and State Health Assessment (MCH Focus Area). The Title V Director met with Medicaid Director and Informatics staff in 2014 to discuss the MCH data snapshot, specifically disparities between the Medicaid/non-Medicaid populations. Detailed information related to Title V, legislation, and programming relevant to the Title V-Medicaid/KanCare partnership, was shared; discussion continues and has resulted in a stronger partnership. Turnover in Medicaid and change in KDHE Secretary has delayed a signed agreement; however, focus has been on the Medicaid MCH data/linked data set and areas where measures and programming align--disparities in prenatal care and birth outcomes (including preterm birth and infant mortality). Joint projects identified with Medicaid include: Collaboration with state Medicaid staff and managed care organizations to ensure consistent reporting of low birth weight, understand current and planned initiatives to improve birth weight, and identify potential performance improvement interventions to improve birth weight for members using KanCare services. Examine the impact of maternal diabetes and pre-diabetes on birth weight, and identify potential performance improvement interventions to improve birth weight for members using KanCare services. Assist Medicaid to identify and address reporting and program requirements related to CMS Abstraction and Reporting Tool related to children's services issues, including childhood immunization status, live birth weight, well child visits, and chlamydia screening.

**State and Local Programs:** The Title V Program provides funding directly to local health departments, health centers,

safety net clinics/FQHCs, coalitions, hospitals, foundations, and other community based organizations to provide local services for legislatively mandated populations. Partnerships were strengthened and networks expanded through the needs assessment process. The primary focus was on collaboration at the state and local levels, assessing what's working and what's not, and utilizing existing resources to guide the process. Using a collective impact framework, KDHE partnered with the March of Dimes Greater Kansas Chapter (MOD) and AMCHP to engage more than 200 partners across the state between May 2014 and February 2015, to focus on forging partnerships to collectively and comprehensively address issues families face in the context of their communities throughout the course of life. The MOD delivered a special presentation during each of the regional meetings to describe the Title V-MOD partnership related to establishing and expanding the Kansas Healthy Babies are Worth the Wait/Becoming a Mom program. Since the meetings ended in February 2015, an additional 12 communities have identified an interest to launch the program through support from Title V and MOD.

**Other State Departments/Agencies:** Several KDHE BFH staff representing MCH/MIECHV/ECCS, Part C, and Child Care, are active members of the State Early Childhood Leadership Team. The team is a formalized group representing early childhood programs within state agencies including KDHE, Department for Children and Families (DCF), Department of Education (KSDE), and the Children's Cabinet and Trust Fund (KCCTF). It was created to represent state agencies as a collective voice on early childhood programs and services for children and families from birth to after kindergarten entry, and to plan and initiate cross-agency unified efforts and outreach directed toward development of a comprehensive early childhood system. The team meets monthly to conduct strategic planning, identify priorities, and implement communication and coordination activities, including MCH. BFH worked directly with the team to promote the Kansas School Readiness Framework, and identified the following priorities: developmental screening including the system for referral and follow up; family engagement practices and standards; use of the Kansas Early Learning Standards; and early childhood professional development system. The Bureau maintains a strong partnership with the KCCTF with primary focus on the Home Visiting program and alignment with the Cabinet's *Blueprint for Early Childhood*.

**Kansas Tribes:** The Kansas Department of Health and Environment has been working over the last three years to develop a working relationship with the four Kansas tribes (Iowa Tribe of Kansas and Nebraska, Prairie Band Potawatomi Nation, Sac & Fox Tribe, and Kickapoo Tribe). As a result of improved communication and established trust with KDHE, the first Kansas Tribal Health Summit was held in 2013. The purpose of the annual Summit is to bring together Kansas Tribes and leadership from KDHE. The partnership grew in 2014 when the Summit involved more KDHE programs and staff including MCH and focused on the status/future plans of each of the tribes community health assessments (following the Healthy Kansans 2020 model/process). The 2015 Summit is scheduled for August and will be a time to align the state MCH priorities for legislatively mandated populations and the Tribes findings as a result of their individual assessments and plans. Title V is planning implementation of MOD's signature program, [The Coming of the Blessing](#), for American Indian and Alaska Native populations. The program offers women and families prenatal education (Becoming a Mom curriculum), training and resources based on traditional beliefs, lessons from ancestors, and a circle of support.

**Family/consumer partnership and leadership programs:** Family/consumer partnership throughout the needs assessment focused on input and what is working well within their community, as well as gaps and barriers to accessing services. Primary activities geared toward family and youth engagement included the Communities for Kids (C4K) meetings, the SHCN strategic planning, and the adolescent health assessment. These initiatives focused heavily on families and consumers, with the intent to gain meaningful input and feedback regarding MCH services to support positive outcomes across the lifespan. There were a total of 253 participants across all meetings, and 21.5% self-identified on the sign-in sheet as a parent or parent of a child with special health care needs. Family and consumer partners of all backgrounds, education levels, and ethnicities were invited to participate in the C4K meetings. Specific demographic data regarding race or ethnicity was not collected. The meetings provided an opportunity for participants to register in advance and notify meeting organizers of needed language or disability accommodations; no meeting participants required or requested these accommodations. It stands to reason that everyone in attendance could be counted from a family/consumer partner perspective; however, many were there in a professional capacity. Parents, siblings, and other family members were engaged in public forum discussions, in both large and small groups. It was clear that those in attendance were extremely passionate about improving the health of children and youth. Many participants were in attendance to support both personal and professional interests; however, they often identified which "hat" they were wearing during the discussions, and most often the "parent hat" was more prominent than the "business hat." Approximately 10 participants were identified as having interest in the Special Health Services Family Advisory Council (FAC), 2 of which who have already joined and attended their first meeting. Families associated with the FAC receive valuable training on Title V and MCH core competencies. The

input obtained was key in discussions for selecting priorities and objectives for the five year plan. Topics addressed through these meetings that were also adopted as part of the State Action Plan include: engaged and empowered families, family supports and peer groups, developmental screenings and follow-up, immunizations, motor vehicle safety, oral health, healthy foods and physical activity for children of all ages, bullying, emotional health and well-being, behavioral health services, training for parents and teachers on child behaviors, care coordination, telemedicine, difficulty accessing services in rural communities, health literacy and system navigation. Additionally, based upon feedback received through these meetings, specific strategies were developed to increase leadership and advocacy among families and consumers, expanding on training of Title V and MCH provided to FAC members. Further description of youth and parent leadership initiatives is outlined in the State Action Plan narrative.

The primary cohort of family/consumer partners engaged within the KS-SHCN strategic planning process included those on the FAC. Family members of all backgrounds, education levels, and ethnicities are invited to participate in the FAC. The family leaders who participated in the strategic planning process represent a wide variety of diverse backgrounds related to their family member's age, disability, and geographic location of the state. Program staff are constantly working towards recruiting FAC members of more diverse ethnic backgrounds. The engagement of the FAC in the KS-SHCN strategic planning supported the program to develop priorities related to care coordination, family caregiver health, behavioral health, training and education, and direct health care services. The strategies developed were based on input from the FAC, including final approval of the FAC as trusted advisors. The FAC will continue to be involved in the implementation of the KS-SHCN Strategic Plan and will assist in identifying areas of improvement or potential changes throughout the five years, to assure the program remains relevant and a valuable resource to families.

The Adolescent Health Needs Assessment consisted of an online survey and in-person focus groups. The statewide online survey received 854 respondents, representing 85 counties. Of the 77 participants over the age of 18, 50 identified themselves as parents. There was no identified need to provide incentives or compensation for youth participation due to location and attendance. The selected sites allowed representation from urban and rural communities, and for a Spanish focus group to be available in Dodge City. The primary recommendation of the adolescent health assessment was to "Address the highest priority adolescent health issues." In order of priority, based on all information obtained/reviewed, those issues are: mental health, substance abuse, reproductive/sexual health, nutrition and physical activity, and injury prevention. Youth participants in the focus groups indicated the need for trusted, supportive adult/mentors in their lives. As a result, a specific strategy to establish networks of adult and peer mentors was incorporated. Youth participants of the focus groups shared that they appreciated being asked for their input. Ongoing engagement of youth with Title V programs is desired and will be integrated into future work. It is believed that including adolescents and parents in assessment and planning processes provides Title V a clearer understanding of the issues the key issues – leading to more identification of solutions that will be effective and accepted.

## KANSAS MATERNAL CHILD HEALTH COUNCIL (KMCHC)

2015-2016

Chair				
Cooley	Dennis	MD FAAP	Pediatrician - current KMCHC chair	Pediatrics Associates of Topeka
Members				
Bemyshek	Katrina	RN	School Nurse Assoc. - 2014 president	Kansas School Nurse Organization (KSNO)
Daldrup	Diane		Community Volunteer	Previously March of Dimes Kansas Chapter
Gabel	Lisa	RN BSN CCM	Director of Health Care Management Services	Amerigroup Kansas, Inc.
Harris	Kari	MD	Pediatrics	KU Wichita
Hortenstine	Sara		Office of Kansas Attorney General Derek Schmidt	State Child Death Review Board
Jones	Wes	PhD	Psychologist	Mental Health Ctr-East Central KS
Lauer	Steve	PhD MD	Associate Chair	Dept. of Pediatrics
McDuffett	Pam	MSW	Consumer Affairs	KDADS
McNamar	Patricia	DNP, ARNP, NP-C	Nurse - Rural Hospital & Clinic	Medicine Lodge Memorial Hospital and Physicians Clinic
Pate	Brian	MD FAAP	Chair, Dept of Pediatrics - KUMC-Wichita	Wesley Medical Arts Tower
Pezzino	Gianfranco	MD, MPH	Media - Kansas Health Institute	Kansas Health Institute
Rodriguez	Melissa	RN, BSN	Family member	
Sage	Cherie		Representative - KS Safe Kids	Kansas SAFE KIDS
Schunn	Christy	LSCSW	KIDS Network - Exec. Dir.	KS Infant Death and SIDS Network
Shaw	Pam	MD FAAP	Pediatrician - KU - developmental screen	KUMC-Dept of Peds
Spainhower	Michele		Health Department MCH Staff	Sedgwick County Health Dept
Vaughn	Erick	LMSW	Director, Headstart	Kansas Head Start Association
Yadrich	Doma		Owner and Principal Patient-Centered Care Advocate	Kansas Title V Family Delegate
Johannes	Elaine	PhD	Youth Health and Education	Kansas State University Research & Extension
Kuhlmann	Zak	MD	Physician	
Pence	Susan	MD	Pediatrician	Community Health Center of SE Kansas (FQHC)
Garrison	Terrie	RN, BSN	Deputy Director /MCH Supervisor/Grantee	Unified Government Public Health Department
Ex-officio				
Akin	Carrie		MCH Consultant	KDHE - Bureau of Family Health
Bigler	Kayzy		Special Health Care Needs Program Manager	KDHE - Bureau of Family Health

Crawford	Greg		Director, Vital Statistics Data Analysis	KDHE - Vital Statistics
Haskett	Lori		Injury Prevention Disability & Health	KDHE - Bureau of Health Promotion
Kim	Jamie	MPH	MCH Epidemiologist	KDHE - Bureau of Family Health
Mosier	Susan	MD	Secretary & State Health Officer	KDHE
Reed	Traci		Director, Children & Families	KDHE - Bureau of Family Health
Richardson	Debbie	PhD	Home Visiting Manager, Children & Families	KDHE - Bureau of Family Health
Seymour-Hunter	Fran		Medicaid	KDHE - Division of Health Care Finance
Sisson	Rachel	MS	Bureau Director	KDHE - Bureau of Family Health
Smith	Heather	MPH	Director, Special Health Services	KDHE - Bureau of Family Health
Steelman	Lori		Director, Child Care Licensing	KDHE - Bureau of Family Health
Thomason	David	MPA	Director, Nutrition & WIC Services	KDHE - Bureau of Family Health
White	Kay		MCH Administrative Consultant	KDHE - Bureau of Family Health
Wolf	Stephanie	RN, BSN	KDHE - MCH/Perinatal Health Consultant	KDHE - Bureau of Family Health
<b>Staff</b>				
Steege	Chris		KAAP Exec. Dir.	Kansas Chapter of AAP
Satzler	Connie		Facilitator	Envisage, Inc.

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Akin	Carrie		MCH Consultant	KDHE - Bureau of Family Health
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## II.C. State Selected Priorities

No.	Priority Need
1	Women have access to and receive coordinated, comprehensive services before, during and after pregnancy.
2	Services and supports promote healthy family functioning.
3	Developmentally appropriate care and services are provided across the lifespan.
4	Families are empowered to make educated choices about infant health and well-being.
5	Communities and providers support physical, social and emotional health.
6	Professionals have the knowledge and skills to address the needs of maternal and child health populations.
7	Services are comprehensive and coordinated across systems and providers.
8	Information is available to support informed health decisions and choices.

Working with the MCH Council to determine the status of Kansas MCH progress since MCH 2015 (2010 Needs Assessment) and identify priorities was central to the needs assessment planning and process. This work assisted in identifying which priorities remained from 2015 and needed to continue. Additionally, the Title V team (and partners) carried out a broad, comprehensive process to identify priorities and develop an effective action plan for improving and addressing MCH needs. For more than 18 months the team facilitated and carried out: eight Public Health Regional Meetings, three MCH Council meetings, 17 Communities for Kids meetings, focus groups with 350 adolescents, and strategic planning meetings with MCH staff and stakeholders.

It became clear that priorities were interconnected as common issues emerged across populations and that to effectively address them, the following criteria for selecting and categorizing priorities and elements of the plan were paramount:

- 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

There is intentionality in building upon and continuing to address 2010 priorities (focused and narrow) while integrating new ones that emerged during this process. It meant developing a comprehensive and integrated Title V plan in which MCH services and activities are coordinated and delivered across funding sources and in partnership with other state agencies and local providers. This approach relies on strong partnerships for service coordination and high quality shared measurement systems to track and measure the impact and effectiveness of coordinated services, activities, and strategies under each priority. All MCH services falling under the Title V umbrella, including those funded by other federal sources, can be assessed comprehensively and locally through KDHE's public health shared measurement system (DAISEY). Using high quality data from local MCH providers will help track and measure progress and impact in meeting priorities while also giving state and local partners a robust system to support continuous quality improvement efforts to improve MCH service delivery and coordination.

**Priority 1: Women have access to and receive coordinated, comprehensive services before, during and after pregnancy (Women/Maternal)**

Priority 1 reflects KDHE's commitment to the MCH guiding principles and work by addressing the *process* as the best way to reach positive outcomes. Throughout the process, women's health was consistently voiced as a priority. It became apparent that the recurring themes in this domain reflected the overall needs of the state as well as each region and community. For example, access to care was a need expressed consistently as overarching not only for individual communities and regions, but also among providers, programs and families throughout the state, yet was so broad that many other priorities began to emerge as objectives that fit within it. KDHE already had successful programs, resources and services and is now in a better position to provide more engaged community partners, build on existing programs, and address the needs of the state's maternal population. The following needs are addressed by this priority: expanded community perinatal collaborative model, expanded home visiting, uniform screening, coordinated care, reduced smoking in the home, increased breastfeeding, increased access to care, increased well woman visits, increased coverage, completed referrals (follow up), and access to transportation.

**Priority 2: Services and supports promote healthy family functioning (Cross-cutting)**

Promoting and providing services for optimal mental and behavioral health were identified as critical issues to a healthy family and overall community well-being throughout the needs assessment. During data collection, questions were asked to determine 1) the nature of mental and behavioral health needs and 2) the role of MCH in mental and behavioral health. This helped inform a broader priority that addressed mental and behavioral health as a component of family functioning. Parents and providers indicated family functioning contributed to stressors across all population domains. Lack of services was an issue, but bigger issues were lack of knowledge of services and stigma. Teachers expressed feeling overwhelmed with young children's behavioral issues, which connected to a stressful home environment, potentially due to interconnected factors, such as overworked parents, lack of time and money leading to poor nutrition, domestic violence, and unhealthy sleep habits, which expressed in children's behavior. To promote children's health, findings suggest the need for resources to manage adult relationships in a healthy way and to interrupt the frequency of stressors -from prenatal care into infancy and beyond. Parent

education through home visiting, opportunities for community engagement, and life skills classes (e.g., cooking, budgeting and job trainings) could be provided.

**Priority 3: Developmentally appropriate care and services are provided across the lifespan (Child)**

Children's healthy development was an observed theme that corresponded to needs identified in every community. While these needs could stand on their own as priorities, they all connected to a common goal, *the health of children across multiple levels and into the adolescent years*. Needs included: injury prevention, safety in the home, and selection of safe childcare. Identified needs provide KDHE with the unique opportunity to focus on cross cutting goals in programs and practices. By strengthening existing successes of programs like Safe Kids Kansas as well as increasing the number of MCH grantees that serve as a lead agency for local Safe Kids coalitions, KDHE can continue to strengthen the guiding principle of collaboration and creating community change. Additional needs in this priority area focused on essential health, safety and education opportunities by providing prevention practices for parents and providers such as: safe sleep initiatives, access to childhood immunizations, oral health education and developmental screenings. For example, the Title V and Special Health Care Needs unit is leading a collaborative effort across state agencies, medical home and primary care providers, and early childhood partners to implement locally driven Help Me Grow models of coordinating developmental assessments and linking to appropriate care and services within a community. Taken together and with input from local and regional providers, Title V seeks to transform how it collaborates and delivers coordinated services across partners and agencies to address needs with existing programs as well as new and innovative approaches to contribute to the whole health of the child throughout the life course.

**Priority 4: Families are empowered to make educated choices about infant health and well-being. (Perinatal/Infant)**

Discussions during the needs assessment regularly focused on the need to address obesity and other issues across population domains. While there was targeted discussion about children related to school lunches, the focus shifted to a broader view of a healthy start/beginning. Over the last year, discussion moved to the Perinatal/Infant Health Domain National Performance Measures and breastfeeding. Areas of need/work began to emerge. In addition to a need for improvement related to exclusive breastfeeding through at least 6 months, there is strong desire to expand existing work related to safe sleep and reducing SIDS/SUID, including the aspects related to breastfeeding/bed sharing/co-sleeping. One way to leverage existing Title V programs to do this is through MIECHV home visiting and Universal Home Visiting curriculum and materials on safe sleep that can be used widely across other settings (WIC, child care, etc). Additionally, family empowerment is an area of emphasis for locally-driven Help Me Grow efforts, which includes the development of a family access point for receiving information about services that address infant health and well-being. Through further development of an existing innovative web-based communication tool (IRIS), now used in MIECHV communities and slated for Help Me Grow communities, a family will be able to initiate a service or referral and be empowered with the right information and warm hand-off among MCH providers and community partners to support coordinated services for infant health and well-being. Other plans include enhanced community baby showers, incorporating cross-cutting issues breastfeeding, safe sleep, and smoking in the home. Additionally, training and messaging around issues will be aligned among existing programs including MCH, home visiting, WIC, and chronic disease.

**Priority 5: Communities and providers support physical, social and emotional health (Adolescent)**

Life skills development such as budgeting, cooking, job training and healthy recreation are important objectives under this priority. The need to promote positive coping mechanisms can be accomplished with yearly mental health screenings (suicide prevention and addressing bullying). Well visits for adolescents can promote overall health (immunizations, healthy eating, and oral health), and social emotional health can be enhanced through trained adults and mentors to help adolescents navigate life skills and set goals (high school completion, employment, youth development). Given that adolescents have a natural desire to become active agents in society and community, this priority can be promoted through community partnerships and engagement, and can reinforce protective factors and promote prevention of risky behaviors. KDHE can support schools and faith based organizations to provide the whole family with education and public awareness campaigns, and implementation of policy and procedures can be explored to promote suicide prevention and address bullying.

**Priority 6: Professionals have the knowledge and skills to address the needs of maternal and child health populations (Cross-cutting)**

Appropriate care for maternal and child health populations is critical to ensuring population needs are met. To provide quality care, professionals interfacing with populations must be properly trained. Ensuring adequate training can impact individuals from birth through the life course. Participants reported that their community was in need of trained, qualified professionals to deliver services across the MCH population domains. When asked what could improve services within the community, responses included *“having trained professionals who take the time and listen to our needs.”* Other responses indicated professionals needed awareness of the populations they served, their environmental stressors, and the health impact stressors might have. In particular, children and youth with special needs was identified as a population that needed improved support. Suggested strategies include incorporating evidence-based trainings and mid-level trainings for home based practitioners. Care coordination was identified as necessary to enhance service delivery. When agencies and providers collaborate, resources are shared creating an interconnected environment that can help MCH populations be more aware of services and lead to appropriate linkages. Objectives include: developing a trained, qualified workforce; providing training to providers to promote diversity, inclusion, and supports; and incorporating the support of early childhood service providers.

**Priority 7: Services are comprehensive and coordinated across systems and providers (CYSHCN)**

While this priority naturally focuses on addressing the needs of children and youth with special health care needs, it is not exclusive and addresses all children in the way that KDHE strives: comprehensively and inclusively. One of the main goals of the Kansas Special Health Care Needs program is care coordination, to support children and their families in navigating systems to gain optimal health in a consistent and comprehensive way. However, throughout the regional meetings, especially Communities for Kids meetings, family support emerged as a high need across families without identified CYSHCN. A primary concern among most communities included access to care (transportation and medical, dental and mental health care providers), especially in rural areas. As the assessment progressed, family supports expanded into the need for social-emotional support and respite for caregivers, specifically to family caregivers of CYSHCN. In addition, pediatric primary and specialty care are sparse among rural communities. .

As previously mentioned, CYSHCN is leading collaborative efforts to establish community-based Help Me Grow models specifically designed to coordinate comprehensive, developmentally appropriate services among providers. The Help Me Grow model is a framework for coordinating MCH and early childhood services across systems and providers. Combined with communities that use the web-based referral and intake tool IRIS, Title V will further drive a coordinated and integrated system of providers that serve families and children. Across the state, patient/family-centered medical homes will be explored to address identified needs and build partnerships. This could also provide foundational support to: engage MCO's and primary care providers; implement telemedicine; and provide professional development training. This priority exemplifies the collaboration and partnership principles KDHE promotes and wants to sustain.

**Priority 8: Information is available to support informed health decisions and choices (Cross-cutting)**

Priority 8 was identified to address the overall needs related to health literacy in the state, including health insurance literacy. Empowering individuals to coordinate their own health care was approached as a cross-cutting priority so that even the very young can understand and practice self-care as well as have a continued awareness into adulthood. Participants stated that understanding the importance of personal health needs, seeking services, and navigating the health care system would promote lifelong habits for well-being and lead to the reduction or prevention of many of the needs heard throughout the process. Issues such as immunizations, well-woman care, provider availability, qualifying for care, and even showing up for appointments were raised as examples of the need for individual's to understand health systems, obtain support to navigate systems, and practice routine care. In addition to the qualitative and survey data, population level data, including NPMs and other identified key indicators, were examined to guide the prioritization process.

CROSSWALK OF TITLE V PRIORITIES	
2011-2015 Priority	2016-2020 Priority
<b>Women &amp; Infants</b>	
All women receive early and comprehensive care before, during and after pregnancy	Women have access to and receive <u>coordinated, comprehensive services</u> before, during and after pregnancy
Improve mental health and behavioral health of pregnant women and new mothers	
Reduce preterm births (including low birth weight and infant mortality)	
Increase initiation, duration and exclusivity of breastfeeding	
	Families are empowered to make educated choices about <u>infant health and well-being</u>
<b>Children &amp; Adolescents</b>	
All children and youth receive health care through medical homes	
Reduce child and adolescent risk behaviors relating to alcohol, tobacco and other drugs	
All children and youth achieve and maintain healthy weight	
	<u>Developmentally appropriate care and services</u> are provided across the lifespan
	Communities, providers, and systems of care support <u>physical, social and emotional health</u>
<b>CYSHCN</b>	
All CYSHCN receive coordinated, comprehensive care within a medical home	<u>Services are comprehensive and coordinated</u> across systems and providers
Improve the capacity of YSHCN to achieve maximum potential in all aspects of adult life, including appropriate health care, meaningful work, and self-determined independence	
Financing for CYSHCN services minimizes financial hardship for their families	
<b>Life course/cross cutting</b>	
	Services and supports promote <u>healthy family functioning</u>
	<u>Professionals have the knowledge and skills</u> to address the needs of maternal and child health populations
	Information is available to support <u>informed health decisions and choices</u>

## II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

- NPM 1 - Percent of women with a past year preventive medical visit
- NPM 4 - A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months
- NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool
- NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19
- NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others
- NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
- NPM 11 - Percent of children with and without special health care needs having a medical home
- NPM 14 - A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

The Kansas Title V needs assessment process focused primarily on identifying and addressing the issues at the state and local levels; priorities were selected with Title V mission, purpose, and legislation in mind. The top state priority issues that most closely aligned with the National priorities and measures were selected. While most of the priorities align closely with the NPMs, there are several important needs that emerged for which there are not corresponding NPMs. In cases where priorities do not directly link with NPMs, the Bureau and Title V Program developed State Performance Measures and will closely monitor ESMs throughout the project period to assess progress being made. Priorities and corresponding NPMs and National Outcome Measures (NOMs) are identified below.

**PRIORITY ONE:** Women have access to and receive coordinated, comprehensive services before, during and after pregnancy (Domain: Women/Maternal)

**Corresponding NPM:**

- NPM 1. Well-woman visit (Percent of women with a past year preventive medical visit)

**Corresponding NOMs:**

- Severe maternal morbidity per 10,000 delivery hospitalizations
- Maternal mortality rate per 100,000 live births
- Low birth weight rate (%)
- Very low birth weight rate (%)
- Moderately low birth weight rate (%)
- Preterm birth rate (%)
- Early preterm birth rate (%)
- Late preterm birth rate (%)
- Early term birth rate (%)
- Infant mortality per 1,000 live births
- Perinatal mortality per 1,000 live births plus fetal deaths
- Neonatal mortality per 1,000 live births
- Post neonatal mortality rate per 1,000 live births
- Preterm-related mortality per 100,000 live births

NPM 1 was selected because of the discussion by stakeholders regarding the need for women's gynecological health to be improved. Service coordination among partners should help to ensure that the proportion of women receiving a well-woman visit is increased, as should the provision of consumer education regarding what services are available to them. The state ESM for this priority focuses on educating all program participants on the importance of preventive care and annual visits. Work also involves collaborating with Title X, FQHCs, and private clinics to improve access to well-woman visits. In addition, there is an overall emphasis on improved screening and care coordination related to physical and mental health.

**PRIORITY TWO:** Services and supports promote healthy family functioning (Domain: Cross-cutting)

There is no corresponding NPM for this priority. A State Performance Measure has been developed. This issue was identified as the continued success of maternal and child health services in Kansas. Participants throughout Kansas voiced a need for trained, qualified professionals who could deliver services across domains. Strategies are focused on developing innovative methods for training the provider workforce.

**PRIORITY THREE:** Developmentally appropriate care and services are provided across the lifespan (Domain: Child)

**Corresponding NPMs:**

- NPM 6. Developmental screening (Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool)
- NPM 7. Child Injury (Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9)

**Corresponding NOMs:**

- Percent of children in excellent or very good health
- Percent of children meeting the criteria developed for school readiness
- Child mortality ages 1 through 9 per 100,000

NPM 6 was selected because of the many discussions with stakeholders about current gaps in developmentally-appropriate care. Strategies focus on care coordination to ensure developmental screenings increase and are accessible through a number of approaches, including via tele-health. The Early Childhood Comprehensive Systems (ECCS) project has provided capacity and infrastructure to expand screenings further, including in child care settings. Continued funding for ECCS (5 years) will support this expansion and alignment and coordination for children birth to five and their families.

NPM 7 was selected in part because of the high rates of unintentional injury in the state. From 2007-2008, there were 50,525 unintentional injury emergency department visits (Safe Kids Kansas, 2012). In addition, meeting participants discussed the need for prevention activities such as those that reduce motor vehicle crash injuries and deaths through addressing distracted/impaired driving, use of seat belts, etc.

**PRIORITY FOUR:** Families are empowered to make educated choices about infant health and well-being (Domain: Perinatal/Infant)

**Corresponding NPM:**

- NPM 4. Breastfeeding (A. Percent of infants who are ever breastfed and B. Percent of infants breastfed exclusively through 6 months)

**Corresponding NOMs:**

- Infant mortality rate per 1,000 live births
- Post neonatal mortality rate per 1,000 live births
- Sleep-related SUID per 100,000 live births

NPM 4 was selected because of widespread support by meeting participants for breastfeeding resources. ESMS for this priority will strengthen existing infant feeding education for mothers and communities. Efforts related to this priority will also be expanded to include safe sleep and linkages between breastfeeding, safe sleep, and smoking.

**PRIORITY FIVE:** Communities and providers support physical, social and emotional health (Domain: Adolescent)

**Corresponding NPMs:**

- NPM 9. Bullying (Percent of adolescents, 12 through 17, who are bullied or who bully others)
- NPM 10. Adolescent well-visit (Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year)

**Corresponding NOMs:**

- Adolescent mortality ages 10 through 19 per 100,000
- Adolescent suicide ages 15 through 19 per 100,000
- Percent of children in excellent or very good health
- Percent of children ages 6 months through 17 years who are vaccinated annually against seasonal influenza
- Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

- Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine
- Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine
- Adolescent mortality ages 10 through 19 per 100,000
- Adolescent motor vehicle mortality ages 15 through 19 per 100,000
- Adolescent suicide ages 15 through 19 per 100,000
- Percent of children with mental/behavioral health condition who receive treatment or counseling
- Percent of adolescents who are overweight or obese (BMI at or above the 85th percentile)
- Severe maternal morbidity per 10,000 delivery hospitalizations
- Maternal mortality rate per 100,000 live births
- Low birth weight rate (%)
- Very low birth weight rate (%)
- Moderately low birth weight rate (%)
- Preterm birth rate (%)
- Early preterm birth rate (%)
- Late preterm birth rate (%)
- Early term birth rate (%)
- Infant mortality per 1,000 live births
- Perinatal mortality per 1,000 live births plus fetal deaths
- Neonatal mortality per 1,000 live births
- Post neonatal mortality rate per 1,000 live births
- Preterm-related mortality per 100,000 live births

NPM 9 was selected because of state statistics that indicate that nearly 8% of school age children in Kansas have been bullied, and more than 7% of Kansas school age children were identified as bullies (U.S. Census, 2000). Bullying will be addressed by communities and systems of care supporting children's social and emotional health. ESMs include integrating behavioral health screenings and services into primary care and school settings, as well as enhancing substance abuse services for adolescents.

NPM 10 was selected because of the many discussions regarding barriers to service access that current exist for this population. To increase community/provider support to improve access and use of adolescent well-visit services, strategies include potential actions for follow up on youth not completing annual visits.

**PRIORITY SIX:** Professionals have the knowledge and skills to address the needs of maternal and child health populations (Domain: Cross-cutting)

**Corresponding NPM:**

- NPM 14. (A) Smoking during Pregnancy and (B) Household Smoking (A. Percent of women who smoke during pregnancy and B. Percent of children who live in households where someone smokes)

**Corresponding NOMs:**

- Severe maternal morbidity per 10,000 delivery hospitalizations
- Maternal mortality rate per 100,000 live births
- Low birth weight rate (%)
- Very low birth weight rate (%)
- Moderately low birth weight rate (%)
- Preterm birth rate (%)
- Early preterm birth rate (%)
- Late preterm birth rate (%)
- Early term birth rate (%)
- Infant mortality per 1,000 live births
- Perinatal mortality per 1,000 live births plus fetal deaths

- Neonatal mortality per 1,000 live births
- Preterm-related mortality per 100,000 live births
- Post neonatal mortality per 1,000 live births
- Sleep-related SUID per 100,000 live births
- Percent of children in excellent or very good health

NPM 14 was selected in part because more than 13% of Kansas women smoked during pregnancy as recently as 2011-2013 (Kansas Health Matters). Household smoking in Kansas is higher than the national average, with 25.3% of Kansas children living in households where someone smokes, versus 24.1% of children living in households where someone smokes throughout the nation (National Survey of Children's Health, 2011-2012). Smoking during pregnancy affects the mother, unborn child, and all members of the household. Increasing the utilization of the Kansas Quitline and other tobacco cessation programs by pregnant women should improve the health of entire households in Kansas. Providing opportunities for families to strengthen their relationships and be educated regarding healthy behaviors will empower households to make positive changes that should include a decrease in the proportion of adults who smoke. Therefore, a corresponding proportion of children living with smokers will also decrease. Reducing risk factors associated with smoking through education and related interventions is a focus of the strategies for this priority.

**PRIORITY SEVEN:** Services are comprehensive and coordinated across systems and providers (Domain: Children and Youth with Special Health Care Needs)

**Corresponding NPM:**

- NPM 11. Medical home (Percent of children with and without special health care needs having a medical home)

**Corresponding NOMs:**

- Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system
- Percent of children in excellent or very good health
- Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1 :4 combined series of routine vaccinations
- Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza
- Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine
- Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine
- Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

NPM 11 was selected because of the current lack of medical homes for children in Kansas. For those with special needs, only 53.8% reported having a medical home. And for those without special needs, only 60.4% reported having a medical home (National Survey of Children's Health, 2011-2012). Strategies target providers from a variety of service designations to engage them in supporting efforts to increase the number of children in Kansas with a medical home.

**PRIORITY EIGHT:** Information is available to support informed health decisions and choices (Domain: Cross-cutting)

There is no corresponding NPM for this priority. A State Performance Measure has been developed. Health literacy was an issue raised by many stakeholders. In order for the MCH population to successfully navigate the medical system, education regarding benefits and reduced cost services must be provided to Kansas families. Strategies target traditional and nontraditional service providers.

## II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

- SPM 1 - Percent of preterm births (<37 weeks gestation)
- SPM 2 - Percent of children living with parents who have emotional help with parenthood
- 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
- SPM 4 - Number of Safe Sleep (SIDS/SUID) trainings provided to professionals
- 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

The Kansas Title V needs assessment process focused primarily on identifying and addressing the issues at the state and local levels; priorities were selected with Title V mission, purpose, and legislation in mind. The top state priority issues that most closely aligned with the National priorities and measures were selected. While most of the priorities align closely with the NPMs, there are several important needs that emerged for which there are not corresponding NPMs. In cases where priorities do not directly link with NPMs, the Bureau and Title V Program developed State Performance Measures (SPMs) to ensure that progress is being made. More information about the SPMs can be found on Form 10b (detail sheets). Note: No State Outcome Measures were developed.

### **State Priorities & Corresponding State Performance Measure (SPM)**

**PRIORITY 1:** Women have access to and receive coordinated, comprehensive services before, during and after pregnancy (Domain: Women/Maternal)

**Corresponding SPM:** 1. Percent of preterm births (<37 weeks gestation)

#### Significance

The Title V program selected this SPM due to the most current data and existing work across the state. Specifically, the Becoming a Mom (BAM) program objectives and Infant Mortality CollIN plan/change ideas focus on this issue. The program is looking to continue efforts related to appropriate utilization of 17P (progesterone) and eliminating early elective delivery to reduce recurrence of preterm birth.

Babies born preterm, before 37 completed weeks of gestation, are at increased risk of immediate life-threatening health problems, as well as long-term complications and developmental delays. Among preterm infants, complications that can occur during the newborn period include respiratory distress, jaundice, anemia, and infection, while long-term complications can include learning and behavioral problems, cerebral palsy, lung problems, and vision and hearing loss. As a result of these risks, preterm birth is a leading cause of infant death and childhood disability. Although the risk of complications is greatest among those babies who are born the earliest, even those babies born "late preterm" (34 to 36 weeks' gestation) and "early term" (37, 38 weeks' gestation) are more likely than full-term babies to experience morbidity and mortality. Infants born to non-Hispanic black women have the highest rates of preterm birth, particularly early preterm birth. In 2012, in the United States, 16.5 percent of non-Hispanic Black infants were born preterm and 5.9 percent were born early preterm--these rates are 1.6 and 2.0 times the rates for infants born to non-Hispanic white women (10.3 and 2.9 percent, respectively). Infants born to Puerto Rican, Cuban, and American Indian/Alaska Native mothers also had elevated rates of preterm and early preterm birth. Non-medically indicated early term births (37,38 weeks) present avoidable risks of neonatal morbidity and costly NICU admission (Clark et al, 2009; Tita et al, 2009). Early elective delivery prior to 39 weeks is an endorsed perinatal quality measure by the Joint Commission, National Quality Forum, ACOG/NCQA, Leapfrog Group, and CMS/CHIPRA.

**PRIORITY 2:** Services and supports promote healthy family functioning (Domain: Cross-cutting)

**Corresponding SPM:** 2. Percent of children living with parents who have emotional help with parenthood

#### Significance

The demands of parenting can cause considerable stress for families. Children and adolescents were less likely to engage in externalizing (acting out behavior) and display depression symptoms (sadness, feelings of worthlessness or withdrawn behavior), or have to be retained in a previous grade, when their mothers reported having emotional support with child rearing. These children and adolescents were also likely to display social competence and school engagement than were their counterparts whose mothers did not report having emotional support.

**PRIORITY 3.** Developmentally appropriate care and services are provided across the lifespan

**Corresponding SPM:** 3. Percent of children 6 through 11 and adolescents 12 through 17 who are physically active at least 60

minutes a day (Domain: Child)

Significance

Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Physical activity in children and adolescents reduces the risk of early life risk factors for cardiovascular disease, hypertension, Type II diabetes, and osteoporosis. In addition to aerobic and muscle strengthening activities, bone-strengthening activities are especially important for children and young adolescents because the majority of peak bone mass is obtained by the end of adolescence.

**PRIORITY 4:** Families are empowered to make educated choices about infant health and well-being (Domain: Perinatal/Infant)

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

Significance

Sleep-related infant deaths, called Sudden Unexpected Infant Death (SUID), are the leading cause of infant death after the first month of life. Risk of SUID increases when babies are placed on their side or stomach to sleep. Placing babies on their back, on a firm surface, and without loose bedding are the recommended practices to follow according to the American Academy of Pediatrics (AAP).

**Priority 8: Information is available to support informed health decisions and choices (Domain: Cross-cutting)**

**Corresponding 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

Significance

Communication barriers often go undetected in health care settings and can have serious effects on the health and safety of patients. Limited literacy skills are one of the strongest predictors of poor health outcomes for patients. Health literacy can affect health status, health outcomes, health care use and health care costs. The entire health care systems relies on the assumption that patients can understand complex written and spoken information. If patients cannot understand health information, they cannot take necessary actions for their health or make appropriate health decisions.

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**NOTE:** There are no State Performance Measures associated with Priorities 5, 6, and 7.

## **II.F. Five Year State Action Plan**

### **II.F.1 State Action Plan and Strategies by MCH Population Domain**

Local MCH grantees across the state provide family centered, community based and culturally competent services and care to MCH populations throughout the life course. Special emphasis on high level areas by domain is identified below.

1. Women/Maternal: well care; prenatal care/education; breastfeeding support/education; home visiting; comprehensive screening (depression, preterm birth, substance use, tobacco/smoking); other education, counseling, referral services
2. Perinatal/Infant: well care and screening, home visiting, breastfeeding support (focus on duration & exclusivity), safe sleep, community outreach and public education (safe haven, text4baby)
3. Child: screenings (vision, hearing, developmental), health education (motor vehicle safety, nutrition), community outreach and public education (child abuse prevention, immunizations)
4. CYSHCN: care coordination, family caregiver health needs, behavioral health, training and education, early screenings, school readiness, collaboration and coordination with early intervention, social services, and family support services
5. Adolescent: immunizations, reproductive health, health education (motor vehicle safety, fitness), community outreach/public education (teen pregnancy, injury, risky behaviors, suicide, abstinence)
6. Cross-cutting: health equity; comprehensive, coordinated care; Medicaid outreach/enrollment; preventive care and immunizations; linking families with needed services through screening, referral, and follow up

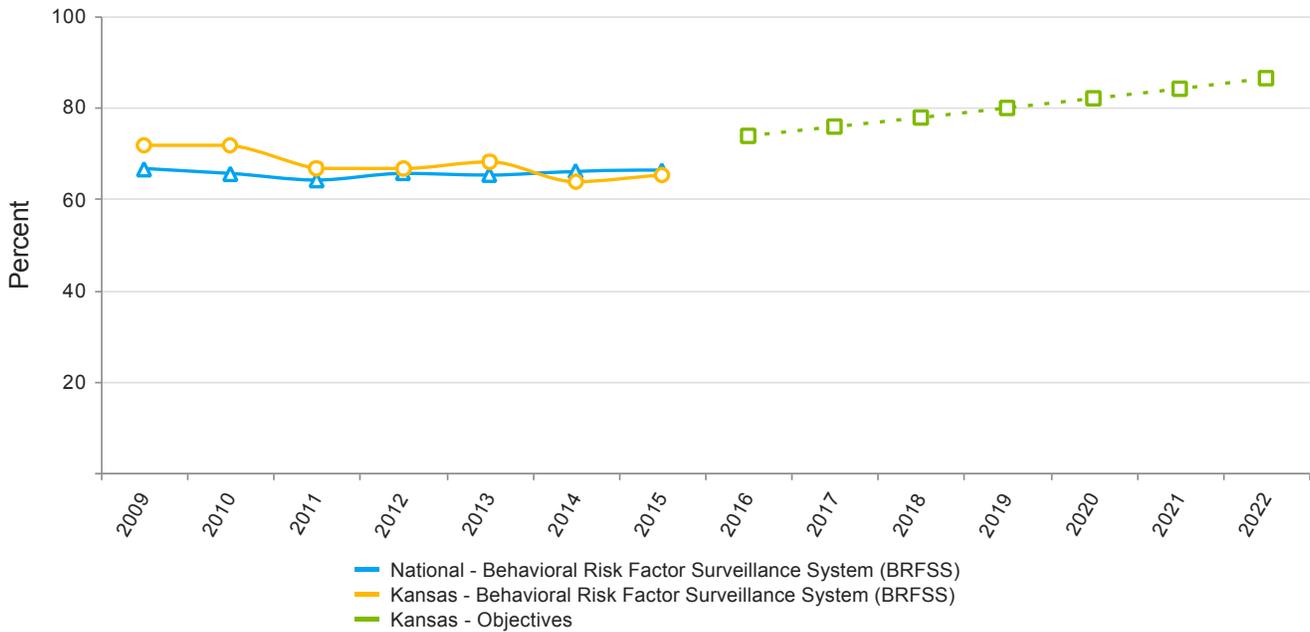
#### **Women/Maternal Health**

#### **Linked National Outcome Measures**

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2014	111.2	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2011_2015	17.8	NPM 1
NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2015	6.8 %	NPM 1
NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)	NVSS-2015	1.2 %	NPM 1
NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)	NVSS-2015	5.6 %	NPM 1
NOM 5.1 - Percent of preterm births (<37 weeks)	NVSS-2015	8.8 %	NPM 1
NOM 5.2 - Percent of early preterm births (<34 weeks)	NVSS-2015	2.4 %	NPM 1
NOM 5.3 - Percent of late preterm births (34-36 weeks)	NVSS-2015	6.3 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2015	24.1 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2014	6.1	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2014	6.2	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2014	4.5	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	1.7	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2014	211.6	NPM 1

National Performance Measures

NPM 1 - Percent of women with a past year preventive medical visit  
Baseline Indicators and Annual Objectives



Federally Available Data	
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)	
	2016
Annual Objective	73.7
Annual Indicator	65.1
Numerator	317,072
Denominator	486,998
Data Source	BRFSS
Data Source Year	2015

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	75.7	77.7	79.8	81.9	84.0	86.3

**Evidence-Based or –Informed Strategy Measures**

**ESM 1.1 - Percent of women program participants (18-44 years) that received education on the importance of a well-woman visit in the past year**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	9.6
Numerator	562
Denominator	5,824
Data Source	DAISEY
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	20.0	30.0	40.0	50.0	60.0	70.0

**State Performance Measures**

**SPM 1 - Percent of preterm births (<37 weeks gestation)**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	8.8
Numerator	3,426
Denominator	39,105
Data Source	Kansas Vital Statistics
Data Source Year	2015
Provisional or Final ?	Provisional

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	8.3	8.1	7.9	7.8	7.6	7.4

## State Action Plan Table

### State Action Plan Table (Kansas) - Women/Maternal Health - Entry 1

#### Priority Need

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

#### NPM

Percent of women with a past year preventive medical visit

#### Objectives

1.1 Increase the proportion of women receiving a well-woman visit annually.

1.2 Increase the number of completed referrals for services in response to prenatal/postnatal risk screening at every visit by 2020.

1.3 Increase the number of established perinatal community collaboratives (e.g., Becoming a Mom (BAM) programs) by at least 5 annually by 2020.

1.5 Decrease non-medically indicated early elective deliveries between 37 0/7 weeks of gestation through 38 6/7 weeks of gestation to less than 5% by 2020.

## Strategies

1.1.1 Increase the number of health departments and health centers with on-site assistance for accessing health care coverage (certified application counselors or Medicaid eligibility workers), especially to ensure coverage beyond the post-partum period. 1.1.2 Utilize peer and social networks for women, including group education models, to promote and support access to preventive care. 1.1.3 Promote individuals' responsibility through the development and documentation of personal health plans. 1.1.4 Promote consumer awareness about the importance of preconception care.

1.2.1 Implement standard screening protocol and utilization of standard tools for smoking/tobacco, alcohol, substance use, and mental health, including maternal depression. 1.2.2 Define completed referral and develop protocol for documenting referrals and tracking follow-up. 1.2.3 Increase knowledge and promote utilization of health coverage benefits and community services related to improving health behaviors, such as tobacco cessation.

1.3.1 Develop new community collaborations and BAM programs, targeting cities, counties, and regions with disparities and poor birth outcomes (follow the Healthy Start model). 1.3.2 Integrate evidence-based tobacco/smoking, safe sleep, and breastfeeding interventions into community-based service models. 1.3.3 Engage Federally Qualified Health Centers (FQHCs) in more communities across the state with the goal of increasing coordination and access to a variety of services for those at greatest risk. 1.3.4 Develop regional models to implement or support rural expansion of community collaboratives. 1.3.5 Integrate telehealth capabilities within the existing community collaborative models in targeted areas.

1.5.1 Integrate early elective delivery (EED) and preterm birth education and materials into community systems, including BAM programs. 1.5.2 Promote training and education for hospitals and OB providers to utilize or apply policies and practices contained in the March of Dimes 39 Weeks Toolkit. 1.5.3 Work with hospitals and providers to eliminate EED through partnership with the Kansas Healthcare Collaborative and March of Dimes. 1.5.4 Gain a shared understanding among partners as to the data source and rate of EED in Kansas.

## ESMs

## Status

ESM 1.1 - Percent of women program participants (18-44 years) that received education on the importance of a well-woman visit in the past year

Active

## NOMs

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

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NOM 3 - Maternal mortality rate per 100,000 live births

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NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

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NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

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NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

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NOM 5.1 - Percent of preterm births (<37 weeks)

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NOM 5.2 - Percent of early preterm births (<34 weeks)

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NOM 5.3 - Percent of late preterm births (34-36 weeks)

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NOM 6 - Percent of early term births (37, 38 weeks)

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

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

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

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NOM 9.3 - Post neonatal mortality rate per 1,000 live births

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

## State Action Plan Table (Kansas) - Women/Maternal Health - Entry 2

### Priority Need

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

### SPM

Percent of preterm births (<37 weeks gestation)

### Objectives

1.4 Increase the percent of pregnant women on Medicaid with a previous preterm birth who receive progesterone to 40% by 2018 and increase annually thereafter.

### Strategies

1.4.1 Increase patient, family and community understanding of progesterone use and full-term births. 1.4.2 ,Promote universal practice protocol and tools to timely, reliably, and effectively screen women for history of preterm birth and short cervix. 1.4.3 Develop protocol and guidelines, including utilization of progesterone to prevent preterm birth. 1.4.4 Utilize Medicaid claims data and data linkages with Vital Records to increase the number of women prescribed progesterone.

## **Women/Maternal Health - Plan for the Application Year**

**PRIORITY:** Women have access to and receive coordinated, comprehensive services before, during and after pregnancy

**NPM 1:** Well-woman visit (Percent of women with a past year preventive medical visit)

**SPM 1:** Preterm births (<37 weeks of gestation)

*Local MCH Reach:* Based on 2017-2018 MCH Aid to Local applications received, 50 of 70 (71%) grantees/local MCH agencies plan to provide services to the Woman & Maternal population.

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### **NPM 1: Well-woman visit (Percent of women with a past year preventive medical visit)**

Objective: Increase the proportion of women receiving a well-woman visit annually.

State Title V staff will continue to support the promotion of women receiving a well-woman visit annually, by messaging the importance of local Title V grantees partnering with other community agencies to provide on-site assistance for accessing health care coverage in the pre/interconception period. We will also continue to promote the development of personal health plans, including a reproductive life plan, for individuals receiving Title V services. In doing so, we will continue to highlight this topic, while sharing associated resources, during our annual Governor's Public Health Conference, MCH Home Visiting Fall Regional training, and other appropriate venues.

As part of the FY2018 Kansas MCH Service Manual revisions/update, grantees were provided with the "Preconception Health and Health Care - My Reproductive Life Plan" resource from the CDC as a recommended resource for incorporation into local program services. As the opportunity arises for building additional forms into our electronic data system, DAISEY, a "Reproductive Life Plan" form will be built and provided for all users of the system to access and incorporate as part of their service delivery plan and client visit/service records.

To support broader reproductive health and MCH goals, discussion is taking place to implement the One Key Question® (OKQ) Initiative, property of the Oregon Foundation for Reproductive Health (with support and technical assistance from the Oregon Foundation) in partnership with Title X clinics. The one key question, "Would you like to become pregnant in the next year?" and responses have already been built into the client data system, DAISEY, in anticipation of planning for implementation of the program.

MCH Local Agency Strategies: Local agencies will either provide direct well woman preventative care or enabling services by providing resources and referrals for women to receive preventive well visits. Women will be assessed for a well woman preventative care visit in the past year and will be educated on the importance of preventative care. Referrals will be made to the local agency's family planning clinic or another provider in the community for clients that have not had a well woman exam in the last year.

Additionally, local MCH agencies will work in collaboration with the Title X Family Planning programs and FQHCs at the local level to provide well woman visits or refer clients to other local providers offering well-woman services. Many local MCH agencies screen all clients on their last well woman exam to determine if they have a preventative visit within the last year. This assists the agency staff, including MCH Home Visitors, with determining if the client needs to be educated and counseled on the importance of receiving preventative well woman checks on an annual basis or if a referral needs to be made.

Home Visiting: Local health agency MCH Home Visitors (the newly branded name for their title) will implement the redesigned program beginning July 1, 2017. This will include implementation of the standard screening tools for smoking/tobacco, alcohol, substance use, and mental health, including maternal depression. MCH Home Visitors will provide guidance on completion of referrals and will document and track follow-up. The Healthcare Insurance Coverage Toolkit will be updated annually, beginning in 2017, to incorporate changes in the Affordable Care Act (ACA) and Medicaid (KanCare) coverage benefits. The toolkit will be distributed through the Kansas Home Visiting website.

MIECHV-funded evidence-based home visiting sites will continue to collect and report data on enrolled mothers who receive a postpartum visit with a healthcare provider within 8 weeks of delivery. This includes preterm births prior to 37 weeks for infants of mothers enrolled in services prior to 37 weeks of gestation. These programs will continue to provide educational information, referrals, and support addressing maternal health including prenatal and postpartum care.

*Perinatal Community Collaboratives/Becoming a Mom® (BaM) Program\**: As part of Kansas Title V's commitment to the continued development and expansion of perinatal collaboratives utilizing the March of Dimes Becoming a Mom® prenatal education curriculum, there is continued commitment to the development and implementation of additional "integration" components that allow for the strengthening of particular priority areas within the curriculum and program delivery model. One area of focus over the next year will include training of BaM sites on the comprehensive integration of personal health plans, including the development of a reproductive life plan, for each woman completing the BaM curriculum. Participants will be encouraged to take their reproductive life plan to their provider for discussion during the remainder of their prenatal care and at their postpartum check-up. Additionally, as a part of this "integration" component during session six of the program, sites will be encouraged to invite a Health Care Exchange Navigator from their community to participate as a guest presenter on the topic of accessing health care coverage following the loss of Medicaid coverage at 60 days postpartum. Ideally, this navigator will be available before and after the session to assist participants in navigating the federal insurance exchange and enrolling in an insurance plan that will increase the likelihood of the women receiving annual well-woman exams following pregnancy.

*Child Care Licensing Program – Promoting Well-Woman Care and Screenings*: Many child care providers that are women of reproductive age in Kansas do not have adequate health insurance or qualify for early detection screening including mammogram and pap screens based on income eligibility. The Bureau of Family Health's Child Care Licensing program will continue to collaborate with the Bureau of Health Promotion to educate child care providers regarding free well-woman care including mammograms and pap screenings. An information card was added to each initial application response mailing and a link was provided to all renewal emails as well as to the program's newsletter and webpage. Based on facility count and additional staff, more than 6,000 women received this preventive health information in 2016.

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### **SPM 1: Preterm births (<37 weeks of gestation)**

Objective: Increase the number of completed referrals for services in response to prenatal/postnatal risk screening at every visit by 2020. (substance use, preterm birth, maternal/perinatal depression)

The Title V MCH program is working on development of a risk screening/assessment tool that can be used across the state by MCH programs, including home visiting. A maternal/parental health screening form has been in place since 2014. It was developed after review of many tools used by other programs and/or recommended at the national level in response to launching the Federal Healthy Start project. Healthy Start OB Navigators have utilized the form; however, review and revision of the form is underway and needs to be completed prior to promoting the form for use across MCH programs. The form is available for use on paper as well as electronically in the DAISEY system (view the Parental Health Screener here: <http://daiseysolutions.org/articles/parental-health-screener/>). The intent is to screen for social determinants and other high risk situations/behaviors without resulting in multiple or lengthy screening forms that interfere with quality patient interaction.

*Local MCH Agency Strategies*: Local agencies are working to reduce the number of preterm births in Kansas by reducing the number of pregnant women who smoke. In addition, integrated screening tools and case management services to identify and support women eligible for progesterone therapy will be utilized. Improved prenatal care and prenatal education should decrease the risk of preterm deliveries. Local agencies will assure that women have access to and receive coordinated, comprehensive care and services before, during and after pregnancy. As a result, fewer preterm births are expected among mothers receiving this comprehensive care. Women will be screened for preterm birth history and the associated risk factors. Local agencies that provide the BaM prenatal education classes will be able to track the percent of preterm births that occur with clients who are program participants.

Related to the "Initial Survey" serving as a prenatal risk screen for BaM participants, DAISEY reports are currently in the planning and development phase that will assist program staff to easily identify participants with specific risk factors (smoking in pregnancy, previous spontaneous singleton preterm birth, lack of prenatal care, etc.) Additionally, state Title V staff are working

with partners to develop a more comprehensive “perinatal risk assessment” tool to be utilized in BaM as well as home visitation and other MCH programs. We hope to have this assessment developed and piloted in early 2018.

With more recent published guidance, public health nurses are increasingly screening for postpartum depression in home visitation and clinical settings. Expansion of MCH services in our state to include the BaM collaborative perinatal education and support program has prompted the need for such guidance on screening prenatally and in the group setting. New evidence shows that maternal mental illness is a more common health concern than previously thought and that many cases of what has been called postpartum depression actually started during the pregnancy. Left untreated, this can be detrimental to the well-being of both the mother and child. As stated by Dr. Michael Pignone, a professor of medicine at the University of North Carolina at Chapel Hill and an author of recommendations issued by the United States Preventive Services Task Force, “there’s better evidence for identifying and treating women with depression during and after pregnancy”, thus “we specifically called out the need for screening during this period.” A mental health integration toolkit with guidance and resources was developed and finalized with support from the KS MCH Council. The toolkit will be adapted and shared with MCH grantees across the state. Public health providers across MCH programs can (and should) serve a unique role in screening, referring, and providing follow-up to our perinatal women and their infants/children. We feel, with the appropriate training and resources, and support of local clinical partners, screening for depression can be done in a caring and confidential manner within a group setting in the context of the mental health and pregnancy/postpartum discussion.

*Infant Mortality CoIIN Expansion:* As part of the CoIIN transition, Kansas is exploring options to replicate the pre/early term pilot developed by Associate’s in Women’s Health (AWH). The systems and processes developed by AWH focus on risk screening and timely, appropriate service referrals – and can be easily replicated by other providers. Developing a comprehensive training package incorporating tools, electronic medical record protocols and processes is a priority. Expansion sites will include obstetric and family practice providers working with existing community collaborative programs, however a priority list needs to be developed. The New Site Survey Tool will be used to conduct infrastructure assessments of proposed replication sites. These assessments will help identify training and technical assistance needs for each community and will provide the foundation for development of an implementation toolkit that can be customized and used statewide.

In addition, the Provider Survey Tool will be relaunched with special emphasis placed on targeted expansion communities. This will provide relevant information for future educational needs. As a reminder, the Provider Survey Tool examines knowledge and practice in the areas of gestational aging, preterm birth risk assessment and screening, prophylactic progesterone utilization and early elective deliveries. This data will also provide insight for development of a standardized Pre/early term risk assessment tool to be utilized in practices statewide. Finally, Kansas will evaluate utilization of the March of Dimes Preterm Labor Assessment Toolkit by Newman Regional Medical Center to determine impact and feasibility of replication in all KPCC/BaM program sites.

Home Visiting: MIECHV-funded program sites will continue to conduct and track screenings of substance use, maternal depression, and domestic violence using standardized tools to identify and address needs for additional information, support, referrals and completed referrals. Furthermore, trainings regarding substance abuse identification, screening, referrals and treatment, specifically pertaining to pregnant women and mothers, will be held in both MIECHV communities in October 2017. MCH Home Visitors will be invited to attend.

Objective: Increase the number of established perinatal community collaboratives (e.g., Becoming a mom<sup>®</sup> (BaM) programs) by at least 5 annually by 2020.

*Kansas Perinatal Community Collaborative (KPCC)\* Development & Expansion (including integration of BaM as a prenatal education curriculum owned by the March of Dimes (MOD):* The Bureau of Family Health has provided extensive staff time and funding to position Kansas for this expansion. A strong foundation has been established through pilot implementation, program refinement and continuous evaluation. Additional resources needed for regional implementation have been identified and are in development. These include 1) an Implementation Guide to promote the model and provide development guidance for future sites, 2) a Website Portal to provide direct access to training, program resources and technical assistance and, 3) a virtual classroom to support programmatic training and to provide ready access to *Becoming a Mom/Comenzando bien<sup>®</sup>* educational modules. These tools will provide the mechanism for statewide expansion and insure both growth and future sustainability.

As of the April 2017 review of MCH Aid-to-Local applications for the 2018 State Fiscal Year, 19 communities/applicants included BaM implementation in their application and 30 more noted interest in launching the program. Plans are in place to engage these interested communities through training opportunities offered in late fall or early spring, with a goal of launching early phases of implementation by summer 2018. Plans are also underway for the creation of an online training course for the program. This online course will consist of 10 modules, covering the following: introduction to the KPCC model; program coordination; group facilitation; one module for each of the six program sessions; program evaluation. Program staff across sites will develop an individualized training plan with designated modules for required completion. Completion of the components of the online training program will certify the staff person for his/her role in program implementation.

In 2018, we hope to continue preliminary discussions that began with our state's Medicaid MCOs in 2016 regarding expanded partnerships to support existing BaM programs, as well as expansion of the program in targeted areas of the state. These discussions will include: potential funding partnerships related to the development of a regional model approach to program delivery in small rural communities where birth numbers are too small to justify a full scale independent BaM program; program incentives; printing of standardized curriculum for consistency of curriculum delivery across all program sites; the idea of partnering in the implementation of telehealth for the delivery of specialized care and monitoring of high risk OB patients in rural/frontier communities across the state. Although some of this work has already begun, as described in the report section, we wish to further develop these conversations and secure commitments from all three MCOs in the next year.

Kansas Title V MCH is planning implementation of the MOD prenatal education curriculum, *The Coming of the Blessing: A Pathway to a Healthy Pregnancy*, (<http://www.comingoftheblessing.com/>) for American Indian and Alaska Native populations. This is based on the MOD BaM curriculum with cultural modifications that include traditional beliefs, lessons from ancestors, and the Native American circle of support. Implementation will involve piloting in Northeast Kansas in partnership with the MOD and University of Kansas.

\*See the Kansas Perinatal Community Collaborative (KPCC) Model Diagram and Site Map in the Women & Maternal Health Report Section.

Southwest Kansas Regional Collaborative Expansion: Results from a Southwest Kansas obstetrical health assessment, a study completed in 2015 and published in 2016, indicated that rural reproductive age women in the catchment area (Kearny County and 11 surrounding counties) are at high risk for pregnancy complications including gestational diabetes leading to an increased risk for developing type 2 diabetes and cardiovascular disease later in life. The majority of women were Hispanic, of young reproductive age, and of low SES (measured by level of education and household income). About three quarters of women were overweight or obese during pregnancy and engaged in minimal physical activity. About one-third had an immediate family member with diabetes and/or heart or circulation problems.

Focus groups were conducted to assess what this targeted segment of the population in SW Kansas would value in an intervention and found similar results that were later confirmed in the larger community health assessment. Some of the findings included:

- Need for a support group during and after pregnancy;
- Need to improve health communication on physical activity, nutrition, and fetal movement/kick counts;
- Need for availability of programs that focus on physical activity, nutrition, and breastfeeding support during and after pregnancy; and
- Mixed emotions on using technology.

Focus group facilitators working with the pregnant and postpartum women observed a lot of peer education happening between participants on topics of breastfeeding, breastfeeding problems, fetal movement/kick counts, referrals, WIC as a resource, names of IBCLC's in the region, etc. The plan of action resulting from the assessment includes activities that are absolutely essential for reproductive age women to have a healthy pregnancy and lead a healthy lifestyle beyond pregnancy. Expansion of the perinatal community collaborative model implementing the BaM curriculum that is currently underway in the region, will be a comprehensive approach that addresses each one of the above mentioned findings. As the Title V agency, we are aware of the many obstacles that rural pregnant women face and are committed to projects in the Southwest Kansas

region, including the regional collaborative, to support every woman with experiencing a healthy pregnancy and have a healthy family.

For reasons outlined above, discussions have been held with clinical service providers in rural southwest Kansas to identify local issues and needs for the region. This region has a significant Hispanic population, many of whom are undocumented and/or uninsured. Four counties provide the bulk of clinical services for women of child-bearing age, yet all are experiencing a shortage of service providers. Most prenatal services are provided by family practice physicians with only a handful of obstetricians and maternal fetal medicine specialists available in this 15 county region. These specialists are often flown into the region from larger metropolitan areas to provide care for high-risk patients. Access related to the lack of payment options also presents a significant issue. In response, the Bureau of Family Health is working with the Kearny County Hospital to assess the regional clinical infrastructure. Health care workforce needs will be identified with the goal of identifying strategies related to recruitment, retention and improved service access. Services for women of child bearing age that are undocumented and/or uninsured will be supported through a Kearny County partnership leveraging local foundation and state Aid-to-Local funding.

Objective: Increase the percent of pregnant women on Medicaid with a previous preterm birth who receive progesterone to 40% by 2018 and increase annually thereafter.

Increasing prophylactic progesterone utilization and the capacity of the Optum OB Homecare program is a FY18 priority. This will require further outreach to providers including expanded assessment of practice protocols and standards. Additionally, targeted promotion to educate patients and providers will necessitate creation of promotional resources and toolkits. Once development of the systems, processes, tools and resources is complete, expansion to additional communities with established perinatal collaboratives will be planned. Understanding the provider culture through examination of provider survey data will support development of a toolkit to include educational materials on the importance of screening for previous preterm birth and benefits to administering 17P, as well as protocols and associated resources for implementing such practice. This phase of implementation will focus on providers, administrative staff and policy makers. A second, consumer-focused toolkit and phase of implementation will also be developed to educate pregnant women as well as women in the interconception period. An "integration" component will be designed and implemented as part of the BaM curriculum that already has session content focused on risk factors for preterm delivery, signs and symptoms to watch for, and what to do if you experience signs and symptoms. The intention will be to first educate providers and then consumers, in an effort to not get the "cart before the horse" by educating consumers to advocate for care that providers may not be fully informed about or on board with such practice methods. As with other "integration" toolkits that have been developed and implemented in our state, once piloting of small tests of change are completed and adjustments are made, the toolkit will be made available and promoted for implementation across other communities.

Objective: Decrease non-medically indicated early elective deliveries between 37 0/7 weeks of gestation through 38 6/7 weeks of gestation to less than 5% by 2020.

39+ Weeks Hospital Banner Program: The KDHE Bureau of Family Health, March of Dimes, Kansas Hospital Association, and the Kansas Healthcare Collaborative will continue promoting the *39+ Weeks Hospital Banner Recognition Program* to encourage continued progress towards eliminating early elective deliveries\* (EED') in our state. Eligible hospitals with rates less than 5% can continue to apply for and receive a customized banner for commitment to improving the quality of care for moms and babies. Read more about this initiative in the Women/Maternal Report Section.

\*babies delivered before 39 weeks without a medical reason

Improving Hospital Policies & Practices: As education on EED and preterm birth prevention is already a standardized component of BaM, we look to partner with the MOD in 2018 to target additional communities for expansion of provider/hospital level policies and practices aimed at decreasing non-medically indicated births before 39 weeks gestation. One resource of continued interest related to this work is the MOD *39 Weeks Toolkit*. Although this toolkit has been available for implementation for several years, it is unclear how many hospitals have utilized it. We hope that through our strong partnership with the Kansas Healthcare Collaborative we can advance the work and goals in this targeted area at a much quicker rate than has been done alone.



## Other Activities Impacting the Women & Maternal Domain: Home Visiting Education

Parent Education Topic Recommendations are included as part of the MCH Home Visiting redesign for FY18. MCH Home Visitors will provide verbal and written education to the prenatal and postpartum mother. Education topics will include:

- Tobacco/smoking interventions
  - Inquiry should occur at initial visit whenever that occurs. Interventions should be offered if smoking is occurring by any person residing in the home. Additional interventions should be regularly offered as long as smoking occurs.
- Breastfeeding supports
  - This topic should be initiated prenatally when visits occur at that time. If visits begin postpartum, the topic should be initiated at the first visit. At either time if prenatal woman/postpartum mother decides to breastfeed, supports should be ongoing.
- Safe sleep practices
  - This topic should be initiated at the first visit whether prenatal or postpartum. The home visit should include a visual examination of the infant sleeping location to insure a safe sleep environment (crib or pack-n-play free of bumper, blankets, toys, etc.) has been established. Referrals for education, and sleeping resources will be made to the KIDS Network of Kansas as needed. Ongoing discussion about safe sleep should occur as long as visits continue.
- Other safety topics such as car seat safety, home safety, injury prevention, etc.
  - A variety of topics are mentioned here. Car seat safety should be discussed at the first late prenatal visit (in preparation for infant transport post birth) or at the first postpartum visit (to ensure safety seat is secured appropriately and used consistently).
  - Home safety checklist should be reviewed at early visit(s) initiated either prenatally or postpartum.
  - Injury prevention discussion can be initiated later in the postpartum period since initially the infant will be rather stationary.
- Health literacy
  - This topic can be initiated postpartum as the infant is likely exposed to increased health threats, particularly if the infant is placed in child care so the parent(s) can return to work or school.
- Health care insurance coverage
  - This discussion should be initiated at first visit, either prenatal or postpartum, to ensure health care benefits are maximized for all family members.
- Well woman and well child medical visit appointments
  - This topic should be initiated early on in visits and should be ongoing.
- Prenatal/postpartum women's health
  - This topic should be initiated early on in visits whether prenatal or postpartum
- WIC and nutrition
  - WIC and nutrition topics for prenatal woman/postpartum mother and infant should be addressed early on and reinforced ongoing
- Infant care
  - This topic should be initiated late prenatal or postpartum if that is when visits begin. The topic should be re-visited often.
- Oral health
  - This topic should be initiated early on whether prenatal or postpartum when visits are initiated. Every effort should be made to connect the prenatal woman with a dental health provider for a cleaning at minimum. Postpartum mothers should be provided information about such topics as baby bottle mouth syndrome and how dental disease can be passed from mother to infant.
- Child development
  - This topic can be initiated postpartum and should be discussed at each subsequent visit.
- Other resources offered by the local health agency, such as MCH, health, education, social services
  - This topic should be discussed on a regular ongoing basis.
- Resources in the community for food, housing, utilities, etc.
  - If a community resource guide is available, it can be offered early on. Otherwise educating prenatal woman/postpartum mother about resources such as United Way 211 and providing support as needed is recommended.
- Transition to long-term intensive home visitation programs, as appropriate

- This topic can be discussed in several circumstances. It will be dependent on what other programs are available in the local community. It may also be discussed if family circumstances have led to ongoing visits to the infant's first birthday. It may also be appropriate when the family's circumstances have required visits more frequently than one/month.
- How to locate a high quality child care program, as appropriate
  - Again, initiation of this topic will depend on the family's circumstances. When one or both parents or caregivers are employed and/or in school it would be an appropriate topic for discussion. It would be very important to inform the parent about the necessity of using a licensed, qualified caregiver.

## Women/Maternal Health - Annual Report

**PRIORITY:** Women have access to and receive coordinated, comprehensive services before, during and after pregnancy

**NPM 1:** Well-woman visit (Percent of women with a past year preventive medical visit)

**SPM 1:** Preterm births (<37 weeks of gestation)

*MCH Local Reach:* During FY2016, 67 of 80 grantees (84%) provided services to the Woman & Maternal population.

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### **NPM 1: Well-woman visit (Percent of women with a past year preventive medical visit)**

A yearly routine checkup is a great way to remain proactive about one's health. The benefits of having an annual checkup include early diagnosis and treatment of existing conditions and prevention of future medical problems. <sup>1</sup> Data from the Kansas Behavioral Risk Factor Surveillance Survey (BRFSS) indicated that, although not statistically significant, from 2011 (66.7%) to 2015 (65.1%), a declining trend was apparent in the overall prevalence of Kansas women aged 18-44 years reported having a routine checkup within the past year (APC=-0.8%, 95% CI: -3.3%, 1.7%).

In 2015, an estimated 65.1% of Kansas women aged 18-44 years reported having a routine medical checkup within the past year. The prevalence of having a routine checkup within the past year increased with household income level. Non-Hispanic black (80.7%) women were significantly more likely than Non-Hispanic white (64.3%) and Hispanic (59.9%) women to have received a routine checkup within the past year. Insured women (69.7%) were significantly more likely to have had a routine checkup within the past year than uninsured women (43.0%). Significantly fewer women with less than high school (54.0%) reported having a routine checkup within the past year than did women who had some college (65.0%) or were college graduates (70.8%). Non-English speaking women (53.6%) were significantly less likely than were English speaking women (65.6%) to report not having a routine checkup within the past year. Age groups (18-24, 25-34, and 35-44), marital status, disability status (activity limitation due to health problems), and place of residence (non-metropolitan statistical area (MSA), MSA/Central City, and MSA/non-Central City) were not significantly associated with use of routine checkups.

<sup>1</sup>Fussman C. 2014. Health Risk Behaviors in the State of Michigan: 2013 Behavioral Risk Factor Survey. 27th Annual Report. Lansing, MI: Michigan Department of Community Health, Lifecourse Epidemiology and Genomics Division, Chronic Disease Epidemiology Section.

APC: Annual Percent Change

CI: Confidence Interval

Objective: Increase the proportion of women receiving a well-woman visit annually.

As part of Kansas Title V's commitment to the continued development and expansion of the *Kansas Perinatal Community Collaboratives* (KPCC) utilizing the March of Dimes Becoming a Mom® (BaM) curriculum, there is continued commitment to the development and implementation of additional "integration" components that allow for the strengthening of specific priority areas within the curriculum and program delivery model. One such priority area we have focused on during 2016 has been women's health in the interconception period. This includes the integration of personal health plans and the development of a reproductive life plan for each woman completing the BaM program. The handout "Keeping Healthy After Pregnancy" and resource "Show Your LOVE – Steps to a Healthier me!" by the CDC have been incorporated into the lesson and activity plans for session 6 of the curriculum, where participants set goals for their health plan, including scheduling their postpartum appointment and annual well-woman exam with their provider. This is just an example of such resources that have been integrated into the curriculum as a part of our state's efforts to "relaunch" the KPCC utilizing the BaM curriculum, as described in greater detail in the MCH Workforce Development and Capacity portion of this application/report.

State Title V staff continued to support the promotion of women receiving a well-woman visit annually, by messaging the importance of local Title V grantees partnering with other community agencies to provide on-site assistance for accessing health care coverage in the pre/interconception period. We have promoted the development of personal health plans, including a reproductive life plan, for individuals receiving Title V services. In doing so, we have highlighted this topic and have shared associated resources, during our annual Governor's Public Health Conference, MCH Home Visiting Fall Regional Meeting, and

other venues.

Local MCH agencies worked in collaboration with Family Planning programs at their agency to provide well woman visits or refer clients to local providers that provide well woman services. Many local MCH agencies screened all clients on their last well woman exam to determine if they have had a preventative visit within the last year. This has helped the agency staff, including MCH Home Visitors determine if the client needs to be educated and counseled on the importance of receiving preventative well woman checks on an annual basis or if a referral needs to be made. Local MCH agencies offer services on a sliding scale if necessary, and, bill the insurer for reimbursement when the client has insurance.

During 2016, the MCH Home Visiting program was redesigned to bring about a more consistent approach to the program, as well as to raise the quality of the work. Parent education topics to be covered were a part of this redesign. The topics include well woman and well child medical visit appointments. The home visitor guide for the provision of education topics indicates this topic should be initiated early on in visits and should be ongoing. Additionally, during 2016, a Healthcare Insurance Coverage Toolkit was developed and placed on the Kansas Home Visiting Website found at [kshomevisiting.org](http://kshomevisiting.org). It provides guidance to Kansas home visitors in accessing healthcare coverage for parents and children they visit through Medicaid (KanCare) or the Affordable Care Act to support access to preventive services, including the annual well visit.

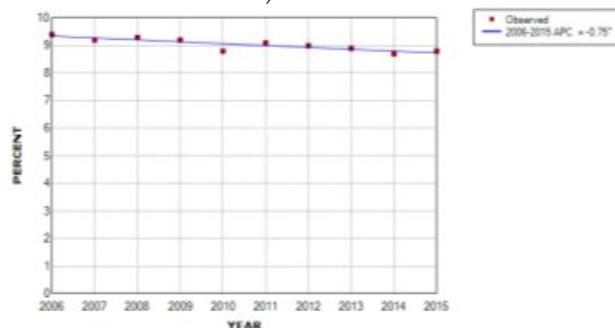
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### SPM 1: Preterm births (<37 weeks of gestation)

The preterm birth rate increased slightly to 8.8% in 2015, compared with 8.7% in 2014. Decreases in preterm births were seen among non-Hispanic black mothers (11.4% in 2015 from 12.8% in 2014), but slight increases in non-Hispanic white (8.5% in 2015 from 8.4% in 2014) and Hispanic mothers (8.3% in 2015 from 8.2% in 2014). In 2015, the rate for preterm births, (occurring before 37 weeks gestational age) has been lower in Kansas (8.8%) than the U.S. (9.6%). The Kansas prematurity rate exceeded the Healthy People 2020 goal of 11.4%. Both non-Hispanic white and Hispanic premature births were lower than the State average. During 2006-2015, the overall preterm birth rate has been significantly decreasing by -0.7% per year (APC=-0.7%, 95% CI: -1.1, -0.4).

APC: Annual Percent Change  
CI: Confidence Interval

*Preterm Births (Source: KDHE, Kansas Birth Certificate Data)*



Objective: Increase the number of completed referrals for services in response to prenatal/postnatal risk screening at every visit by 2020.

Infant Mortality CoIIN: Kansas joined the Collaborative Improvement & Innovation Network (CoIIN) to Reduce Infant Mortality network in 2014, launching Learning Networks focused on smoking cessation and prevention of pre and early term births. The Kansas CoIIN Pre & Early Term Birth pilot project was launched with Associates in Women's Health (AWH) in July 2015 with a primary focus on risk screening and timely, appropriate service referrals. This pilot site was chosen based on data demonstrating community need, existing practice infrastructure and provider readiness and willingness to design and test

practice changes. The AWH pilot focused on practice changes in three areas: provider recording of the expected delivery date, early identification of a previous preterm birth and the initiation of progesterone treatment among high risk patients with specific gravida. System and process changes were implemented first. Screening protocols for gestational age, preterm birth risk assessment and documentation consistency were reviewed and specifically included the patient intake form, obstetric history chart, medication module and electronic medical record (EMR). Patient assessment and treatment protocols were mapped to determine information gaps and pressure points to promote system changes. This comprehensive assessment was documented and led to the development of the New Site Survey Tool to be utilized in future expansion efforts. The tool was designed to review the systems, processes and data resources within a provider site to understand their current practices related to preterm birth screening, identification and prevention.

The next phase of this pilot focused on provider practices and highlighted practice discrepancies, knowledge gaps and educational opportunities. Standardized screening protocols were established and system changes were implemented to alert providers to specific actions when seeing high risk patients. It was determined that AWH providers interpreted gestational age, previous preterm birth and late preterm birth differently and that consistency in interpretation and screening protocols must be established for true systems change to occur. Education was provided to AWH providers on preterm birth risk identification (gravida vs parity), prophylactic progesterone utilization and non-medically indicated late preterm birth risk. Providers also met monthly to examine practice data and make change recommendations as needed. It is important to note that a provider survey tool – gauging knowledge and practice related to prophylactic progesterone administration was developed in partnership with AWH physicians. This tool has been field tested through partnerships with the Kansas Chapters of the American College of Obstetrics and Gynecology (ACOG), Association of Certified of Nurse Midwives (ACNM) and will soon be distributed to Kansas Medicaid (KanCare) providers. The work developed through this CoIIN pilot laid the foundation for future efforts to reduce Kansas' pre and early term birth rates and subsequently contribute to a reduction in the state infant mortality rate.

In addition to the CoIIN pilot work, Kansas is exploring utilization of the Preterm Labor Assessment Toolkit (PLAT) developed by the March of Dimes. This evidence-based toolkit helps medical providers establish a standardized clinical pathway for the assessment and disposition of women with suspected preterm labor. It can be implemented at all levels of maternity care and incorporates best practices that outline a step-by-step guide to standardized assessment and care. In the upcoming year we plan to investigate the toolkit further and determine our role in helping to support our partner, the March of Dimes, in piloting this toolkit among Kansas Perinatal Community Collaboratives. The collaborative in Lyon County (BaM site at Newman Regional Health Center) expressed interest in piloting this toolkit in January 2017 and has already completed the background work required for implementation. This will serve as the precursor for future toolkit utilization and will add to any risk screening protocols Kansas develops.

*Perinatal Community Collaboratives:* Since July 2015, we have developed and implemented a comprehensive “smoking cessation integration toolkit” for our KPCC utilizing the MOD BaM curriculum, as a part of our CoIIN work. We have continued our work on this initiative throughout 2016 and 2017, with additional tests of change and PDSA cycles, in an effort to continually improve rates of screening, referral, and follow-up related to smoking in the perinatal period, and to improve the rate of engagement by women in the evidence-based smoking cessation programs we have made available in our state (which include the Kansas Quitline and *Baby and Me Tobacco Free (BMTF)* program (read more about BMTF in the Cross-cutting section). One test of change in 2016-2017 included a provider survey on smoking cessation support that is provided by the clinic/agency. This survey was built in a REDCap data system and distributed to all MCH, Family Planning and WIC grantees with the request that they share with their partner networks. Data received from the survey has helped us identify a number of existing gaps and needs at the local level around the use of evidence-based resources and strategies. At the state level, we have worked to provide support to locals in this area through education, training, and identification of resources (read more about this in the Cross-cutting section). Another toolkit that was developed and piloted, then reviewed, revised, and endorsed by members of our Kansas Maternal and Child Health Council (which serves as an advisory council for our state Title V program), was the “mental health integration toolkit”. This toolkit focuses on routine depression screening as an integrated component of the BaM curriculum along with referral, resources and follow-up as outlined in algorithms that include locally developed protocols.

Currently, screening forms related to tobacco use in pregnancy and perinatal depression have been created and made available in our electronic data system, DAISEY, for use by all Title V grantees. The plan for 2018 is to build additional

screening tools related to alcohol and substance use (i.e. T-ACE screening tool) within DAISEY as well. Currently in DAISEY, the “KDHE Referral Form” is a required form for completion and submission anytime a referral for service is made by our Title V grantees. Within this form, there are particular referrals that require follow-up and documented “completion status” within the system. Specific to BaM, DAISEY also houses an “Initial Survey” that serves as a prenatal risk screen in addition to evaluating pre-program knowledge and behaviors. This is utilized by program staff to identify at-risk women who may need additional resources/services.

Home Visiting: The redesigned MCH universal home visiting program (previously known as Healthy Start Home Visiting) includes protocol and utilization of standard tools for smoking/tobacco, alcohol, substance abuse, and mental health, including maternal depression.

MCH Home Visitors will make every effort to ensure that prenatal and postnatal mothers and their infants receive screening assessments with persons that are trained and qualified to conduct them. The screenings will include:

- Maternal and postpartum depression
- Domestic/Intimate Partner Violence
- Alcohol/Substance abuse
- Child development and child social emotional development

The redesigned home visiting program guides home visitors in completing referrals and tracking follow-up. Based upon the results of these screening assessments, the MCH Home Visitor, in conjunction with the assessor, will counsel the mother on resources to assist her. Written documentation including the completed screening forms and any subsequent follow-up will be maintained in the parent file/chart. Records will be monitored for inclusion of this documentation.

Home Visiting: The Maternal, Infant and Early Childhood Home Visiting (MIECHV) funded evidence-based and promising approach program sites in Southeast Kansas and Wyandotte County continued to provide educational information, referrals, and support addressing multiple areas affecting maternal health including prenatal and postpartum care. Screenings for substance use, maternal depression, and domestic violence using standardized tools were also conducted and tracked to identify and address needs for additional information, support, and referrals as well as completed referrals. In FY16, approximately 80% of enrolled mothers were screened for substance abuse, depression, and intimate partner violence.

Specialized trainings regarding maternal depression and domestic violence were provided to local home visiting staff. In Wyandotte County, mothers enrolled in MIECHV-funded home visiting and who screened positive for depression, were referred to the Moving Beyond Depression™ evidence-based in-home cognitive behavioral therapy program. Evaluation findings have shown depression symptoms steadily diminished throughout the sessions with many mothers experiencing no clinical depression symptoms at the end of the intervention. Furthermore, the full-day comprehensive domestic violence training for home visitors was provided as a pre-conference institute at the Governor’s Conference for Prevention of Child Abuse and Neglect in fall 2016, attended by over 60 individuals. The full-day training regarding domestic violence will be offered in four regions across the state in August/September 2017 and will be open to MCH Home Visitors from local health departments and staff from all home visiting models. The MIECHV Program has partnered with the Kansas Coalition Against Sexual Assault and Domestic Violence to develop and conduct these trainings and facilitate improved collaboration and service coordination between local home visiting and domestic violence agencies.

Objective: Increase the number of established perinatal community collaboratives (e.g., Becoming a Mom® (BaM) programs) by at least 5 annually by 2020.

The Bureau of Family Health, in partnership with the March of Dimes Kansas Chapter and in collaboration with local communities and the broader network of local health care and community service providers, is leading the implementation of *Kansas Perinatal Community Collaboratives* (KPCC). The Kansas model was launched in partnership with the March of Dimes (MOD) in 2010 as a vehicle to provide enhanced prenatal care and education utilizing the March of Dimes *Becoming a Mom/Comenzando bien*® (BaM) curriculum. This approach to reducing infant mortality and improving birth outcomes leverages public and private relationships providing the foundation for delivering comprehensive services to vulnerable populations. The collaborative approach enables organizations to launch programs on a broader scale by plugging into an established system and becomes the vehicle for delivery of services for prenatal care and education, smoking cessation, safe sleep,

breastfeeding, mental health and more. The approach/model is comprehensive in nature and effectively aligns public health services and programming such as MCH, WIC, Family Planning, Home Visiting; integrates public and private sector services; and results in more effective coordination of infant mortality/healthy birth initiatives. The community collaborative model brings about permanent MCH infrastructure, leveraged and shared resources, change in the prenatal care services delivery paradigm, a vehicle to identify community needs, a standardized evaluation system, and new funding opportunities for greater collective impact and improved birth outcomes.

In late 2015 and early 2016, KPCCs utilizing the MOD BaM curriculum expanded from 7 sites to 11 sites. As mentioned in last year's report, the Regional Public Health Meetings provided an opportunity to engage interested communities in looking outside the box for opportunities to partner and collaborate with other community agencies in providing greater services to their MCH population. Among the models presented was the KPCC model. At that time, as well as during several other opportunities this year, interested sites were encouraged to include their plans for program implementation in their 2018 MCH Aid-to-Local application. KDHE has also made other special efforts to engage the southwest region of the state, where greater disparities and fewer resources exist in these largely rural/frontier areas.

Since inception, the KDHE Bureau of Family Health has promoted this model extensively providing training and technical assistance on community collaborative development and MCH program integration. The Bureau also included it in the Title V Aid-to-Local grant application criteria in FY 2016 and 2017 to encourage statewide implementation utilizing Block Grant resources. Eleven counties launched successful community collaboratives by the close of 2016. Currently, there are 19 counties that included plans to launch this model and the Becoming a Mom program in their FY18 ATL application. Thirty additional counties have indicated their interest in launching this program model in the future. Training and technical assistance will be provided to these counties throughout 2017/18.

Success has demonstrated that group prenatal care/education\* can impact birth outcomes, enhance participant's social support, and create behavior change. Adding to the impact is the community collaborative backbone that is a basis for program delivery at the community level. It is believed that it is this spirit of collaboration across agencies and programs that is contributing to a much greater collective impact than any one agency working in isolation could do on its own. The 2016 BaM State Aggregate Report reveals improvements in preterm delivery, low birth weight, and breastfeeding initiation in comparison to non-implementing communities. As testimony to this, we have seen the Infant Mortality Rate (IMR) decrease for the five-year period from pre-program implementation (2006-2010) to post-program implementation (2011-2015) for the two longest-running program locations [Saline Co. 8.5 to 4.2; Geary Co. 10.4 to 6.4 (deaths/1000 live births)] \*Source: Kansas Vital Statistics 2006-2010 and 2011-2015

- Note: Kansas initially launched several Centering Pregnancy sites, however ongoing program costs made it prohibitive - particularly in smaller, rural communities.

Kansas Perinatal Community Collaboratives Model Diagram and Site Map



**Perinatal Community Collaboratives**  
Utilizing Becoming a Mom/Comenzando bien® Curriculum



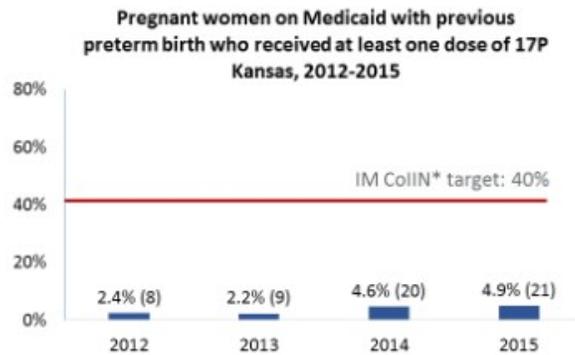
**Expansion is Key:** KDHE continues to refine and expand the KPCC Model through development of new collaboratives in targeted high-need areas. In 2016, statewide expansion maps were developed based on demonstrated need (number of births, disparities, infant mortality rates, etc.) and community willingness to collaborate. County infrastructure assessments examining clinical service providers (hospitals, Federally Qualified Health Centers) and MCH programming (Home Visiting, Teen Pregnancy Targeted Case Management, Pregnancy Maintenance Initiative, WIC, safe sleep campaign, breastfeeding initiatives) were mapped to identify service gaps statewide. Expansion and programmatic recommendations were developed in response to demonstrated need, services access, and funding availability. Up to that point, successful perinatal collaboratives had been launched in larger communities; however, this assessment clearly highlighted the need for outreach into smaller communities with limited resources and services. It was determined that a regional approach to future expansion could provide the “network” Kansas was seeking while supporting the unique needs of specific geographic areas.

The Southwest Kansas region (15 counties) was identified as the FY17 expansion priority with development begun in August 2016. This is the regional collaborative prototype that will be replicated in additional communities in FY18. Infrastructure assessments, training and technical assistance have been ongoing throughout the year with the official launch scheduled for September 2017. In addition, the Central Kansas region (8 counties) was identified for priority launch of the BaM virtual education pilot (July 2017). This is led by the 2010 BaM pilot site in Saline County and represents an engaged group of stakeholders willing to develop cooperative education services. This virtual training pilot will provide the foundation for prenatal education delivery in small communities across the state, such as with the regional approach in Southwest Kansas.

Objective: Increase the percent of pregnant women on Medicaid with a previous preterm birth who receive progesterone to 40% by 2018 and increase annually thereafter.

Optum Health OB Homecare 17P Partnership: Increasing the utilization of prophylactic progesterone among women with the appropriate treatment indications is a priority in Kansas. This presents a significant opportunity for reduction of the state preterm birth rate with 4.9% of eligible women currently receiving the medication, according to the Medicaid data available to the MCH Epidemiologist (see chart below).

## Potential for Impact in Kansas



Source: Kansas Medicaid claims data via Truven Health Analytics  
\*Infant Mortality Collaborative Improvement and Innovation Network

In an effort to leverage multiple resources, KDHE is also partnering with Optum OB Homecare to increase utilization of 17P/prophylactic progesterone among high-risk obstetric patients through targeted home visitation services that provide patient-centered medication management and obstetric care coordination. This partnership brings together public health professionals, prenatal care providers and payers to improve screening and early identification of high risk patients. Key components of the program include provider education, patient case management (education, home medication administration, treatment compliance) and outcome tracking and reporting. Services are provided by Optum nursing staff through existing contracts with Kansas' three Medicaid (KanCare) providers under their established fee-for-service payment schedules. There are no associated costs for patients or providers in this enhanced service delivery model where providers screen patients, provide prescriptions and make referrals to Optum for treatment administration. Program participants also receive weekly pregnancy assessments with reports going directly to the referring provider.

Optum OB Homecare services were introduced in the Kansas City market in November 2017. Optum is currently focusing on establishing provider partnerships and referral mechanisms to increase program capacity. Plans are also underway to launch additional program sites in Wichita and Hutchinson Kansas. Offices are secured and nursing staff hired with the official launch pending state licensure. Going forward, KDHE will assist the expansion effort by integrating this innovative service package into the Kansas BaM prenatal education model. This partnership will bring together key stakeholders (public health professionals, prenatal care providers and payers) for the purpose of patient education, increased referrals, home medication administration and obstetric care coordination. Data from the Associates in Women's Health (AWH) provider survey on screening for previous preterm birth and progesterone utilization will also be incorporated as we integrate the two program models.

*Clinic-based 17P IM ColIN Pilot:* In addition to the Optum partnership, KDHE is also working with the AWH ColIN pilot site to develop provider mechanisms that will increase the appropriate utilization of prophylactic progesterone (17P). The AWH pilot has developed practice-wide, consistent practices for gestational aging and preterm birth screening with causal specificity. The goal was to not only assess risk and make appropriate timely referrals, but to also identify women with a specific gravida (spontaneous preterm birth) making them eligible for 17P treatment. Building risk identification into the current practice protocols was a success with a modest improvement in progesterone utilization. The April through June 2015 baseline showed 25% of eligible women received progesterone compared to 57% during the pilot implementation from July 2015 through December 2016. However, this left a significant percentage of eligible women that declined treatment. Understanding the reasons for this rate of decline and tracking medication compliance rates are priorities for FY18. AWH also attempted to track utilization of vaginal progesterone due to cervical length during this pilot study. They quickly realized that there are no universal screening protocols or established systems to identify short cervix nor are there insurance payment mechanisms in place for uniform vaginal sonograms. Determining cervical length is an accidental or incidental process at best. Future work on this issue will require collaborations among providers, insurance companies and policy makers.

Objective: Decrease non-medically indicated early elective deliveries between 37 0/7 weeks of gestation through 38 6/7 weeks

of gestation to less than 5% by 2020.

39 Weeks Promotion – March of Dimes Toolkit: In 2010 the March of Dimes (MOD) introduced the early elective delivery issue to Kansas stakeholders with a conference presentation on the California Early Elective Delivery (EED) Toolkit. This came at a time when the Kansas Blue Ribbon Panel on Infant Mortality released preliminary recommendations designed to reduce the state's infant mortality rate. In 2011, the two would come together and the elimination of early elective deliveries would emerge as one of the state's key priorities. Since that time KDHE has worked closely with the MOD to develop programs and practices that support this effort and in 2016 they joined forces with the Kansas Hospital Association (KHA) and the Kansas Healthcare Collaborative (KHC) to encourage continued progress towards elimination of EED's in our state.

The intent was to support Kansas birthing hospitals in adopting the American Congress of Obstetricians and Gynecologists (ACOG) guidelines that highlight the importance of allowing babies to reach 39 weeks gestation through the elimination of elective labor inductions and cesarean sections. The goal of this partnership was to decrease the number of early elective deliveries and scheduled inductions or cesarean sections before 39 weeks when not medically indicated. KDHE, KHC and MOD partnered to provide the EED "39 Weeks" toolkit to all birthing hospitals and professional education on EED issues, tools and resources - all aimed at promoting discontinuation of the associated practices. A physician roundtable featuring Dr. Bryan Oshiro, Chief Medical Officer with Health Catalyst in California, and March of Dimes Board national spokesperson was provided in summer 2016 through a March of Dimes grant from Amerigroup (Kansas Medicaid Managed Care Organization). In addition, the KHC facilitated hospital quality improvement efforts through their Health Engagement Network and KDHE tracked Vital Stats data to assess state progress annually. It's important to note that this collaboration combined with the hard work of hospitals has resulted in a rapid and significant reduction in the statewide EED rate from 8% in 2013 to 2% in 2015 (Source: CMS Hospital Compare).

Kansas EED Hospital Surveys: KDHE is also working with the KHC to collect information from hospitals on the current status of their EED reduction efforts. KHC surveyed hospitals in 2015 and 2016 to identify internal policies and practice patterns related to early elective deliveries. These surveys also provided insight on the provider knowledge and culture surrounding this issue. Each year's response rate (89%, 88% respectively) provided a solid snapshot on the status of hospitals current EED reduction efforts. Key takeaways include a list of hospitals that are not implementing any EED reduction efforts and/or hospitals that are implementing, but do not have a hard stop policy or peer review process in place. Though small in number (<12), these facilities are a priority in Kansas' effort to further reduce the EED rate. In the survey process respondents also asked for technical assistance in developing a standardized scheduling tool, a standardized documentation system and creation of enforcement/peer review processes. Provider education to keep physicians and nursing staff current on policies and practices was also identified as a need. Next steps include a comparative analysis of Kansas Vital Stats and hospital discharge data to inform future action and target training and technical assistance to birthing hospitals to insure sustained efforts and to worked towards full elimination of EED's.

EED Reduction – Hospital Recognition: To keep the momentum going, KDHE, the KHA, KHC and MOD 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. The Bureau of Family Health is proud to supply banners at no cost to qualifying hospitals, and 31 have already been approved since launch in February 2017. Of those approved, 27 have ordered their customized 2016 banner recognizing the hospital for their commitment to improve the quality of care for moms and babies in their community. Each hospital also receives a press kit from the March of Dimes so that patients, families, community leaders and donors can be made aware of the hospital's achievement.

The Banner Proof image and a media release issued by KDHE on May 18, 2017, are included below. More information can be found at this link (under Family Health): <http://www.kdheks.gov/health/index.html>.

\*babies delivered before 39 weeks without a medical reason

*Kansas Hospital Banner Proof (hospitals customize)*



Our Hospital is  
committed to improving the quality  
of care for  **moms and babies**   
39+ weeks: Healthy babies are worth the wait

2017

**FOR IMMEDIATE RELEASE**  
May 18, 2017

Contact: Kara Titus  
(785) 291-3684  
Kara.Titus@ks.gov

### **KDHE honors area hospitals**

#### ***Mercy Hospital in Ft. Scott and Susan B. Allen Memorial Hospital in El Dorado honored for decreasing early elective delivery rate***

**TOPEKA, Kan.** – The Kansas Department of Health and Environment (KDHE) recognizes Mercy Hospital in Ft. Scott and Susan B. Allen Memorial Hospital in El Dorado for achieving a less than five percent early elective delivery birth rate. In 2013, the Kansas early elective delivery birth rate was eight percent. KDHE, in collaboration with the March of Dimes, the Kansas Hospital Association and the Kansas Healthcare Collaborative, began work toward eliminating early elective delivery (EED).

Babies that undergo an EED are delivered before 39 weeks gestation without a medical reason. This puts them at risk of immediate life-threatening health problems, long-term complications and developmental delay. Preterm birth is the lead cause of infant death and childhood disability.

Together the collaboration encouraged Kansas birthing hospitals to adopt practices allowing babies to reach 39 weeks. KDHE is proud to report that in 2016 the statewide EED rate was two percent. The March of Dimes created a national banner recognition program to recognize hospitals that have achieved an EED rate of less than five percent. KDHE supports this recognition program and congratulates Mercy Hospital and Susan B. Allen Memorial Hospital as the first of 32 hospitals in the state to receive this banner of recognition.

"I applaud the health leaders across Kansas who worked together to lower the early elective delivery rate in our state", said KDHE Secretary Susan Mosier, MD, MBA, FACS. "This initiative demonstrates the great results we can achieve through collaborative partnerships. I look forward to further collaborations in the future to drive improved health for Kansans."

"Our OB girls were elated." Brenda Stokes of Mercy Hospital in Fort Scott shared. "When I walked down the hall with the banner still rolled up, they jumped out from behind the desk asking if that was their banner. They are proud of their accomplishment." When asked how Ft. Scott lowered their EED rate, Stokes said bringing it to the forefront and tracking it was key. Her advice to other hospitals working towards a lower rate is to partner with providers and help them document exclusions.

The banner was hung near the cafeteria following a small internal celebration a couple weeks ago. Stokes said having the banner where patients will see it will help them ask the right questions during their appointments.

###

*KDHE's mission is to protect and improve the health and environment of all Kansans.*

### ***39+Weeks Hospital Banner Recognition Program Media Release***

The final component of Kansas effort to reduce the EED rate is the incorporation of patient prenatal education. A standardized component of the BaM curriculum is the inclusion of education on risk factors for preterm labor, signs and symptoms of preterm labor and what to do, and early elective delivery (EED). Specific to EED, participants and their supports are educated on what an induction is, why it might be medically necessary, what an elective induction is, and why it is best to wait until at least 39 weeks to deliver as long as the pregnancy is healthy. To support this message, educational materials produced on the topic by the MOD are provided as supplemental resources. One particular resource that is used as a visual aid and discussion point is the March of Dimes "Brain Card" which shows a comparison of a baby's brain at 35 weeks and at 40 weeks, emphasizing the amount of development that occurs the last two to three weeks of the pregnancy. Participants and their support persons are encouraged to discuss their desires around early elective delivery, to discuss any concerns with their provider, and to communicate their wishes in a Birth Plan, which is also provided to them as part of the curriculum. Since launch of the BAM program nearly six years ago, evaluation data has shown a statistically significant increase in knowledge of "how many weeks gestation a full term pregnancy is" and the "importance of the last few weeks of pregnancy from week 36 to week 39 for baby's brain growth and development".

***Kansas Perinatal Community Collaboratives (KPCC):*** Focused education on preterm labor risk reduction has been a priority component of "relaunch" efforts by the KPCC utilizing the BaM curriculum, as described in greater detail in the MCH Workforce Development and Capacity portion of this application/report. Specific to preterm labor risk reduction, this "relaunch" has included: PowerPoint slides including embedded videos from the MOD on signs of preterm labor and "Is It Worth It" from the Eunice Kennedy Shriver National Institute of Child Health and Human Development, National Child & Maternal Health Education Program; handouts on preterm labor and risk reduction (including the use of preventive medications like progesterone); activities, including the use of a "signs of preterm labor" magnet customized by each participant to include the date they reach 37 completed weeks of pregnancy and their provider's phone number; repeat messaging across multiple sessions of the curriculum.

## **Other Activities Impacting the Women & Maternal Population (related to Priority 1)**

*Improving Rural Kansas Health – Pioneer Baby:* The Title V program partnered with University of Kansas School of Medicine (Wichita) and Kearny County Hospital (Southwest Kansas) in a collaborative quality improvement initiative titled “Pioneer Baby” to improve pregnancy and birth outcomes among reproductive-aged women in western Kansas. Pioneer Baby is a collaborative partnership between Kearny County Hospital (KCH) and the University of Kansas School of Medicine-Wichita to improve pregnancy and birth outcomes in an underserved, frontier rural area in western Kansas. (Target population: Pregnant women who receive prenatal care and/or give birth at Kearny County Hospital, the local health clinic, or Scott County Hospital and who reside in one of the following 11 counties: Finney, Greeley, Grant, Gray, Hamilton, Haskell, Kearny, Scott, Stanton, Wallace, and Wichita.

Kearny County Hospital serves this 12-county area which experiences a high rate of obstetrical complications including gestational diabetes mellitus (11%) and cesarean section (33%). A needs assessment was conducted in three of the cohort counties. Total sample size included 175 women. Most respondents were Hispanic (in line with region demographics), 18-25 years old, a high school graduate, and earned <\$25,000/year. About 36% reported being overweight/obese prior to pregnancy and 25% reported limited exercise. One third had an immediate family member with diabetes, heart, or circulation problems. Results provide a framework for improving health outcomes among women.

As part of this larger project, Title V supported six focus group sessions held in 2015 (English and Spanish languages) to inform a health promotion program for pregnant women to increase healthy behaviors and improve birth outcomes. Sessions assessed women's perceived value of an intervention that addresses physical activity, nutrition, breastfeeding support and social support during and after pregnancy. Focus group and data was coded and analyzed. An article was published in the [Journal of Pregnancy and Child Health](#) (2016). Current work (described in the Women & Maternal Domain Plan Section) involves applying the findings to design an intervention that aims to reduce the likelihood of pregnancy complications including gestational diabetes among a vulnerable population in western Kansas thereby improving pregnancy and birth outcomes. This project and the results provided the infrastructure/foundational framework for developing interventions.

Related Videos: [https://www.youtube.com/watch?v=3bZW2\\_EkDOA&feature=youtu.be](https://www.youtube.com/watch?v=3bZW2_EkDOA&feature=youtu.be)  
<http://rhlradio.libsyn.com/017-a-conversation-with-benjamin-anderson-ceo-of-kearny-county-hospital>

**Perinatal/Infant Health**

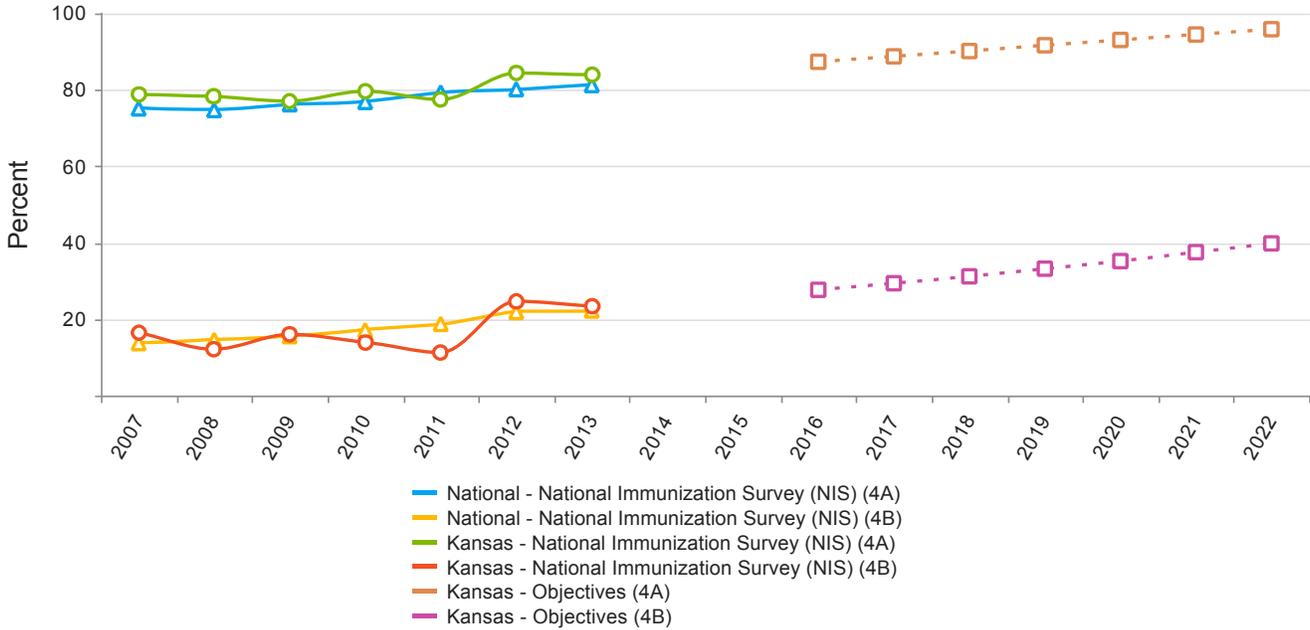
**Linked National Outcome Measures**

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	1.7	NPM 4
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2014	89.2	NPM 4

**National Performance Measures**

**NPM 4 - A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months**

**Baseline Indicators and Annual Objectives**



**NPM 4 - A) Percent of infants who are ever breastfed**

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	87.2
Annual Indicator	83.8
Numerator	32,783
Denominator	39,126
Data Source	NIS
Data Source Year	2013

State Provided Data	
	2016
Annual Objective	87.2
Annual Indicator	87.4
Numerator	34,078
Denominator	38,998
Data Source	Kansas Vital Statistics
Data Source Year	2015
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	88.6	90.0	91.5	92.9	94.3	95.7

**NPM 4 - B) Percent of infants breastfed exclusively through 6 months**

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	27.7
Annual Indicator	23.4
Numerator	9,025
Denominator	38,643
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	29.4	31.2	33.2	35.2	37.5	39.8

**Evidence-Based or –Informed Strategy Measures**

**ESM 4.1 - Percent of WIC infants breastfed exclusively through six months in designated Communities Supporting Breastfeeding**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	19.5
Numerator	1,022
Denominator	5,254
Data Source	KWIC
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	22.5	25.0	27.5	30.0	32.5	35.0

**State Performance Measures**

**SPM 4 - Number of Safe Sleep (SIDS/SUID) trainings provided to professionals**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	2,588
Numerator	
Denominator	
Data Source	KIDS
Data Source Year	FY2015
Provisional or Final ?	Provisional

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	5,000.0	5,500.0	6,000.0	6,500.0	7,000.0	7,500.0

## State Action Plan Table

### State Action Plan Table (Kansas) - Perinatal/Infant Health - Entry 1

#### Priority Need

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

#### NPM

A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

#### Objectives

2.1 Increase the number of communities that provide a multifaceted approach to breastfeeding support across community sectors by at least 10 by 2020.

2.2 Increase the proportion of live births delivered in birthing facilities that provide recommended care for breastfeeding mothers by 2020.

2.3 Increase the proportion of mothers and pregnant women receiving education related to optimal infant feeding by 2020.

#### Strategies

2.1.1 Expand the number of communities that achieve the criteria for the Community Supporting Breastfeeding designation. 2.1.2 Partner with the Kansas Breastfeeding Coalition (KBC) and WIC in their efforts to promote and support breastfeeding with businesses through the Breastfeeding Welcome Here and Business Case for Breastfeeding initiatives. 2.1.3 Develop standard curriculum for prenatal parent education about infant feeding for use by local communities across the state, integrating it into the Becoming a Mom prenatal education sessions. 2.1.4 Increase access to professional and peer breastfeeding support through referrals and linkages between birthing facilities and community resources. 2.1.5 Partner with Medicaid and Managed Care Organizations to increase awareness of and access to breastfeeding support benefits such as access to lactation consults and breastfeeding supplies as recommended by the U.S. Preventive Services Task Force.

2.2.1 Partner with WIC and KBC to expand the High 5 for Mom and Baby program by increasing the number of hospitals trained and number implementing the program. 2.2.2 Promote and support the Kansas hospitals seeking to achieve the Baby-Friendly Hospital designation Empower Initiative in partnership with United Methodist Health Ministries Fund (UMHMF), KBC and WIC. 2.2.3 Provide education to hospital and maternity care/OB staff to support implementation of evidence-based maternity care policies and practices known to increase breastfeeding initiation and duration rates.

2.3.1 Deploy evidence-based breastfeeding education tools through WIC and Home Visiting programs to support an accurate, consistent message about infant feeding for women and families. 2.3.2 Align and strengthen optimal infant feeding education and support through existing MCH programs, including Becoming a Mom, Home Visiting, and WIC. 2.3.3 Increase the number of referrals to WIC and WIC Breastfeeding Peer Counselors for breastfeeding support and education, including the expansion of WIC Breastfeeding Peer Counseling sites.

ESMs	Status
ESM 4.1 - Percent of WIC infants breastfed exclusively through six months in designated Communities Supporting Breastfeeding	Active

NOMs
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

## State Action Plan Table (Kansas) - Perinatal/Infant Health - Entry 2

### Priority Need

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

### SPM

Number of Safe Sleep (SIDS/SUID) trainings provided to professionals

### Objectives

2.4 Implement a multi-sector (community, hospitals , maternal and infant clinics) safe sleep promotion model by 2018.

### Strategies

2.4.1 Enhance safe sleep instructor skill sets to include training home visitors and facilitating community baby showers expanding to address safe sleep, smoking cessation, and breastfeeding. 2.4.2 Provide essential supplies including sleep sacks and pack and plays to families and caregivers identified as at risk and in need. 2.4.3 Expand promotion of the AAPs Safe Sleep guidelines by activating the Safe Sleep Instructors to roll out the Hospital Safe Sleep Bundle Intervention and the Safe Sleep Toolkit for outpatient clinics. 2.4.4 Increase the number of Safe Sleep instructors by approximately 5 per year through targeted recruitment in areas with identified need for instructors, high rates of sleep-related injury or mortality, and low levels of related resources.

## Perinatal/Infant Health - Plan for the Application Year

**PRIORITY:** Families are empowered to make educated choices about infant health and well-being

**NPM 4:** Breastfeeding (ever breastfed; breastfed exclusively through 6 months)

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

*Local MCH Reach:* Based on FY2018 applications, 66 of 70 (94%) grantees plan to provide services to the Perinatal/Infant Health population.

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### **NPM 4: Breastfeeding (ever breastfed; breastfed exclusively through 6 months)**

Objective: Increase the number of communities that provide a multifaceted approach to breastfeeding support across community sectors by at least 10 by 2020 (expand the Communities Supporting Breastfeeding initiative).

Communities Supporting Breastfeeding (CSB): The Kansas MCH program will continue to support the Kansas Breastfeeding Coalition and partners to increase the number of designated “Communities Supporting Breastfeeding”. CSB is a designation recognizing communities that provide multifaceted breastfeeding support across several sectors: businesses, employers, hospitals, child care providers and peer support. “Community” may be defined as a city or county. The CSB initiative aims to improve exclusive breastfeeding rates for infants at three and six months by maximizing existing efforts and incorporating existing breastfeeding support projects within six criteria for designation: 1) a local breastfeeding coalition; 2) peer support group(s) such as La Leche League or similar mother-to-mother group; 3) at least one community hospital enrolled in [High 5 for Mom & Baby](#) or [Baby Friendly Hospital USA](#); 4) business participation in the “[Breastfeeding Welcome Here](#)” program; 5) businesses receiving a “[Breastfeeding Employee Support Award](#)” from the Kansas Business Case for Breastfeeding; and 6) a child care provider completing the KBC’s *How to Support the Breastfeeding Mother and Family* course as provided by [Kansas Child Care Training Opportunities](#), Child Care Aware<sup>®</sup> of Kansas or KBC staff. More information about CSB can be viewed here: (<http://ksbreastfeeding.org/cause/communities-supporting-breastfeeding/>). The criteria can be viewed here: <http://ksbreastfeeding.org/wp-content/uploads/2014/08/CSB-Criteria-Guidelines.docx>.

Recent news from the Kansas Breastfeeding Coalition reveals the Prairie Band Potawatomi Nation signed on as a committed community to become a CSB by December 31, 2017. Along with a signed letter of commitment, a resolution signed by the Council Edler was provided. This is an exciting advancement with the Kansas CSB effort! “We want to shine the spotlight on communities who are making it easier for mothers to meet their breastfeeding goals serving as an example to other communities in Kansas,” said Martha Hagen, KDHE Breastfeeding Coordinator.

#### *Communities Supporting Breastfeeding Model Diagram*



Capacity Building & Systems Development to Support Breastfeeding: KDHE works with partners across the state to increase breastfeeding rates (initiation, exclusivity, and duration) as a strategy to improve maternal and infant health and reduce infant mortality.

Direct support to communities is provided by the Kansas Breastfeeding Coalition (KBC) through an agreement for infrastructure/capacity support funded by MCH and WIC. The purpose of the Agreement is to: 1) increase the capacity of the KBC to facilitate broad cross-sector statewide collaboration to sustain long-term systemic change; 2) build capacity within the KBC to provide breastfeeding resources and organize cross-sector partners to transform the approach to improving breastfeeding rates in Kansas; and 3) scale up interventions to increase breastfeeding rates by stimulating action across the state and among many partners. KBC leads the following activities in partnership with KDHE, MCH and WIC.

- Provide overall direction and policy strategy for breastfeeding in Kansas, ensuring alignment with the Title V Maternal & Child Health (MCH) state plan and measures for Title V Maternal and Child Health (MCH) and Women, Infants, and Children (WIC).
  - Title V National Performance Measure 4: (A) Percent of infants who are ever breastfed and (B) Percent of infants breastfed exclusively through 6 months.
  - Title V Priority 4: Empowering families to make educated choices about nutrition.
  - Title V Priority 6: Professionals have the knowledge and skills to address the needs of maternal and child health populations.
  - Title V Priority 8: Information is available to support informed health decisions and choices.
- Utilize a collective impact model and public health intervention approach to create the conditions needed to decrease disparities and increase overall breastfeeding rates.
- Focus on structural and social determinants that create systemic barriers and assure conditions where all mothers can choose to breastfeed their infants.
- Foster system-level change that is sustainable by building relationships with and including institutional decision-makers across sectors, bringing breastfeeding into the conversation of other public health issues including but not limited to infant mortality, racial health equity, maternal and child mental health and oral health.
- Actively support efforts targeting African American and low-income, high-risk women to address the racial and socioeconomic disparities in breastfeeding rates.
- Continue support and direction for breastfeeding projects in Kansas, including but not limited to: [Business Case for Breastfeeding](#), [Communities Supporting Breastfeeding](#), [Building Local Breastfeeding Coalitions](#), [Prenatal Breastfeeding Class](#), [Breastfeeding 101 Training](#), [Breastfeeding Welcome Here](#), [Continuity of Care](#), [High 5 for Mom & Baby](#).
- Act on collaborative opportunities as they arise, given they align with, support, and advance the KDHE priorities, objectives, and strategies outlined in the joint agency agreement as it relates to the Title V Breastfeeding National Performance Measure.
- Act on funding opportunities as they arise, disseminating information about sources and assisting KDHE Bureau of Family Health, grantees, and partners with planning and writing as requested and necessary.
- Serve as a point of contact for national, state, and local organizations, providing consistent messaging and resources, serving as a clearinghouse for breastfeeding information.



Objective: Increase the proportion of births delivered in birthing facilities that provide recommended care for breastfeeding mothers by 2020.

The Kansas MCH program is partnering with the United Methodist Health Ministry Fund to support up to six hospitals seeking to work towards Baby-Friendly Designation. An invitation to apply via a funding proposal was disseminated to hospitals in January 2017 for a three-year project beginning July 1, 2017. The maximum funding per hospital during the three-year period is \$25,000. The grants are intended to assist hospitals with successfully implementing the *Ten Steps to Successful Breastfeeding*, a collection of evidence-based practices shown to increase breastfeeding initiation and duration rates, and a requirement for attaining Baby-Friendly designation. An abundance of scientific evidence has demonstrated lower risks for certain diseases and improved health outcomes for both mothers and babies who breastfeed. Hospitals receiving the grants are Hays Medical Center; Lawrence Memorial Hospital; Pratt Regional Medical Center; Ransom Memorial Hospital, Ottawa; Saint Luke's South Hospital, Overland Park; and Salina Regional Health Center.

The ten steps include having a written breastfeeding policy, training staff in skills to implement the policy, informing pregnant women about benefits and management of breastfeeding, helping mothers initiate breastfeeding within one hour of birth, showing mothers how to breastfeed and maintain lactation even if separated from their infants, giving infants no food or drink other than breastmilk unless medically needed, allowing mothers and infants to room together 24 hours a day, encouraging breastfeeding on demand, giving no pacifiers or artificial nipples to breastfeeding infants, and fostering availability of breastfeeding support groups and resources for mothers after their hospital stay. More information on Baby-Friendly may be found at [babyfriendlyusa.org](http://babyfriendlyusa.org).

Becoming a Baby-Friendly facility is a comprehensive, detailed and thorough journey in providing evidence-based maternity care with the goal of achieving optimal infant feeding outcomes and mother/baby bonding. It compels facilities to examine, challenge and modify longstanding policies and procedures. It requires training and skill building among all levels of staff. It entails implementing audit processes to assure quality in all aspects of maternity care operations. It creates opportunities to develop high performance work teams and build leadership skills among staff, promotes employee pride, enhances patient satisfaction and improves health outcomes by implementing the gold standard of breastfeeding support among hospitals.

Technical assistance and collaborative learning will be provided throughout the project, with support from HRSA's Maternal & Child Health Bureau. We have secured the Carolina Global Breastfeeding Institute (CBGI) for this purpose. The assistance planned is intended to set up a much more intense level of coaching for success than provided by Baby Friendly to ensure the support being providing is effective--this will assist with their progress. The consultants will serve as "coaches" throughout the process, facilitating the development and implementation of the plans. Feedback from national partners and hospitals that have been through the process reveals although some assistance from Baby Friendly is included in the fee, it's not enough and the TA doesn't actively move them into the next phase(s). Many hospitals struggle with advancing without additional technical assistance; therefore, we plan to set up learning collaboratives for ongoing support and TA in state as well as this support from

CGBI.

Objectives of the TA, specifically targeted to the hospitals, include:

- Ensure common understanding of the practices included in the Ten Steps to Successful Breastfeeding;
- Provide step-specific tips, resources, and lessons learned;
- Completion of at least one of D2 plan during the workshop; and
- Foster collaborative learning among facilities.

The CGBI consultants will travel to Kansas to provide a 1 1/2 day face to face training/kick off meeting (September 2017). Following the kick off, the consultants will lead and facilitate webinars at least monthly between October and December 2017. More details on what will be provided during the face to face training/meeting and webinars are below.

#### September 28-29, 2017 (1.5 day workshop)

*Attendees:* Hospital team lead, physician champion, and a few others (they can consider now who to bring even if they don't yet have their multidisciplinary teams organized).

*Content/Agenda:* The day will include training/plenary sessions on the following topics as well as "working sessions", time dedicated to the teams to work on their plans and applying information to the steps.

- Ten steps: overview
- Setting up multidisciplinary committee
- Change management
- Plan guidance (working session)
- Implementation (Ready, Set, Baby, or Other)
- Community partnerships for success

October, November, December 2017: Virtual Training and TA (1 hour each with Q/A after and office hours for individual questions and needs)

Webinars led by CGBI planned by topic include:

- Following up on the plans (what issues are they having and what feedback have they received)
- Moving into the next phase (implementation) and what that will look like (QI, training, resources)
- Hospital sharing and discussion of D4 phase (if ready)

#### **Other Breastfeeding Activities**

*Home Visiting:* The MCH Home Visiting program, relaunched on July 1, 2017 as discussed elsewhere in this report/application, will provide education and support related to breastfeeding initiation and duration. The Healthy Start and MIECHV sites in the state will continue to provide pregnant and postpartum mothers with information, referrals and support to promote breastfeeding. Training plans and additional resource information are being compiled regarding breastfeeding to encourage best practices and consistency in the home visiting programs. These resources and trainings will be provided to MIECHV sites and will also be made available to MCH Home Visitors. All MIECHV and MCH home visitors will be invited to Kansas Breastfeeding Coalition training "Breastfeeding 101" and "The Intersection of Breastfeeding and Safe Sleep" webinar. The MIECHV Program sites will continue to collect and report data on infants of enrolled mothers who were breastfed any amount at 6 months of age. To drive improvement, this topic may be targeted in the coming year's MIECHV CQI Plan.

Objective: Increase the proportion of mothers and pregnant women receiving education related to optimal infant feeding by 2020.

*MCH Local Agency Strategies:* All grantees that chose the Perinatal/Infant Health domain in their FY18 Title V Aid-to-Local grant application will provide breastfeeding education, support, and services. Local agency nurses and home visitors will educate families on the benefits of breastfeeding infants exclusively for the first six months. They will collaborate with local hospitals and physicians to develop and/or adapt policies to support initiation and continuation of breastfeeding infants in their community. Collaboration between local agency staff, employers and childcare providers in their communities to support the continuation of breastfeeding after the mother returns to work. Local agencies participate in local breastfeeding coalitions

along with the Kansas Breastfeeding Coalition. There are also a growing number of communities that have achieved the “Community Supporting Breastfeeding” designation. Many local agencies participate in the Breastfeeding Welcome Here campaign and the Breastfeeding Friendly Work Place initiative.

KDHE MCH staff have committed to assisting local partners, including health departments and BaM sites, with the development of a comprehensive follow-up process and data collection system. This will likely be in the form of an “integration toolkit”, much like those that have been created for the smoking cessation and mental health integration (as presented elsewhere in this report/application). A flow chart will be developed with follow-up calls, home visitation, and support/educational resources being offered at targeted points when mothers are most likely to stop breastfeeding (i.e. in the first week following birth and upon return to work). Additionally, as capacity is available to build additional data collection fields and reports within our state data collection system (DAISEY), these will be built in an effort to support local Title V program staff in tracking breastfeeding status and follow-up efforts. Work will be done with KPCC to develop plans for targeted outreach to disparity populations. As experience with the new evaluation and data collection system (DAISEY) increases, sites will be encouraged to compare participant demographic data to identified high-need/risk groups in their individual counties to assess if the targeted population is being appropriately served. This will support improved breastfeeding rates among the teen and non-Hispanic black populations in our state. Coordinated efforts and collaboration across initiatives at the state level will coordinate targeted outreach to all KPCC’s, to encourage each to achieve designation as a *Community Supporting Breastfeeding*.

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

Objective: Implement a multi-sector (community, hospitals, maternal and infant clinics) safe sleep promotion model by 2018.

Kansas Infant Death & SIDS (KIDS) Network Partnership: In alignment with the Kansas Maternal & Child Health State Plan and Infant Mortality COLLN initiative, the MCH program is partnering with the 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. The KIDS Network will coordinate and oversee the following activities:

- Enhance the Safe Sleep Instructors skill sets to include training Home Visitors and facilitating Community Baby Showers.
- Expand the scope of the existing community baby shower model—targeting new areas of the state and integrating new topics impacting safe sleep including smoking cessation and breastfeeding. Initial and ongoing planning and implementation must involve communication and partnership among the KDHE Bureau of Family Health, Kansas Breastfeeding Coalition (and local coalitions/leagues) and the KDHE Bureau of Health Promotion State Tobacco Program.
- Expand promotion of the American Academy of Pediatrics (AAP) Safe Sleep guidelines by activating the Safe Sleep Instructor cohort to roll out the Hospital Safe Sleep Bundle Intervention and the Safe Sleep Toolkit for outpatient clinics.
- Increase the number of Safe Sleep Instructors by approximately five per year to reach a total of 40 at the end of three years.

In the first year it has been clearly shown that a network of instructors can be trained to provide safe sleep education and promote the Community Baby Shower Model. Retaining existing instructors, accommodating for staff attrition and expanding the trainer pool for broader outreach are ongoing priorities. Future recommendations include over-recruiting potential instructors, incorporating instructor activities into existing positions or otherwise incentivizing instructors. Strategies will include oversampling for the training and partnering with employers who may embed safe sleep trainings into existing positions, such

as health department employees, home visitation workers or other non-profit groups focused on reducing infant mortality. The continuation of the project will allow safe sleep instructors to provide ongoing safe sleep trainings, facilitate community baby showers, promote hospital safe sleep certification and embed the safe sleep outpatient toolkit within maternal child clinical provider offices. More details related to each specific project aim follow.

Specific Aim 1: Increase capacity to provide safe sleep education statewide. Support current SSI cohort (ad hoc training and technical assistance) and continue to offer SSI/CBS training for new cohort. Enhance the Safe Sleep Instructors skill sets to include training Home Visitors and facilitating Community Baby Showers. Facilitate and promote integration of associated programs to include, but not limited to breastfeeding and tobacco cessation. Foster partnerships with KanCare Managed Care Organizations to promote safe sleep education, provide program resources and deliver collaborative Community Baby Showers.

- Continue to provide Safe Sleep Instructor training reaching no less than 15 new instructors annually. This aim will be accomplished through targeted recruitment of additional Safe Sleep Instructors from areas in the state with no current instructors, high rates of sleep-related infant mortality and/or low levels of related resources. Priority outreach in FY 2018 should include Cherokee, Clay, Cowley, Dickinson, Douglas, Finney, Kearny, Labette, Linn, Pottawatomie, Rice and Riley counties. In addition, any attrition of current instructors will be addressed through recruitment from the city or county where the attrition occurred. Training guidelines established in Year 1 including integration of the Community Baby Shower Model will continue to be utilized.
- Schedule and conduct Safe Sleep and Community Baby Shower training for current Home Visitors/health care providers/caregivers at least annually. Participants of the Home Visitors/health care providers/caregivers training program will complete a pre- and post-education survey to assess knowledge of infant mortality risks, AAP recommendations for reducing risk of sleep-related death, and strategies to reduce barriers to following these recommendations. Data will be submitted to the KIDS Network, Inc. for analysis.
- Participants of the Home Visitors/health care providers/caregivers training program will complete a pre and post-education survey to assess knowledge of infant mortality risks, AAP recommendations for reducing risk of sleep-related death, and strategies to reduce barriers to following these recommendations. Data will be submitted to the KIDS Network, Inc. for analysis.
- Coordinate and evaluate Community Baby Showers provided by SSI's in targeted (home) communities throughout the year. Utilize the established CBS evaluation protocols including: participant pre and post-intervention surveys to assess their ability to understanding of infant safe sleep recommendations and confidence in implementing those recommendations, based on the Health Beliefs Model, as well as intentions to use "safe sleep" for their babies. CBS evaluation should also include event date and location, communities/counties served, number of participants, collaborating partners/vendors and funding sources.
- Establish safe sleep partnerships with all KanCare MCOs. Provide MCO education on Kansas Safe Sleep Campaign including current safe sleep practices, program offerings, the KIDS Network Community Baby Shower Model. Promote partnerships to connect communities with MCO's for the provision of Community Baby Showers.

Specific Aim 2: Hospital Safe Sleep Initiative/Certification

Expanding the scope of existing SSIs is a primary goal in FY18. Eighty percent of second-year Safe Sleep Instructors will receive additional training that will enable them to launch and support implementation of the Hospital Safe Sleep Initiative and the Star Certification Program. Within 3 months of training 80% of these SSI's will be expected to engage at least one hospital in their region. Within one year the SSI will facilitate the practice submission of documentation for Cribs for Kids Safe Sleep Certification. The SSI's will observed each hospital's certification progress, track the achieved certification level and provide progress data to the KIDS Network of Kansas. Hospitals applying for Cribs for Kids certification will achieve the gold (10%), silver (20%) or bronze (70%) level.

In addition, these same SSI's will be expected to engage at least one clinical provider (obstetrical, family or pediatric practice) in the Safe Sleep Star program within 6 months of receiving training. SSI's will provide clinic staff with safe sleep training utilizing the outpatient safe sleep toolkit. Participants at the Safe Sleep Star program training will complete a pre- and post-education survey to assess knowledge of infant mortality risks, AAP recommendations for reducing risk of sleep-related death, and strategies to reduce barriers to following these recommendations. Data will be submitted to the KIDS Network for analysis. Within 12 months of the session, the safe sleep toolkit will be embedded in at least one outpatient clinic and an application for

safe sleep certification will be submitted to the KIDS Network at the appropriate level: 10% gold, 20% silver, 70% bronze.

To attain silver and gold levels, further commitment will be needed from hospitals. The Safe Sleep Instructor will be able to provide information about the HALO® SleepSack® program and will be able to answer questions about it; however, the hospital will ultimately need to make the commitment to obtain and maintain them. Further, the PDSA cycles and audits will be the responsibility of the hospital, though the Safe Sleep Instructor will be able to provide information and resources to support their efforts. The requirement of community outreach can be partially fulfilled by participating in Community Baby Showers which should be underway by the time Safe Sleep Instructors are engaging hospitals. We believe that hospitals attaining silver should be able to attain gold as is reflected in our goals below.

The certification designation does not represent a change, but acknowledges a state achieved by the participating hospital. The KIDS Network will supply hospitals with annual safe sleep training, access to training materials and resources for auditing infant safe sleep practices in the hospital. Cribs for Kids® has a strong commitment to supporting hospitals achieve certification and can support, alongside the Safe Sleep Instructor, all hospitals engaged through our initiative. Assigning the certification will be done by the Cribs for Kids® program; however, for internal tracking, Safe Sleep Instructors will collect and record at what level each hospital certifies and their ongoing progress.

*Safe Sleep Star Program:* The Safe Sleep Star program is a new initiative to address infant mortality by providing tools to help outpatient maternal and infant healthcare providers improve safe sleep promotion utilizing evidence-based (or evidence-informed) best practices, including the Medical Society of Sedgwick County's Safe Sleep Toolkit. The Safe Sleep Instructor will facilitate the roll out of the intervention within each participating practice, including initial training on the Safe Sleep Toolkit, annual staff training, and provision of support and resources necessary to reach the desired certification level. The certification program identifies three designations. The certification levels are cumulative (advanced levels of certification are reliant on fulfilling requirements of lower levels).

- Bronze Safe Sleep Star provides annual training to employees, has a safe sleep policy regarding educating all appropriate patients/parents and includes information on referral to further safe sleep education. They utilize the Safe Sleep Toolkit and at minimum embed the Safe Sleep Quiz and brief provider script into the practice. They also provides cribs or safe sleep resources and bereavement services when appropriate.
- Silver Safe Sleep Star provides patients with take-home materials on safe sleep, such as brochures, door hangers, "this side up" onesies, or wearable blankets.
- Gold Safe Sleep Star engages in safe sleep education at the community level through health fairs, community baby showers or other community outreach at least twice a year.

When a medical practice achieves success within the Safe Sleep domain, they receive a "star". In order to maintain earned stars, practices must continue to report success with standards on an annual basis. Practices may upgrade their status at any time a higher level is reached. We envision that practices could market their star rating and their outcomes to potential clients. We feel that a public listing of sites and their standings would help to motivate a culture of improvement. By marketing the Safe Sleep Star model to consumers, as well as providers, we hope to drive demand for participating sites to improve their services. As with safe sleep trainings described above, effectiveness will be evaluated through pre/post knowledge assessment of all participants. Mortality outcomes will be continually analyzed using state data to help identify potential shifts in trends on both county and state levels over time.

Read more about this initiative in the Perinatal/Infant Report section.

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## **Other Safe Sleep Activities**

*KIDS Network Infrastructure/Capacity Building:* The Title V program will contract with the KIDS Network during FY18 to provide a statewide support system to assist families, relatives, friends, caregivers and all others who are affected by the sudden death of an infant. A 100% funding match will be required of the KIDS Network. Objectives of the partnership/agreement include:

- Enhance referral network and protocols to enable a minimum of 75% of referred families affected by the unexpected or sudden death of an infant receive initial contact and/or support services;

- Finalize a statewide network for families to assure parents and extended family members access to follow-up and support services based on individual/family needs;
- Utilize an organizational structure to include an executive director and, as appropriate, support staff to fulfill agreement provisions;
- Provide organizational structure to include professional and parent/family representation on the KIDS Network, Inc. Board of Directors; and
- Implement a public information initiative to inform professionals, families, and other Kansas citizens of the KIDS Network, Inc. services, resource center, and infant safe sleep education.

*MCH Local Agency Strategies:* Information will be provided to all pregnant and postpartum women regarding the importance of safe sleep practices. Local agency staff will educate and encourage pregnant and postpartum women to discuss safe sleep with all of their infants care providers (family members, friends, childcare providers). They will also collaborate with community partners and other health care providers to promote safe sleep in their community in a consistent manner.

*Kansas Perinatal Community Collaboratives (KPCC)/Becoming a Mom<sup>®</sup> (BaM) Program:* Training on the SIDS/Safe Sleep integration component, along with the other comprehensive integration components, will be provided to new KPCC preparing to implement the BaM curriculum. This, along with the breastfeeding, smoking, and mental health integration components are certainly best suited for in-depth, in-person, training, and KDHE Title V staff are committed to providing such training for new program sites.

In addition to the development of the smoking cessation and mental health integration toolkits, “integration” tool kits have also been built for the incorporation of evidence-based curriculum on safe sleep and breastfeeding. These toolkits are described under different sections of this report/application, however we want to mention here that plans are certainly in place to continue to develop and update these components on an annual basis in addition to the integration of new toolkits as priority areas are identified. Training on updates, as well as training for new sites and new integration components, will be provided within the KPCC model. Plans for FY2018 are to take these integration toolkits and adapt them for use in a generalized clinic or home visit setting and to make them available for use by MCH programs/Title V grantees across the state.

## Perinatal/Infant Health - Annual Report

**PRIORITY:** Families are empowered to make educated choices about infant health and well-being

**NPM 4:** Breastfeeding (ever breastfed; breastfed exclusively through 6 months)

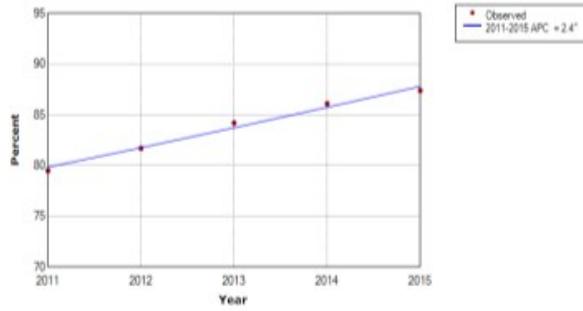
**SPM 4:** Number of Safe Sleep (SIDS/SUID) trainings provided to professionals

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### NPM 4: Breastfeeding (ever breastfed; breastfed exclusively through 6 months)

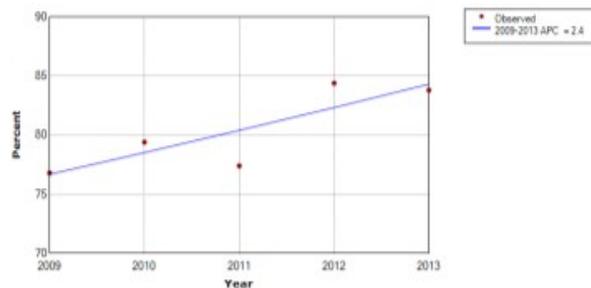
The 2015 **Kansas birth certificate data** (children born in 2015) showed that mothers initiated breastfeeding in 87.4% of resident live births. This was an increase from the 86.1% reported in 2014 and exceeded the Healthy People 2020 target of an 81.9% breastfeeding initiation rate. Non-Hispanic Asian mothers had the highest breastfeeding initiation rate (92.9%), followed by non-Hispanic white (88.9%) and Hispanic (85.4%) mothers. Non-Hispanic black mothers had the lowest breastfeeding initiation rate (75.1%). The overall breastfeeding initiation rate has been significantly increasing by 2.4% per year (95% CI: 1.8%-3.0%) for the five year period 2011-2015.

*Breastfeeding Initiation (Source: KDHE, Kansas Birth Certificate Data)*

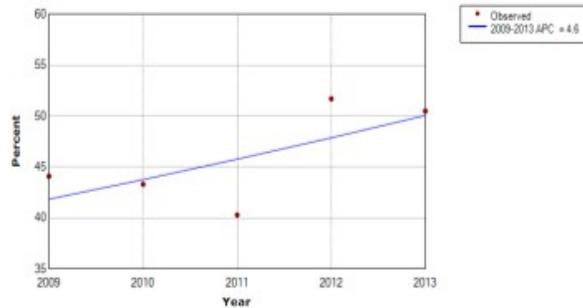


According to the 2015 **National Immunization Survey (NIS)** (children born in 2013), Kansas' breastfeeding initiation rate was 83.8%. This was a decrease from the 84.4% (children born in 2012). During the five birth year period (2009-2013), an upward trend was observed. While initiation rates have improved, more work is needed to increase breastfeeding at 6 months (50.5%) and exclusive breastfeeding at six months (23.4%) to meet the Health People 2020 goals. Healthy People 2020 aims to increase breastfeeding rates to 60.6% at 6 months and exclusive breastfeeding to 25.5% at 6 months. Babies who are breastfed exclusively for six months receive the most benefits from breastfeeding as do their mothers. Preventative health through exclusive breastfeeding can save health care dollars through reduction in acute illness and chronic disease.<sup>1,2</sup>

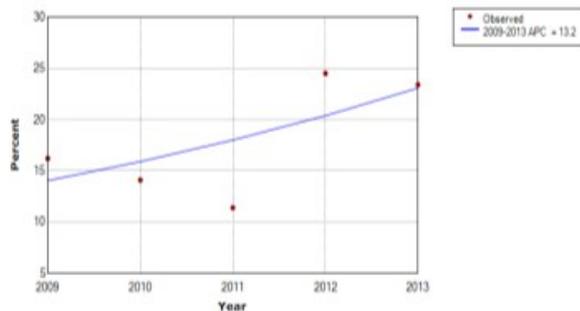
*Breastfeeding Initiation (Source: National Immunization Survey)*



*Breastfeeding at 6 months (Source: National Immunization Survey)*



*Breastfeeding exclusively through 6 months (Source: National Immunization Survey)*



The 2015 Maternity Practices in Infant Nutrition and Care Survey, known as the mPINC was completed by 64 Kansas hospitals (93%) that deliver babies participated in the survey. Kansas scored 76 and ranked 36<sup>th</sup> out of 53 in the nation.<sup>3</sup> Kansas hospitals are doing well in teaching prenatally about breastfeeding and teaching breastfeeding techniques which results in early initiation. However, there are few policies to support these measures to assure that all staff is trained in assisting breastfeeding families. This may be a reason for poor rates of exclusive breastfeeding at six months in Kansas.

1. U.S. Department of Health and Human Services. Healthy People 2020.

[www.healthypeople.gov/2020/topicsobjectives2020/pdfs/HP2020objectives.pdf](http://www.healthypeople.gov/2020/topicsobjectives2020/pdfs/HP2020objectives.pdf)

2. Centers for Disease Control and Prevention. National Immunization Survey. [www.cdc.gov/breastfeeding/data/NIS\\_data/](http://www.cdc.gov/breastfeeding/data/NIS_data/)

3. Centers for Disease Control and Prevention. Kansas 2015 Report, CDC Survey of Maternity Practices in Infant Nutrition and Care. Atlanta, GA. September 2016. <https://www.cdc.gov/breastfeeding/pdf/mpinc/states/2015/kansas-2015-mpinc-report.pdf>

Objective: Increase the number of communities that provide a multifaceted approach to breastfeeding support across community sectors by at least 10 by 2020 (expand the Communities Supporting Breastfeeding initiative).

Communities Supporting Breastfeeding: Communities Supporting Breastfeeding (CSB) is a designation, administered by the Kansas Breastfeeding Coalition (KBC), recognizing communities that provide multifaceted breastfeeding support across several sectors: businesses, employers, hospitals, child care providers and peer support. The CSB project integrates several existing breastfeeding initiatives and aims to improve exclusive breastfeeding rates for infants at three and six months. As of July 1, 2017, 17 communities have achieved the CSB designation since the program's inception in 2014 with support from the KDHE Bureau of Family Health (MCH Program), Kansas Breastfeeding Coalition (KBC), and the Kansas Health Foundation. Two (2) additional communities are on track to achieve the CSB designation by December 31, 2017.

An example of press/media revealing the impact at the community level can be found here:

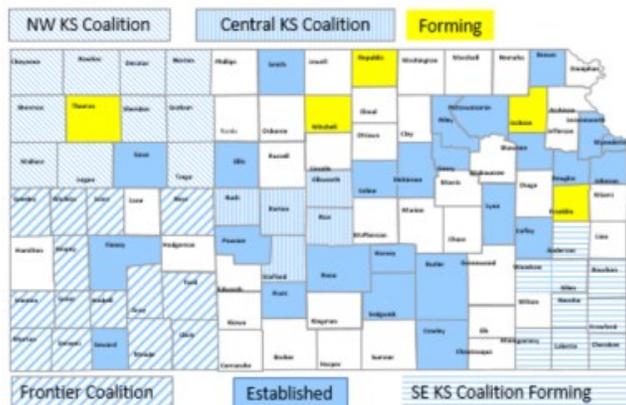
[http://www.leaderandtimes.com/index.php?option=com\\_content&view=article&id=26182:breastfeeding-not-only-offers-better-nutrition-for-babies-it-can-aslo-save-the-state-funds&catid=12:local-news&Itemid=40](http://www.leaderandtimes.com/index.php?option=com_content&view=article&id=26182:breastfeeding-not-only-offers-better-nutrition-for-babies-it-can-aslo-save-the-state-funds&catid=12:local-news&Itemid=40).

*Map of Designated Communities Supporting Breastfeeding*



One of the six CSB criteria requires the presence of a local breastfeeding coalition. Since the formation of the KBC in 2008, the number of local breastfeeding coalitions has increased from 8 to 34, covering 68 counties or 65% of the state. A new coalition is forming in Wyandotte County (Kansas City area) as of June 21, 2017. Another one of the six criteria involves training child care providers. The KBC hosts an annual “Kansas Breastfeeding Coalitions Conference”. Resources developed or shared at the conference, along with general coalition tools, are archived on the KBC “[Tools for Coalitions](#)” webpage. In 2016, over 80 individuals attended, representing 37 communities. The 2017 conference is planned for Oct. 13, 2017.

*Map of Local Breastfeeding Coalitions & Status*



A second CSB criteria requires a minimum of 20 child care providers complete a 2-hour training to support breastfeeding families. As of February 2017, a total of 2,745 child care providers have completed the training since its launch in 2013, most through an online course hosted by our partner, Kansas Child Care Training Opportunities (KCCTO). MCH funds granted to Child Care Licensing support the KBC instructor for this online course, allowing the course to be offer to child care providers at no cost.

A third CSB criteria requires a minimum number of public establishments, both private and public sector, to participate in the “[Breastfeeding Welcome Here](#)” (BWH) program. As of February 2017, 635 public establishments are enrolled in this program and are displaying the BWH window decal to let the public know that those needing to breastfeed while there will be welcome.

The Kansas CSB project has received state and national attention. The program was selected as an Emerging Practice for [AMCHP’s Innovation Station](#) where best practices in maternal and child health are shared with the public and state health departments. Additionally, the CSB project has been or *will be* presented as either a poster, webinar or concurrent session at the following national and state conferences:

- Association of Maternal & Child Health Programs (April 2016)
- American Public Health Association (October 2016)
- U.S. Breastfeeding Committee's National Breastfeeding Coalitions Conference (August 2016)
- University of Kansas School of Medicine – Wichita, faculty meeting (March 2017)
- Society of Behavioral Medicine (March 2017)
- United Association of Conferences, K-State Research & Extension/Family & Consumer Science educators (March 2017)
- National Assoc. of City and County Health Officials (April 2017)
- National WIC Association (April 2017)
- United States Lactation Consultants Association (May 2017)
- National Collaborative for the Advancement of the Ten Steps (June 2017)
- *Kansas Public Health Association (scheduled for October 2017)*

Read more about CSB here <http://ksbreastfeeding.org/cause/communities-supporting-breastfeeding/> and in the Perinatal and Infant Health Plan Section.

*MCH-WIC-Becoming a Mom® (BaM) Program Collaboration:* Working together collaboratively across WIC, MCH, and BaM, as well as with community partners such as local hospitals and birthing centers, breastfeeding coalitions, and La Leche League groups, much progress is being made to improve breastfeeding initiation and continuation rates in Kansas, as is evident by the above presented data. MCH Home Visitors are working alongside WIC Breastfeeding Peer Counselors (BPC) to provide breastfeeding support to individuals in their homes and clinic settings in both the prenatal and postpartum periods to improve rates as well as address another action plan objective: Increase the proportion of women and pregnant women receiving education related to the impact of prenatal and postpartum nutrition and exercise on optimal infant feeding. The new “*Your Guide to Breastfeeding*” from the Office on Women’s Health is referenced in the BaM course.

Through the work of the Kansas Perinatal Community Collaboratives (KPCC) BaM Integration Pilot in 2016, Kansas Title V contracted with the Kansas Breastfeeding Coalition (KBC) for the development of a two-hour evidence-based breastfeeding curriculum component. This evidence-based curriculum supplemented the original MOD BaM curriculum handout that was determined to not be near extensive enough to cover this priority topic. Primary focus of this infant feeding session is on getting breastfeeding off to a solid start, partner support, and successful transition back to work, all of which have a great impact on rates of continuation. Following piloting of the curriculum in 2016 and feedback gathered from program sites, updates and changes to the curriculum were made in the spring of 2017 and shared back with program sites for implementation. The curriculum has also been made available to WIC/MCH programs in counties across the state where KPCC are not in place, through the work of the KBC. According to the 2016 BaM Aggregate Report for KPCC, initiation rates rose to 94% (over the 87.4% state rate, according to Kansas Birth Certificate data, 2015), which we feel is reflective of efforts by KPCC to provide extensive education and support around this priority. Additionally, data consistently show the BaM session focused on infant feeding as the highest ranking related to “helpfulness of the session”.

Although breastfeeding initiation rates across the state have improved steadily in recent years, there is still continued work to be done to improve continuation and exclusivity rates at six months. KPCC and local MCH programs around the state have acknowledged a lack of a structured follow-up process for the offering of support at targeted points following the initial postpartum home visit as well as lack of a system for data collection related to tracking continuation rates.

*MCH Local Agency Strategies:* Local MCH agencies provided education to prenatal and postpartum clients. Referrals for breastfeeding assistance were made by MCH staff, including MCH Home Visitors. Many MCH home visitors and staff are also Certified Breastfeeding Educators and/or breastfeeding peer counselors. They participated in breastfeeding coalitions in their communities/regions. Collaborations continued with WIC, hospitals, child care providers and local physicians in providing consistent messaging about breastfeeding.

Several communities in the state have hosted community baby showers, using the Kansas Infant Death and SIDS (KIDS) Network model, to promote breastfeeding, safe sleep, and to connect pregnant women and their support persons with community resources. The Cherokee County Health Department home visitor collaborated with the MIECHV My Family coordinated outreach and referral (central intake) program and the Sunflower State Health Plan (Medicaid) to host a baby shower open to residents who were pregnant or had a new infant less than a month old. Participants were entered into drawings for several prizes that were donated by various businesses, agencies, organizations and local citizens.

Coffey County Health Department and Southeast Kansas Multi-County Health Department are working with the local hospital to implement the “High 5 for Baby” program which includes community-based efforts among employers, hospitals, and community partners. MCH staff collaborated with local community members to start a breastfeeding coalition. The coalition is promoting breastfeeding awareness within the community and recruiting businesses to make a pledge to be breastfeeding friendly businesses. The health department made the formal declaration and became a breastfeeding friendly business.

Hays Area Children's Center participated in the Communities Supporting Breastfeeding initiative through the Kansas Breastfeeding Coalition and are working to get local businesses to participate in supporting breastfeeding for their employees as well as customers.

Reno County Health Department has worked with the Kansas Breastfeeding Coalition to become a “Community Supporting Breastfeeding.” Local agency staff worked with the Reno County Breastfeeding Coalition to make community members and businesses more aware of the policy and practices in regards to the benefits of breastfeeding. MCH nursing staff and home visitors offer the follow-up visit for all breastfeeding mothers to ensure successful transitions from hospital to home and support in those first few critical days at home.

University of Kansas Medical Center Research Institute School of Medicine staff are members of the breastfeeding coalition and attend events to support efforts including the “Community Supporting Breastfeeding” designation. MCH program staff have also attended the Continuity of Care workshop presented by the Kansas Breastfeeding Coalition.

*Home Visiting:* MIECHV evidence-based and promising approach home visiting programs provided enrolled pregnant women and mothers with information, referrals, and support to promote breastfeeding. The MIECHV Program collected and reported data on the number of weeks that enrolled mothers breastfed their infants. For FY'16, enrolled mothers reported breastfeeding over 6 months on average (28.3 weeks). As of 10/1/16, in accordance with redesigned federal MIECHV Program performance measures, the MIECHV Program sites now are collecting and reporting data on infants of enrolled mothers who were breastfed any amount at 6 months of age.

Other activities in partnership with the [Kansas Breastfeeding Coalition](#) (KBC) and WIC:

- Promote and support breastfeeding with businesses through the *Breastfeeding Friendly Business* and *Business Case for Breastfeeding* initiatives. As of February 2017, [Breastfeeding Welcome Here](#) window decals are displayed by 635 business establishments in Kansas. As of July 1, 2017, 196 employers have received the [Breastfeeding Employee Support Award](#) from the KBC. Of these 196 award-winning employers, 86 (44%) have a written breastfeeding support policy.
- Increase access to professional support through referrals and linkages between birthing facilities and community resources. The KBC maintains a state-wide “[Local Resources Directory](#)” to allow families and health care providers to find local breastfeeding support by entering their zip code. A Google map is populated with breastfeeding resources from a wide variety of sources to include health departments, hospitals, private practice lactation consultants, peer breastfeeding support groups and walk-in clinics. The range of the search can be enlarged to encompass a large area if the family is willing to travel. This resource is promoted through a business card with a QR code and full URL to the page. Thousands of these cards (see image below) have been distributed to hospitals and health departments.



- Partner with Medicaid and Managed Care Organizations to increase awareness of and access to breastfeeding supportive benefits. The KBC prepared a White Paper for the Medicaid Managed Care Organizations, making the business case for covering breastfeeding support services. The KBC and WIC staff met with one of the MCOs in January 2017 to discuss the possibility of expanding their current coverage from only breast pumps to include breastfeeding support services. Conversations with all KanCare MCO's are ongoing.

Objective: Increase the proportion of births delivered in birthing facilities that provide recommended care for breastfeeding mothers by 2020.

The MCH program partners with KBC and WIC to expand the [High 5 for Mom and Baby](#) program by increasing the number of hospitals trained and number implementing the program. The KBC modified one of the six Community Supporting Breastfeeding (CSB) designation criterion related to hospitals from “enrolled in High 5 for Mom & Baby” to “recognized as a “High 5 for Mom & Baby” hospital. The rationale for this change is to motivate hospitals who have been enrolled in the program for some time to take the steps necessary to fully implement the High 5 for Mom & Baby program. The local breastfeeding coalitions are prepared to assist these hospitals to achieve the High 5 for Mom & Baby recognition.

With support from MCH, the KBC offered 9 “Breastfeeding 101” trainings across Kansas in 2016. A total of 503 individuals from diverse employment settings, including hospitals, were educated in evidence-based practices to support breastfeeding families. FYI: Five additional trainings are scheduled for the fall of 2017 to include workplace law session as well as the “Breastfeeding 101” curriculum.

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Objective: Increase the proportion of mothers and pregnant women receiving education related to optimal infant feeding by 2020.

Coeffective education tools (<http://www.coffective.com/>) were distributed in 10 communities in 2016-2017 as part of their technical assistance for the Community Supporting Breastfeeding (CSB) program. These counseling tools were provided to all community programs who serve mothers and infants in the 10 selected CSB communities. The wide-spread use of the high-quality tools increased consistent messaging about breastfeeding and supported the hospital's maternity care practices that support breastfeeding, such as skin-to-skin and rooming-in. All partners are working together in an effort to increase the number of referrals to WIC and breastfeeding peer counselors for breastfeeding support and education. As part of the Coffective tools, families are encouraged to contact WIC (see image below--the back of the Coffective “Build Your Team” counseling sheet).

## Women, Infants, and Children (WIC)

You can join WIC as soon as you think you may be pregnant. You can receive food benefits right away and receive nutritional information and education through group classes, peer counselors and spending time with a dietitian.

Find out more, and if you qualify, online at:  
[www.fns.usda.gov/wic/wic-income-eligibility-guidelines](http://www.fns.usda.gov/wic/wic-income-eligibility-guidelines)

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

A sleep-related infant death is the death of an otherwise healthy infant with no obvious trauma or disease process present, birth to one year of age, where elements of an unsafe sleeping environment were present. This encompasses infant deaths classified as Sudden Infant Death Syndrome (SIDS, ICD10 code: R95), Accidental Suffocation and Strangulation in Bed (ASSB, ICD10 code: W75) and Undetermined (ICD10 code: R99). Unsafe sleep environment includes soft bedding, articles in the crib or bed, infant sleeping in an adult bed or on other sleep surfaces such as a couch or chair, infant sleeping with another adult or child, and infant sleeping in a non-supine position (i.e. on the stomach or side).<sup>1</sup> The Sudden Unexpected Infant Death (SUID) rate is the combination of SIDS, ASSB, and unknown cause deaths.

During the 10-year period (2006-2015), overall SUID rates in Kansas decreased significantly by -5.3 per year [95% CI: -8.4, -2.0], from 151.6 deaths per 100,000 live births in 2006 to 102.2 deaths per 100,000 live births in 2015. While non-Hispanic black infants (annual percent change: -12.0, 95% CI: -17.6, -6.0) and non-Hispanic white infants (annual percent change: -5.0, 95% CI: -8.6, -1.2) experienced a significant decrease in rates of SUID, the rate for Hispanic infants remained unchanged (annual percent change: -0.4, 95% CI: -10.7, 11.0).

During 2011-2015, 210 Kansas infants died due to sleep-related deaths. Sleep-related deaths are the third most common cause of infant deaths in Kansas (17.1%), behind deaths due to prematurity or low birthweight (21.0%) and congenital anomalies (22.8%). Non-Hispanic black infants (205.3 deaths per 1,000 live births, 95% CI: 135.3-298.7) died at a significantly greater rate than non-Hispanic white infants (93.0 deaths per 1,000 live births, 95% CI: 77.0-108.9), but not compared to Hispanic infants (96.3 deaths per 1,000 live births, 95%CI: 65.0-137.5), where the cause of death was SUID. No narrowing of the disparity between the rate of WNH and BNH infants was observed.

According to the Kansas State Child Death Review Board Annual Report, published in 2016 containing 2014 data, there were 18 SIDS deaths, 10 deaths due to unintentional suffocation/strangulation, and three Unclassified Sudden Infant Deaths (undetermined) in Kansas in 2014. Based on the 18 SIDS deaths reviewed, 83% had one or more factors that contributed to an unsafe sleep environment; 50% were co-sleeping with adults and/or other children; 22% were sleeping on a couch; 39% were sleeping in an adult bed; 72% occurred at the decedent's residence; 11% occurred in a child care setting; and 33% were not placed on their back to sleep (recommended position). Based on the 10 deaths reviewed due to unintentional suffocation/strangulation, which were all sleeping related, 100% of these deaths occurred while both the child and caregiver were sleeping; 100% were reported to have an unsafe sleep environment; 100% were not sleeping in a crib; 60% took place on an adult bed, 30% on a couch and 10% on a recliner; 40% had prior and/or current Kansas Department for Children and Families (DCF) involvement; and 40% of the caregivers in charge of the decedent at time of death were under the influence of drugs or alcohol.

Objective: Implement a multi-sector (community, hospitals, maternal and infant clinics) safe sleep promotion model by 2018.

Kansas Infant Death & SIDS (KIDS) Network of Kansas Partnership: The KIDS Network reaches across the entire state of Kansas in their efforts to reduce the number of infant deaths. Safe sleep promotion is the focus of most of the Network's outreach activities including Safe Sleep Community Baby Showers, Cribs for Kids, Dissemination of Safe Sleep Education, Health Care Provider Education, Child Care Provider Education. In alignment with the State MCH Plan and Infant Mortality

Collaborative Improvement and Innovation Network (CoIIN) initiative, the Title V program partners with the KIDS Network to reduce infant mortality through expanded safe sleep efforts. The KIDS Network provides training across the state for health professionals, child care providers, home visitors and more.

In FY2016, 101 Kansas counties were impacted by the KIDS Network through outreach and education. The KIDS Network provided safe sleep training to 4,623 caregivers and professionals, and provided other outreach to an additional 13,475 people: 1,500 caregivers were educated about safe sleep through demonstrations at baby showers, safe sleep instructors' trainings; 3,123 professionals and child care providers were trained on safe sleep and bereavement through presentations at hospitals and universities, public health conferences, and Becoming a Mom trainings; 13,475 community members were connected with through outreach activities including professional meetings, community events, and KIDS network events (candle lighting, scramble, step up, trunk or treat).

*Safe Sleep Initiative Expansion:* The KIDS Network has developed a comprehensive safe sleep program that includes consumer and provider education and participant incentives delivered through a unique community baby shower model. Expansion of the model is underway with funding from KDHE and integrates cross-cutting issues such as breastfeeding and smoking as they relate to safe sleep environments and sudden infant death. All three MCO's are supporting the baby showers through event promotion, financial support for cribs, and streamlined on-site KanCare (Medicaid) enrollment. The expansion initiative is guided by the following aims.

- Specific Aim 1: Enhance the Safe Sleep Instructors skill sets to include training Home Visitors and facilitating Community Baby Showers.
- Specific Aim 2: Expand promotion of the AAP's Safe Sleep guidelines by activating the Safe Sleep Instructors to roll out the Hospital Safe Sleep Bundle Intervention or the Safe Sleep Star program for outpatient clinic.

*Safe Sleep Instructor Training and Community Baby Showers:* Kansas boasts one of the most effective safe sleep campaigns in the country and serves as a best practice model supporting the national Infant Mortality CoIIN effort and partnering closely with the Association of SIDS and Infant Mortality Programs (ASIP). Additionally, the KIDS Network safe sleep program model was presented at the International Conference on Stillbirth, SIDS and Baby Survival in the Netherlands and Uruguay. In FY16 and under contract with KDHE, the KIDS Network established a regional network of 23 trainers able to provide community-level safe sleep education based on recommendations from the AAP. In the first nine months, 13 of these trainers provided safe sleep education at 21 events reaching more than 375 participants. The trainings were predominantly for healthcare providers, but included home visitors and childcare providers. It's important to note that this train-the-trainer model provides a solid foundation for sustainability and expansion of the Kansas safe sleep campaign and is the vehicle for delivery of the KIDS Network Community Baby Shower model statewide. In an effort to integrate breastfeeding and smoking cessation into the baby showers, local breastfeeding coalitions and tobacco prevention programs are included in all KIDS Network community baby showers to address breastfeeding and smoking along with safe sleep. They are invited to have a display booth as well as present a session. Since July 2016, 28 KIDS Network baby showers have included local breastfeeding coalitions and tobacco prevention programs where established across the state.

In this safe sleep model, instructors attend a 2-day training designed to build the skills necessary to implement established, evidence-supported safe sleep programs in their regions. Specific topics addressed include a) physiologic reasons believed to be risk factors for SIDS, b) how to further address issues related to breastfeeding-related promotion of bed sharing, c) local smoking cessation tools and resources, and d) how to facilitate brainstorming regarding strategies to reduce the barriers to following the safe sleep guidelines. In addition, they engage in activities that prepare them to successfully introduce regional Community Baby Showers to provide safe sleep education and tools for high risk mothers and their support persons. A universal evaluation system, developed by the University of Kansas School of Medicine, provides data for quality improvement efforts and support future outreach planning. Program outreach and participation numbers are tracked as are participant knowledge and behavior changes.

The *Hospital Safe Sleep Certification* and *Safe Sleep Star Program* are key strategies of this initiative that provide multi-sector (clinical) outreach focusing on consistent patient-level education and reinforcing universal safe sleep practices.

*Hospital Safe Sleep Initiative:* The Safe Sleep Hospital Certification initiative was developed by Cribs for Kids to identify and

recognize hospitals that demonstrate a commitment to community leadership for best practices and education on infant sleep safety. The certification program identifies three designations. The certification levels are cumulative; that is, advanced levels of certification are reliant on fulfilling requirements of lower levels.

- Certified Safe Sleep Hospital (Bronze):
  - Develop and maintain a safe sleep policy that is consistent with the AAP recommendations. It must be documented, in current operation, and include provisions for training providers/staff as well as educating parents prior to discharge. Policy must be in place for three months prior to application.
  - In accordance with the above policy, hospitals must provide all staff working on units serving infants with training on safe sleep. New staff should be trained within three months of hire, and training should recur on an annual basis to keep staff current.
  - In accordance with the above policy, hospitals must provide and document provision of safe sleep education to parents of infants before discharge. Most commonly this would be an educational video and/or materials, supplemented with direct dialogue. Safe sleep must be modeled by staff behavior during hospital stays.
- Certified Safe Sleep Leader (Silver):
  - Implement the use of wearable blankets in neonatal intensive care unit (NICU) and well-baby nursery. Wearable blankets are available at no cost from HALO® for in-hospital use.
  - At least two of instances of either Plan-Do-Study-Act (PDSA) cycles of new interventions or audits of safe sleep modeling must be done each calendar year. Hospitals can also perform one PDSA cycle and one audit to fulfill this requirement.
- Certified Safe Sleep Instructor (herein, “Gold”; not to be confused with State Safe Sleep Instructors):
  - Hospitals must conduct at least two community outreach activities (e.g. health fair, public service announcement regarding safe sleep) each year.
  - Hospitals must readily display safe sleep education materials (e.g. poster) and must include safe sleep information on their hospital website (if available).
  - Affiliate, support, or partner with either local or national Cribs for Kids® program.

Current Safe Sleep Instructors supplied training and training materials to help all delivering hospitals get to at least the bronze level. Additionally, hospitals were supplied with a safe sleep educational DVD and training on how to properly educate families. Hospitals were required to develop a policy, with templates provided by the Safe Sleep Instructor, document compliance with the policy, and maintain these changes for at least three months.

Kansas Perinatal Community Collaboratives (KPCC) & Becoming a Mom® (BaM) Prenatal Education: Integration efforts have also included standardization of the SIDS/Safe Sleep component of the BaM curriculum, led by state MCH staff and the KIDS Network. An updated Power Point presentation was built for consistent use across all BaM program sites. During the February 2016 “BaM Integration Training, Part II” training day, all BaM staff were trained on presentation of the slides and associated resources from the KIDS Network. Additionally, staff were trained on the demonstration of an “unsafe sleep environment” and a “safe sleep environment” that is to be incorporated within the presentation as part of the “Infant Care” session of the BaM program. This component of the integration training initiative was exceptionally well received by BaM program staff, as many of the new group facilitators had felt inadequate in presenting this component of the curriculum, as their areas of expertise were more clinical than public health. In addition to curriculum content having a SIDS/Safe Sleep focus, program incentives across every site include the pack-n-play crib which provides a safety approved crib for expectant mothers with limited resources.

MCH Local Agency Strategies: Local agencies provide education and resource material related to safe sleep. MCH and MIECHV home visitors evaluate sleep environments when providing home visiting services for pregnant/parenting moms. This includes a safe sleep demonstration and provision of a sleep sack for the infant. MCH home visitors attended the “Wrestling with Safe Sleep” instructor training provided by the KIDS Network. Certified Safe Sleep instructors across the state have provided the program to local community members. See more about the Safe Sleep expansion initiative and partnership with the KIDS Network in this section and the Perinatal & Infant Health Plan section.

Home Visiting: MIECHV provided enrolled pregnant women and mothers with information and support to promote safe sleep practices. As of 10/1/16, in accordance with redesigned federal MIECHV Program performance measures, the MIECHV

Program sites now are collecting and reporting data on parent-reported safe sleep practices (infants that are always placed to sleep on their backs, without bed-sharing or soft bedding).

## Child Health

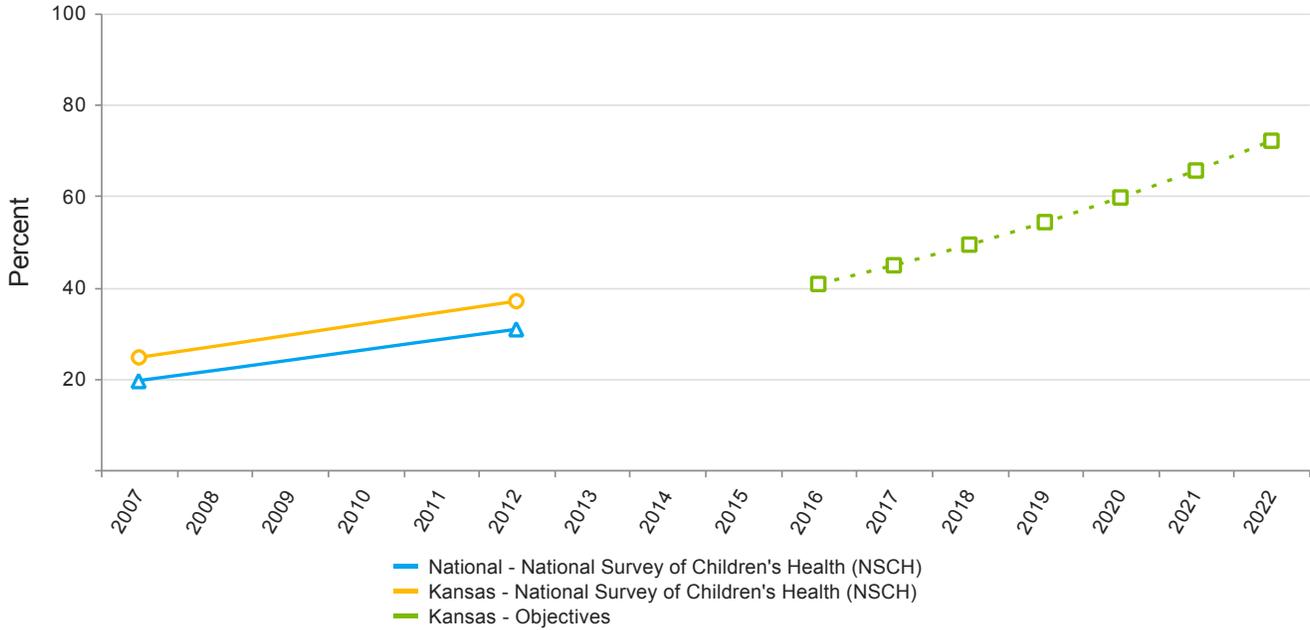
### Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available	NPM 6
NOM 15 - Child Mortality rate, ages 1 through 9 per 100,000	NVSS-2015	20.8	NPM 7
NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000	NVSS-2015	30.7	NPM 7
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000	NVSS-2013_2015	14.0	NPM 7
NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000	NVSS-2013_2015	11.0	NPM 7
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	86.8 %	NPM 6

**National Performance Measures**

**NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool**

**Baseline Indicators and Annual Objectives**



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	40.7
Annual Indicator	37.0
Numerator	70,393
Denominator	190,075
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	44.8	49.3	54.2	59.6	65.5	72.0

**Evidence-Based or –Informed Strategy Measures**

**ESM 6.1 - Percent of program providers using a parent-completed developmental screening tool during an infant or child visit (ages 10 through 71 months)**

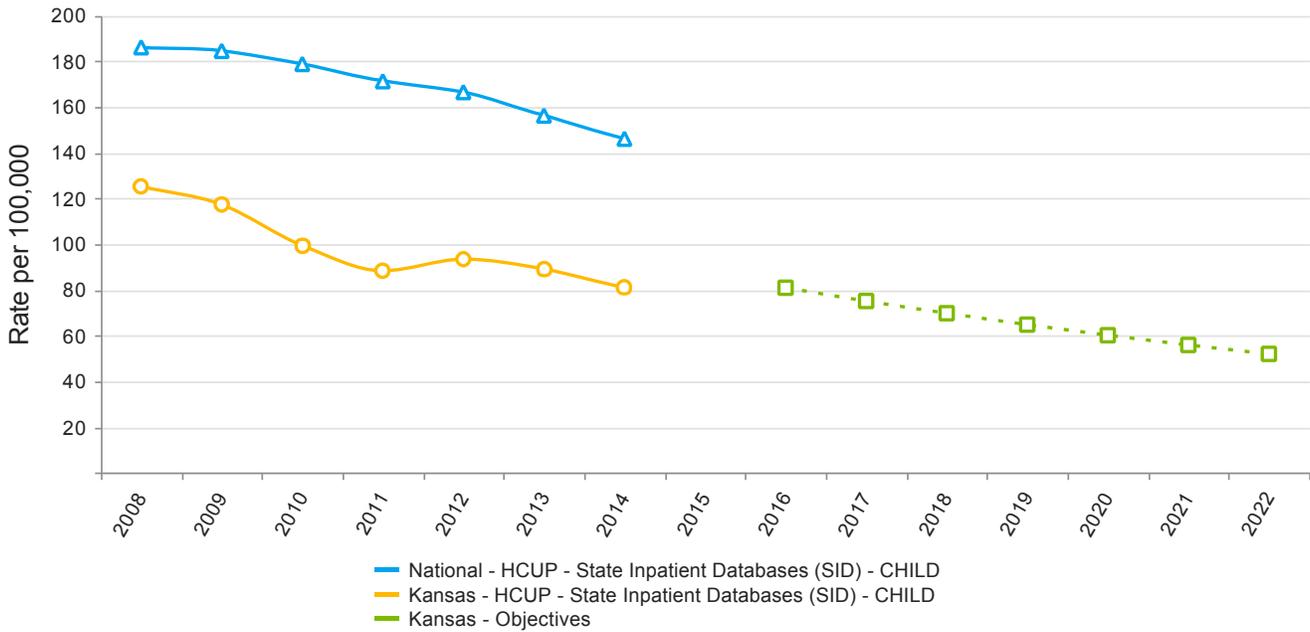
<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	88.4
Numerator	38
Denominator	43
Data Source	DAISEY
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	90.0	91.0	92.0	93.0	94.0	95.0

**NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19**

**Baseline Indicators and Annual Objectives**



**NPM 7 - Child Health**

Federally Available Data	
Data Source: HCUP - State Inpatient Databases (SID) - CHILD	
	2016
Annual Objective	80.9
Annual Indicator	80.8
Numerator	325
Denominator	402,420
Data Source	SID-CHILD
Data Source Year	2014

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	75.1	69.8	64.8	60.2	55.9	52.0

**Evidence-Based or –Informed Strategy Measures**

**ESM 7.1 - Number of free car seat safety inspections completed by certified child passenger safety technicians**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	969
Numerator	
Denominator	
Data Source	Kansas Traffic Safety Resource Office
Data Source Year	2015
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	1,050.0	1,100.0	1,200.0	1,250.0	1,300.0	1,350.0

**State Performance Measures**

**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**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	28.2
Numerator	133,276
Denominator	473,426
Data Source	NSCH
Data Source Year	2011_2012
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	29.6	31.1	32.6	34.3	36.0	37.8

**State Action Plan Table**

State Action Plan Table (Kansas) - Child Health - Entry 1

Priority Need

Developmentally appropriate care and services are provided across the lifespan.

NPM

Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Objectives

3.3 Increase by 10% the number of children through age 8 riding in age and size appropriate car seats per best practice recommendations by 2020.

3.4 Increase the proportion of families receiving education and risk assessment for home safety and injury prevention by 2020.

Strategies

3.3.1 Increase the number of MCH grantees, as a lead for or partner of local Safe Kids Coalitions, providing education and installation of car seats. 3.3.2 Increase the number of trained car seat technicians, support additional check lanes for MCH, and incorporate information and check lane locations into BAM site education and information. 3.3.3 Provide targeted training and technical assistance to child care providers related to regulatory and transportation requirements. 3.3.4 Assure appropriate motor vehicle safety education is provided for all individuals transporting infants and children.

3.4.1 Enhance home safety information and education provided as part of prenatal and postnatal visits/sessions. 3.4.2 Provide education and support through use of online systems and tools to assist parents with selecting a child care setting that meets health and safety requirements. 3.4.3 Develop a standard home visiting tool for MCH home visitors to assess environments for potential harm or injury in the home environment. 3.4.4 Track changes to the home environment between visits in response to education and consultation provided by MCH home visitors to reduce the potential for harm or injury.

ESMs

Status

ESM 7.1 - Number of free car seat safety inspections completed by certified child passenger safety technicians	Active
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## NOMs

NOM 15 - Child Mortality rate, ages 1 through 9 per 100,000

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NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000

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NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

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NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

State Action Plan Table (Kansas) - Child Health - Entry 2

Priority Need

Developmentally appropriate care and services are provided across the lifespan.

NPM

Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Objectives

- 3.1 Increase the proportion of children aged 1 month to kindergarten entry statewide who receive a parent-completed developmental screening annually.
- 3.2 Provide annual training for child care providers to increase knowledge and promote screening to support healthy social-emotional development of children.

Strategies

- 3.1.1 Conduct an environmental scan to identify providers conducting developmental screening and determine the tools being utilized. 3.1.2 Improve coordination of referral and services between early care and education, home visitors, medical homes, and early intervention. 3.1.3 Build MCH capacity for screening and follow-up through complete referrals to providers and community-based services. 3.1.4 Provide training to MCH grantees on developmental screening and use of Ages and Stages Questionnaires (e.g., ASQ-3; ASQ:SE2).
- 3.2.1 Develop a standard and consistent message to communicate importance of developmental screening among child care programs. 3.2.2 Make available and provide training to child care providers on social-emotional development, milestones, and age-appropriate activities using the Kansas Early Learning Standards. 3.2.3 Build child care provider capacity to support coordination and referrals with other providers and community-based services. 3.2.4 Partner with statewide networks such as Child Care Aware of Kansas (CCA-KS) and Kansas Child Care Training Opportunities (KCCTO) to assess the training needs of providers and develop training to meet their needs.

ESMs

Status

ESM 6.1 - Percent of program providers using a parent-completed developmental screening tool during an infant or child visit (ages 10 through 71 months)	Active
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NOMs

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

NOM 19 - Percent of children in excellent or very good health

Priority Need

Developmentally appropriate care and services are provided across the lifespan.

SPM

Percent of children ages 6 through 11 and adolescents ages 12 through 17 who are physically active at least 60 minutes per day

Objectives

3.5 Increase the percent of home-based child care facilities implementing daily routines involving at least 60 minutes of daily physical activity per CDC recommendations to decrease risk of obesity by 2020.

3.6 Increase the percent of children and adolescents (K-12 students) participating in 60 minutes of daily physical activity.

Strategies

3.5.1 Provide training and resources to child care providers related to healthy practices and regulatory requirements.

3.5.2 Provide training to child care surveyors regarding the regulatory requirements related to daily routine and physical activity, including protocol for assessing and determining compliance. 3.5.3 Provide resources for child care facilities and surveyors to encourage and support children's participation in activities that raise their heart rate for a minimum of 60 minutes a day.

3.6.1 Support schools and communities in promoting events and securing essential supplies for Bike to School and Walk to School events, including the walking school bus. 3.6.2 Partner with schools and communities to identify safe biking and walking routes between home and school. 3.6.3 Increase the number of community programs collaborating with MCH programs to promote whole-family participation in regular physical activity including engaging and educating businesses. 3.6.4 Support local health departments, schools, and community centers in local initiatives to promote physical activity and utilization of safe walking and biking trails.

## Child Health - Plan for the Application Year

**PRIORITY:** Developmentally appropriate care and services are provided across the lifespan

**NPM 6:** Developmental Screening (10 to 71 months)

**NPM 7:** Child Injury (0 to 9 years)

**SPM 3:** Physical Activity (children 6 through 11; adolescents 12 through 17)

*Local MCH Reach:* Based on 2017-2018 MCH Aid to Local applications received, 57 of 70 (81%) grantees/local MCH agencies plan to provide services to the Child population.

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### **NPM 6: Developmental Screening (10 to 71 months)**

Objective: Increase the proportion of children aged 1 month to kindergarten entry statewide who receive a parent-completed developmental screening annually.

The primary focus for MCH regarding developmental screenings over the next year will be to coordinate with key partners (Medicaid, pediatricians/physicians, American Academy of Pediatrics, Academy of Family Physicians, Child care/early childhood education agencies, Head Start/Early Head Start; Parents As Teachers, Children's Cabinet and funded programs, health departments, Part B and Part C, United Methodist Health Ministries Fund, FQHCs/safety net clinics) to develop and conduct a statewide survey to identify providers (all sectors) who are conducting developmental screening and what tools they use. It will be important to determine a way to capture and analyze data. While there has been some progress through existing work (KIDOS\*\*) a good comprehensive picture of providers conducting screening and use of tools is still not available. Considerations for partnering with hospitals has been discussed. Some potential challenges and barriers identified by MCH staff and Council members include: need for a road map as to how doctors can screen, lack of reimbursement for providers who do the screening, and lack of places to refer children for an assessment.

With support from the United Methodist Health Ministry Fund, KDHE (led by the MIECHV program) currently partners with the University of Kansas to coordinate and provide ASQ training on an ongoing basis. Several trainings have been provided since 2016. The training is designed for any professional from a community agency that works with parents and young children under age 6, such as home visitors, public health and other health providers, and early childhood educators. Attendees come from various agencies in local communities surrounding the training. MCH local agencies are strongly encouraged to attend the training when offered.

Local MCH Agency Strategies: Local MCH agencies provide a developmental screening at least once a year to all children they serve, ages birth to age 6. A total of 29 of 70 (41%) local agencies use the Ages and Stages Questionnaire (ASQ-3; ASQ-SE/ASQ-SE2) for developmental screenings for ages 2 to 60 months old and Bright Futures Pediatric Symptoms Checklist (PSC) for over 60 months. Local MCH agencies also provide required ASQ screenings during the KAN Be Healthy (KBH)/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program (well visits/screenings) well child visits. Developmental screening is a vital component to the continuum of care for children. The ASQ parent-completed questionnaire is intended to screen children for developmental delays in the areas of communication, gross motor, fine motor, problem solving and personal-social skills. During these visits, educational material is provided to parents regarding developmental milestones.

Child Health programs use an outline and multiple screening assessment tools to determine the needs of each child. This guides the formulation of plans to meet the needs directly and indirectly through appropriate referrals. The web-based shared measurement system (DAISEY) collects data related to education provided during MCH visits about child development as well as referrals for developmental screening and early childhood intervention services.

Effective July 1, 2017, the MCH home visitors will begin providing child development and child social emotional development screenings for families. This requirement is related to the redesign of the MCH home visiting program. Universal Home Visiting will provide developmental screening for participants who have continued to receive services and are not eligible for other community based home visiting programs. Technical assistance and training will be provided to local agencies related to the

protocol and expectations for incorporating the developmental screening (parent completed tool) into the child well visit. Additionally, distinctions between use of Bright Futures and the ASQ (intent, purpose, use together) will be provided. Billing procedures for the screenings vs. and/or the comprehensive well visit will be clarified as well.

**Resource and Referral System:** The development of the new resource and referral system to support optimal service coordination during the early childhood years at the community level will continue over the next 12-18 months, with plans to implement locally across the state. The core leadership team has only just begun to work through the details and logistics of what this system will look like, plans for implementation, and data measurement and evaluation requirements. The leadership team is expected to meet regularly either in-person or virtually until the implementation phase begins. At that time, it will be determined who will continue on the leadership team and who may need to be added. As part of this initiative, Kansas has decided to become a *Help Me Grow* affiliate state. There are currently 50 Help Me Grow systems in over 20 states (learn more: <https://helpmegrownational.org/>). The data system to be used to track indicators related to coordination and referral is IRIS. IRIS is a web-based communication application to enhance family engagement and better MCH service coordination with other partners and is currently being piloted in MIECHV communities. IRIS supports Title V priorities by enabling better integration of MCH services with community partners to mutually reinforce effective activities.

IRIS website (<http://connectwithiris.org/>)



Throughout the coming year external partner meetings will be held to gain buy-in from agencies and providers across the state for *Help Me grow* in Kansas. A large stakeholder group will meet in the summer or fall of 2017 to address the four core components and develop the necessary workgroups to plan for implementation. Help Me Grow will be piloted within several communities or regions across the state before full statewide implementation occurs. The partnership with the Wichita State University Community Engagement Institute, University of Kansas Center for Public Partnerships and Research, and the Help Me Grow National Center are expected to continue.

**Developmental Evaluation Clinics:** KS-SHCN plans to continue to support the developmental evaluation clinics identified as a way to provide increased support for developmental evaluation, especially in rural Kansas. Children participate in these clinics after the completion of a developmental screening. These clinics are designed to focus on evaluating children of all ages from any referral source for a concern of a developmental delay or perform an evaluation to confirm a diagnosis. This supports stronger partnerships with early intervention providers through the Part C/Infant-Toddler networks. Community education around these clinics will continue to be enhanced in the coming year to support more community referrals including from the local health department, primary care providers, hospitals, and child care providers. In addition, the clinic team desires to continue focusing on other at risk populations, such as rural residents and military families.

Additional plans for this year include expanding evaluation services through telehealth so that more children living in rural locations can receive a diagnosis and treatment; collaboration with the Kickapoo Tribe to continue partnership building with the Native American population to hold additional diagnostic clinics through telehealth within the reservation setting to assist with early diagnosis; and expansion of clinics for children whose parents are in the military. Lastly, the clinics are designed to serve as a “training ground in developmental disabilities” for the Leadership Education in Neurodevelopmental Disabilities (LEND) program. This partnership is valued and has been an area of improvement for Title V over the years. This will continue to be a focus area for partnership building in the coming year.

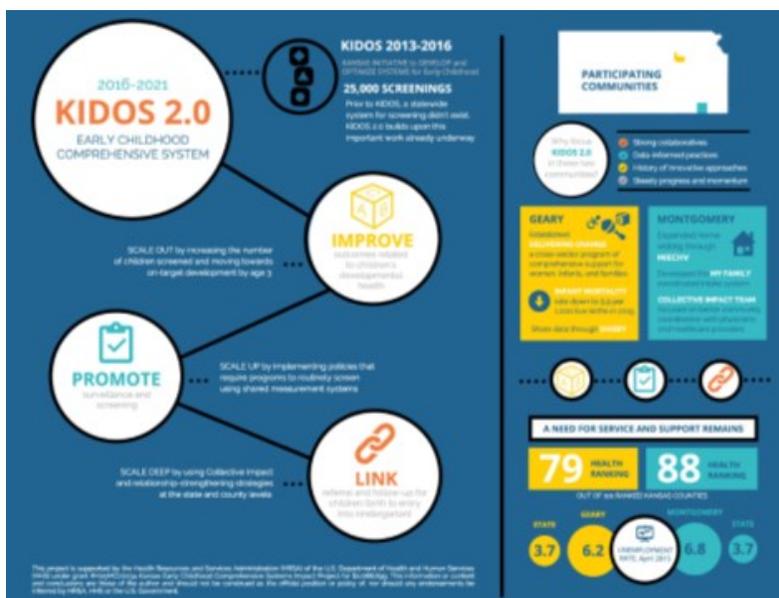
*KS-SHCN and Newborn Screening Collaboration:* In FY18, the KS-SHCN program will continue the collaborative partnership with the Kansas Newborn Screening and Newborn Hearing Screening programs. The referral process in place will be expanded to include the newly developed Kansas Birth Defect Program. Within this partnership, once a child is diagnosed with an eligible birth defect condition a care coordinator can immediately begin assisting the family.

*Title V CYSHCN and Medicaid Partnership:* Through the collaborative partnerships developed with the Managed Care Organizations (MCOs), KS-SHCN program families are assisted in identifying referrals and services between early care and education, home visitors, medical home, and early intervention. Care coordinators encourage and assist families in making sure their children are screened regularly according to the bright future recommendations. Care coordinators assure the completion of referrals to providers and community based services occur. This will be documented in each child’s Action Plan.

*Early Childhood Comprehensive Systems (ECCS) Impact Initiative (KIDOS 2.0):* The KIDOS 2.0 initiative focuses on improving and promoting the developmental health and screening of young children (birth to kindergarten entry) using CoIIN strategies and the Collaborative Impact framework in two place-based communities, Geary County and Montgomery County. The state advisory team will initiate work based on learning from the local communities as well as issues that need specific attention to improve state-level system policies and coordination across multiple agencies, organizations, programs, and service providers. KIDOS 2.0, which expands on the previous KIDOS efforts ([www.screenearlystartstrong.org](http://www.screenearlystartstrong.org)) is providing an opportunity to align or integrate some practices and data elements across Title V MCH, Healthy Start, and MIECHV initiatives as well as with other partners and systems. Our work in Kansas on leveraging and coordinating among existing early childhood data systems is multi-faceted and multi-disciplinary; many agencies and organizations serve Kansas children and families (e.g., education, child welfare, public health, early childhood programming, and direct services) and existing systems of record for those agencies each capture different indicators relevant to their charge and mission. DAISEY ([www.daiseysolutions.org/kdhe](http://www.daiseysolutions.org/kdhe)), as selected for this project, is currently the early childhood shared measurement system being utilized by two of the major disciplines and agencies for early childhood indicators (Children’s Cabinet early childhood programs; KDHE Bureau of Family Health Title V and MIECHV programs). We also leverage KIDOS 2.0 as a point of integration and infrastructure to: 1) maximize efforts by building on successful work at the state and local levels; 2) integrate CQI in meaningful ways by building in more shared measurement systems such as DAISEY and coordination tools such as IRIS (Integrated Referral and Intake System) that provide real-time feedback to make programmatic improvements; and, 3) influence changes at the state, local and organizational levels to build in sustainability beyond the project period. IRIS is a web-based communication tool to help organizations connect the families they serve to the right resources in their community. DAISEY can also be used to link records among state agency partners in other disciplines with the appropriate high-level buy in and agreements as needed. This work is beyond the scope of the proposed project, but the thoughtful planning of such opportunities is critical for future larger early childhood system coordination and impact analysis.

\*\*KIDOS – Kansas Initiative for Developmental Ongoing Screenings: The current ECCS Impact grant commenced on August 1, 2016 and the project be implemented for up to 5 years. New grant activities will build on the previous KIDOS project and continue a focus on developmental screening and referral processes as well as family well-being (i.e., maternal depression and trauma-informed care) utilizing CoIIN and Collective Impact strategies.

*KIDOS 2 Project Flyer (learn more: [www.screenearlystartstrong.org](http://www.screenearlystartstrong.org))*



Home Visiting: Title V will continue to learn from and collaborate with the MIECHV-funded evidence-based home visiting programs. MIECHV home visiting programs conduct developmental screenings with enrolled primary caregivers and their child(ren) using the ASQ-3. MIECHV sites will report data on children who receive a timely screening at 9, 18, and 24 months. For those Children with positive screens for developmental delays, data will also be tracked on who receive services in a timely manner (a. received individualized developmental support from a home visitor; b. were referred to early intervention services and assessed within 45 days; or c. were referred to other community services and received services within 30 days). Additionally, home visitors will document the primary caregivers concerns by routinely asking enrolled primary caregivers if they have any concerns regarding their child’s development, behavior, or learning. MIECHV programs also collect data as to whether a family member/caregiver read, told stories and/or sang songs with their child daily during a typical week. Programs will also track and report data on receipt of well-child visits based on the AAP schedule, and conduct and report caregiver-child interaction using a validated observation tool.

Objective: Provide annual training for child care providers to increase knowledge and promote screening to support healthy social-emotional development of children.

The Title V MCH program provides support to the Child Care Licensing (CCL) program to improve the health and well-being of children receiving care away from their home and parents. Health and safety is always a focus based on the program’s purpose; however, collaboration over the last few years has expanded reach of the Title V program to include those children in regulated child care facilities. The Child Care Licensing (CCL) program director participates as a member of the KIDOS state work group to develop a standard and consistent message needed to communicate the importance of developmental screening among child care programs.

In addition to increasing awareness about the importance of developmental screening (and resources to support/implement), the Child Care program is promoting training to child care providers in all settings (day care homes, child care centers, preschools, and school age programs) to increase knowledge of social-emotional development. To assist with this, the state program has agreements in place with state training organizations and statewide networks including Child Care Aware of Kansas (CCA-KS) and Kansas Child Care Training Opportunities (KCCTO) to assess the training needs of providers and develop training to meet their needs. Specifically, training specifically for child care providers focused on social-emotional development, milestones, and age-appropriate activities has been made available for in-service hours. There are currently several trainings related to social-emotional development approved/available to child care providers for in-service training. Examples of courses are listed below.

- Behavior & Guidance (ways to encourage positive behavior in young children)
- FLIP IT! (steps to help young children identify their feelings, learn healthy self-control, and reduce challenging

behavior--Feelings, Limits, Inquiry, and Prompts)

- Understanding Temperaments of Young Children (understanding various temperaments and how adjustments can be made in your approach or environment)
- Supporting Relationships through Engaging Environments (strategies to support social and emotional development for small and large groups)
- Play: Problems and Interventions (behavior patterns that can signal children need help and the process for helping children through observation, reflection and intervention; using direct support, curriculum activities and peers to help children develop play skills)
- Infant/Toddler Social-Emotional Development Series (three courses)
  - Social Emotional Development within Relationships (social emotional development within caregiving relationships, the influences of culture, how behavior is used as a way of communication with strategies)
  - Responsive Routines, Environments and Targeted Strategies to Support Social Emotional Development (keys to connecting the child care environmental physical components, caregiver responsiveness, routines and strategies)
  - Individualized Intervention: Determining the Meaning of Behavior and Appropriate Responses (strategies are introduced to enable a partnership with families to address behavior in the development/implementation of a support plan)

The guiding document utilized for developmentally and age-appropriate activities is the Kansas Early Learning Standards (KELS) (<http://www.ksde.org/Portals/0/Early%20Childhood/Early%20Learning%20Standards/KsEarlyLearningStandards.pdf>). The current KELS document is the third revision of the Kansas Early Learning Standards and is aligned with the K-12 College and Career Ready Standards. These standards will be used to support the learning and development of young children ages birth to kindergarten and will also support the work of teachers in kindergarten through third grade, clearly showing the continuum of learning from birth through grade three. The Kansas Early Learning Standards are not an assessment or a curriculum; however, the standards can assist child care providers, early childhood educators, and home visitors with addressing the needs of the children in their care. This document also serves as a resource for planning activities and conversations with young children and their families. These activities will result in greater capacity for child care providers to support identified needs through coordination and referral to other providers and community-based services. Online training on the KELS has already been launched for providers for two hours of credit.

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### **NPM 7: Child Injury (0 to 9 years)**

The MCH program plans to continue working closely with the Bureau of Health Promotion, Injury Prevention Program and Safe Kids Kansas to implement strategies in partnership with MCH grantees across the state. KDHE's Bureau of Health Promotion provides leadership in the prevention of unintentional injuries in Kansas.

Safe Kids Kansas is supported by over 60 statewide and regional organizations and businesses and 24 local chapters dedicated to preventing unintentional injuries to Kansas children ages 0-19. As of 2014, nearly 80 percent of the child and adolescent population in Kansas was covered by a local Safe Kids coalition. The Title V Director serves on the Safe Kids Board and has been working closely with the Executive Director and Board to align MCH priorities and efforts with Safe Kids priorities based on the most current needs assessment. Partnership with Safe Kids is evident in the MCH State Action Plan. As part of the "shared work" across the MCH Action Plan and Safe Kids Kansas Strategic Plan, staff are working to increase the number of MCH grantees, as a lead for or partner of local Safe Kids Coalitions, providing education and installation of car seats. A webinar will be held for all MCH local agencies during 2017-2018 to educate about Safe Kids and how to become a local coalition.

At the local level, MCH agencies provide child injury education and information based on age and development of the child. Child injury education is provided during developmental screenings, immunizations and during home visits. Local agencies collaborate with Safe Kids Kansas for injury prevention and program guidance on topics including water safety, sun safety, poison control, car seat safety, choking and prevention falls. Local agencies collaborate with local school districts to provide presentation to students regarding injury prevention.

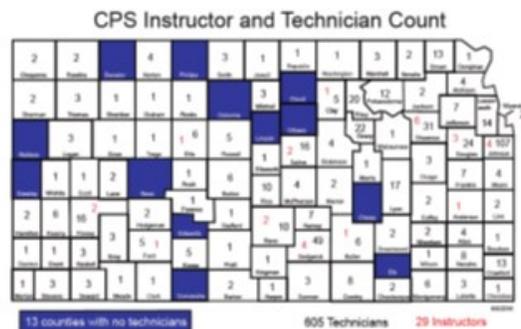
Objective: Increase by 10% the number of children through age 8 riding in age and size appropriate car seats per best practice recommendations by 2020.

As part of the five-year needs assessment, injury data (2014) was reviewed to determine the area of focus for children. Motor vehicle accidents were a top cause for ages 0-14 years and 15-24 (most injuries of all causes). Therefore, the MCH program is working to increase the number of trained car seat technicians, support additional check lanes for MCH, and incorporate information and check lane locations into prenatal education classes. Many county health departments (local MCH agencies) partner with their local Safe Kids Coalition to provide training about child safety, injury prevention and car seat checks. In addition, communities utilizing the Becoming a Mom® program curriculum provide information related to car seat education and installation during prenatal education sessions. Many local MCH agencies are certified technicians qualified to conduct car seat checks, and Home Visitors provide car seat safety/installation education. Parents are referred for car seat installation and provided education from Safe Kids worldwide. Curricula used for car seat safety education is from the Kansas Traffic Safety Resource office. MCH local agencies are encouraged to partner at the community level and share information with all participants.

*Becoming a Mom*® (BaM) is a collaborative perinatal education program in our state, discussed in more detail in the Women & Maternal sections of this application. Integration efforts are planned for the expansion of curriculum components and resources around infant/child safety in 2017-2018. Preliminary discussions have occurred between the Kansas Safe Kids Coalition Coordinator and the Kansas BaM Program Coordinator, regarding the development and implementation of such components. Already in place as part of the Saline County BaM program, is session content on safe infant car seat selection and installation. As a part of this session, partnering Kansas Highway Patrol Trooper Ben Gardner, has developed a PowerPoint presentation specific for the BaM audience. Sites will be trained on presentation of the slides, which can either be presented by the trained BaM group facilitator or a partnering child car seat technician in the community. Additionally, program sites will be encouraged to offer infant car seat installations/ checks as a part of program services or in partnership with those already providing services.

The KS-SHCN care coordinators continue to share safety tips with families per the Safe Kids Kansas recommendations. Both programs are committed to working together to keep all Kansas children safe and healthy and to developing additional partnership projects in the future. Safe Kids Kansas will be presenting safety information to all care coordinators through a webinar training to be conducted late summer of 2017. One of the topics to be discussed will be car seat safety and where to refer families to the nearest car seat check lanes. Care coordinators will then share the information they learn with CYSHCN families.

Child Passenger Safety Instructors and Inspection Stations are promoted and utilized to advance efforts and increase access to car seat checks (see maps included below).





Home Safety Checklist

**HOME SAFETY Checklist**  
KANSAS MATERIAL & CHILD HEALTH HOME VISITING

**Guidance for Parents:** You can use this checklist to help make your home safe for your child. Go through your home and check off for each question depending on what you find in your home. If you check "No," part of your home is safe for your children. If you check "Yes," you will need to make some changes to make your home safer. When you finish this HOME SAFETY checklist, you will have taken a BIG STEP toward making your home safer!

**CHILD AREA Safety**

- Is furniture away from children to prevent your child from climbing up and falling out?  Yes  No
- Are all windows, baseboards that are cracked?  Yes  No
- Have you put window guards in windows that might be used for your child to reach?  Yes  No
- Are baby gates used at the top and bottom of all stairs to prevent falls?  Yes  No
- Are baby gates secure when gates are closed (DO NOT use an extension strap)?  Yes  No
- Have the crib mattress fit tight to the crib?  Yes  No
- Is mattress that fits loosely in the crib can result in injury or suffocation (Leave no more than 2 finger spaces between the mattress and crib frame).  Yes  No
- Are toys and the toy storage bins labeled "Safety Hazards"?  Yes  No
- Are toys in good condition with no loose parts or recalls (For more information, visit [www.saferchildren.org/toys\\_safety.html](http://www.saferchildren.org/toys_safety.html))  Yes  No
- Is a CPSC approved toy recalled on the toy check list (Go to [www.saferchildren.org/toys\\_safety.html](http://www.saferchildren.org/toys_safety.html) for more information, and [www.saferchildren.org/toys\\_safety.html](http://www.saferchildren.org/toys_safety.html) for more information.)  Yes  No
- Have your baby's sleep setup "Safety Hazards" removed?  Yes  No
- Your baby is not in a crib with no bumpers, pillows, other soft items, or toys on their back, and in a Crib ABC's of Safe Sleep. (This crib must also have safety pins on the sides for crib recall.) (Including crib can providers, grandparents, friends, and other caregivers. For more information, visit [www.saferchildren.org/toys\\_safety.html](http://www.saferchildren.org/toys_safety.html).)  Yes  No

**BATHROOM Safety**

- Are hot liquids and trash out of your child's reach? "Hot of water" means:  Yes  No
- NOT on the hands of an adult holding a cup
- NOT on the edge of a counter or table
- NOT on a surface which could be pulled down
- "Hot of water" also means in your child's reach (e.g., hot water tap)
- Are cleaning supplies covered out of your child's reach?  Yes  No
- Are cleaning supplies covered separately from food?  Yes  No
- Are food, toys, and other things your child might want to eat or play with away from the stove?  Yes  No

**BATHROOM Safety**

- Do you use extra care when walking on the stairs? "Extra care" means:  Yes  No
- Leaving your hands toward the back of the stairs
- Leaving handrails in the bathroom when going to prevent falls
- Keeping your child supervised and/or in a safe chair while you cook
- Are babies and other things kept out of your child's reach?  Yes  No
- Do you keep small items such as buttons, batteries, and pieces of food that can choke your child out of their reach?  Yes  No

**BATHROOM Safety**

- Remember to keep the bathroom door closed after use
- When your child is in the bathtub, are they within arm's reach of an adult the entire time?  Yes  No
- Child can sit down in just a few inches of water until you get a few seconds
- Child can be in the tub for more than 10 minutes
- Are whistles, medications, toiletries, and cosmetics kept out of your child's reach?  Yes  No
- Are electrical appliances unplugged, away from water and beyond your child's reach?  Yes  No
- Electrical appliances such as blenders, hair dryers, curling irons, and space heaters are unplugged and can be checked if they are plugged in and not in use
- In your hot water heater tank is a safe water temperature?  Yes  No
- Water temperature is set to 120 degrees Fahrenheit
- Temperature of 120 degrees or less is recommended to prevent hot water burns

**GENERAL HOME Safety**

- Are all children accessible to your child's room?  Yes  No
- Are latches or locks installed on all doors, windows, and doors where hazards exist?  Yes  No
- In your facilities entered on that it will not be used if your child enters on it? (The single blocks or another pieces of toys for children to use the wall) (The furniture that can be pulled down or your child reaches but not locked to)  Yes  No
- Back of chair or table chair
- Tables
- Benches or benches (standing items)
- Chairs
- TV stands (Place TV on low furniture, as far back as possible.)
- Are all signs removed? "Signs" means:  Yes  No
- Out of your child's reach
- Identifying the Consumer Product Safety Commission
- Labels on the floor
- Identifying the printing or other markings
- All hard floor (e.g., linoleum, carpet, and tile)
- If you have a second building access or fireplace, is it in safe condition and out of your child's reach? "Safe" means:  Yes  No
- Has a good inspection of stove, stove gas, and chimney
- Has a protection screen around the stove/fireplace

Based on 2014 Injury Prevention program data, poisonings were the number two cause of childhood injury for children 0-9 years (falls was first). In response, plans are also in development for the incorporation of other educational resources provided by Safe Kids Coalitions into prenatal and postnatal visits and sessions. Such plans include the incorporation of education and resources from the poison control for family resources, specifically the *Poison Diaper Bag*, in *Becoming a Mom*® prenatal education classes (session two). This fits nicely with the information about risks to pregnancy from chemical/ environmental exposures that is already part of the curriculum. The MCH and Child Care Licensing programs contributed directly to content and pressed for the importance of materials specifically related to the dangers of diaper bag contents, resulting in the *Poison Diaper Bag* handout (English and Spanish) <http://www.kumed.com/medical-services/poison-control/info-for-families>.

Continuation of the Safe Kids Kansas and KS-SHCN smoke and carbon monoxide detectors project will continue in FY18 until funding runs out. At this time, Safe Kids Kansas provides the funding for the detectors and the KS-SHCN program provides funding for the installation for those families requiring special detectors that require a trained electrician to install. Both programs are committed to securing other funding sources to continue the program in the future.

Collaborative efforts to integrate resources from the "Charlie's House" initiative (in connection with Safe Kids Coalition) are also planned for development and implementation in 2018 along with the newly developed MCH Home Safety Checklist. Some local sites have already taken the lead in integrating resources to assist parents with selecting a child care setting that meets health and safety requirements. Plans are to replicate existing *integration* efforts across other Kansas BaM sites, by providing training on the resources available through partnership with the Child Care Licensing program and Child Care Aware of Kansas. The KDHE Child Care program already hosts an online website (portal) that provides parents and the public with access to licensing and compliance history information. The site has been a source of information that has assisted families with making informed decisions about selecting healthy and safe child care that fits their needs. The site and access to the "child care search" function is here: <http://www.kdheks.gov/bccir/capp.htm>.

**SPM 3: Physical Activity (children 6 through 11; adolescents 12 through 17)**

Objective: Increase the percent of home-based child care facilities implementing daily routines involving at least 60 minutes of daily physical activity per CDC recommendations to decrease risk of obesity by 2020.

Local MCH Agency Strategies: There are 20 local MCH agencies working on initiatives to increase children's physical activity. Local agencies discuss and provide information on the importance of daily physical activity as well as encourage, promote and evaluate physical activity among children and youth at developmental screenings, well child visits, immunizations, and WIC

appointments. Families are educated at each visit about physical activity the entire family can focus on. Families are encouraged to take part in at least 60 minutes of physical activity daily for children and adolescents. Some local MCH agencies will provide presentations to students in elementary/middle schools regarding physical activity.

Neosho County Health Department will provide parents and day care providers with education and information on ways to get children their daily physical activity, including ideas and activities to help parents and day care providers get children moving during inclement weather.

*Child Care Licensing Initiative:* The Child Care Licensing Program will launch the physical activity initiative to include training developed by the KDHE Bureau of Health Promotion. The training (one hour) is titled, Promoting Physical Activity in Early Childhood Education Settings: A Training for ECE Professionals, and is targeted to early childhood professionals. After completing the training, the learners will be able to identify and implement best practices for promoting physical activity among the children served by a child care center or day care home. The instructional objectives follow:

- Define different types of physical activity
- State the recommended minimum amount of time for children to receive physical activity
- List best practices for promoting physical activity both indoors and outdoors
- Include physical activity guidelines in child care center or day care home policy
- Talk to parents and caregivers about physical activity and screen time

The training will focus on the "Let's Move" principles and be made available to child care providers online through KS-TRAIN. *Let's Move!* is a comprehensive initiative, launched by the former First Lady, dedicated to solving the challenge of childhood obesity within a generation, so that children born today will grow up healthier and able to pursue their dreams. Combining comprehensive strategies with common sense, *Let's Move!* is about putting children on the path to a healthy future during their earliest months and years. The initiative gives parents helpful information and fostering environments that support healthy choices. Pre and post surveys will be conducted after the training to assess and measure provider understanding related to what physical activity means per the CDC.

The goal is to help children increase the number of minutes per day of physical activity, that raises their heart rate, performed while in out of the home settings. In addition to training related to the CDC recommendations, child care surveyors will receive refresher training on the regulatory requirements related to daily routine and physical activity, including the protocol for assessing and determining compliance. This in turn will support the surveyors in their efforts to provide technical assistance and consultation during on-site visits for centers and homes.

Objective: Increase the percent of children and adolescents (K-12 students) participating in 60 minutes of daily physical activity.

*Local MCH Agency Strategies:* Many local MCH agencies are leading activities related to children participating in 60 minutes of physical activity. Jefferson County Health Department's goal for children is that they develop healthy habits for a lifetime of improved health. They teach children that physical activity is a normal part of life, so that as they will strive to remain physically active throughout their lives. To promote physical activity, they intend to initiate a before school activity program called Adventures to Fitness. This program is based on research showing that physically active children perform better academically socially, and behaviorally. Adventure to Fitness is the nation's #1 educational fitness program, used by over 120,000 teachers across more than 22,000 schools, and the nation's top children's hospitals and organizations. Nemaha County Community Health Services collaborate with local schools on their annual Family Run/Walk to promote family fun and fitness as well as teaching young children the importance of lifetime physical activity. Rooks County Health Department promotes nutrition and physical activities including walking/biking trails, recreation centers, and fitness centers in their community. They also encourage families to participate in the Walking School Bus. Wilson County Health Department address physical activity through collaboration with community partners such as the Healthy Living Action Team (HLAT) and the Community Health Improvement Planning group. They are working to provide new trails, a bike/skate park, and Every Child Deserves a Bike. Through Every Child Deserves a Bike, 2nd graders from families that qualify for free/reduced lunches can receive a bike and helmet. In order to receive these, the child has to complete a bicycle safety course provided by the local police department

*Child Care Licensing Initiative:* The child care physical activity initiative outlined previously is targeted to children who have not yet reached school age. In order to support school-age children, the MCH program intends to implement the following

strategies in partnership with local MCH agencies and schools. As noted above, many local agencies are already working at the community level to implement strategies in the MCH Action Plan.

- Work with schools, before- and after-school programs, and communities in promoting events and securing essential supplies for Bike to School and Walk to School events, including the walking school bus, non-competitive sports leagues, and intramural sports (opportunities in and out of school hours).
- Partner with schools and communities to identify safe biking and walking routes between home and school.
- Increase the number of community programs collaborating with MCH programs to promote whole-family participation in regular physical activity including engaging and educating businesses.
- Support local health departments and community centers in local initiatives to promote physical activity and utilization of walking and biking trails.

In addition to the Child Care initiative related to physical activity in the child care setting, the program is collaborating with the Bureau of Health Promotion to increase the number of participants completing the online physical activity training/course available through KS-TRAIN.

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### **Other Activities Impacting the Child Population (related to NPM 11 Medical Home – children with and without special health care needs)**

The Title V program is partnering with the University of Kansas School of Medicine - Wichita and Kearny County Hospital as part of a collaborative quality improvement involving the Pioneer Care Advocacy Team (PCAT) to reduce non-emergent Emergency Department (ED) use through coordination of regional health care and other health and social resources. The purpose of this quality improvement project is to identify: assess community members' perceptions, knowledge, attitudes, and desires related to health/wellness resources in multiple sectors of frontier counties of Southwest Kansas, using the model that was developed for and tested successfully in Kearny County in 2015-2016 (with support from Title V). The data from the assessment will then be used by the community members and leaders to develop quality improvement plans. See more in the Child Report section for results from the 2015-2016 efforts that resulted in the expansion from Kearny County to Finney, Haskell, and Grant Counties. Other organizations funding the expansion are the Kansas Health Foundation, Sunflower Health System and Anthem Foundation. See more about the foundational work in Kearny County in the Child Health Annual Report.

## Child Health - Annual Report

**PRIORITY 3:** Developmentally appropriate care and services are provided across the lifespan

**NPM 6:** Developmental Screening (10 to 71 months)

**NPM 7:** Child Injury (0 to 9 years)

**SPM 3:** Physical Activity (children 6 through 11; adolescents 12 through 17)

*Local MCH Reach:* Kansas MCH has shown its commitment to children through the work it has completed and continues to pursue. For example, during FY16, 68 of 80 (85%) local agencies provided services to the Child population. Towards the third MCH priority, KDHE strives to increase developmental screenings, reduce child injury, increase the amount of physical activity performed by children, and increase the number of children with a medical home. KDHE also strives to educate all types of caregivers on ways to assist children in achieving goals and building systems of services and care that allow children to thrive.

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### **NPM 6: Developmental Screening (10 to 71 months)**

Kansas has made great strides in its ability to provide developmental screenings to the child population. According to the 2011/2012 National Survey of Children's Health, 37.0% of Kansas parents reported they completed a standardized screening tool during a health care visit, compared to 30.8% nationally. Children with Special Health Care Needs (CSHCN) (44.3%) were more likely to receive a standardized developmental screening compared with children who did not have a special health care need (36.0%).

In fiscal year 2016 (10/01/2015-09/30/2016), according to the Kansas Medical Assistance program, Annual EPSDT Report, 73,843 (70.1%) of the 105,303 eligible children aged less than 1 year through 5 years old, received at least one initial or periodic screen. However, room for improvement remains and MCH is utilizing collaboration and coordination of multiple initiatives to address the objectives.

Objective: Increase the proportion of children aged 1 month to kindergarten entry statewide who receive a parent-completed developmental screening annually.

*Local MCH Agency Strategies:* Currently local MCH agencies provide all children they serve a developmental screening at least once a year from birth to age 6. Agencies use the Ages and Stages Questionnaire (ASQ-3; ASQ-SE 2) for developmental screenings for ages 2-60 months old and then for ages above 60 months, the Bright Futures Pediatric Symptoms Checklist (PSC) is used. Local MCH agencies also provided health screenings in accordance with the KAN-Be-Healthy/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) guidelines.

During the 2016/2017 review of the prenatal education curriculum (March of Dimes Becoming a Mom® and supplemental KDHE materials) by MCH sites and partners, recommendations were made to include parent handouts on developmental milestones, the importance of reading to an infant/child in the early years, and school readiness. As a part of standardization efforts related to existing sites and use of the curriculum, supplemental handouts and video clips were added on these topics.

*Resource and Referral System (Help Me Grow):* As a component of the State Implementation Grant for Enhancing the Systems of Services for Children and Youth with Special Health Care Needs through Systems Integration (D-70), Kansas was charged to create or improve a shared resource and referral system for the children and youth with special health care needs (CYSHCN) population. While KS-SHCN oversees the Kansas Resource Guide (KRG), opportunities for improvement were quickly realized in order to better meet the needs of children in Kansas. Throughout the series of grant and state plan meetings it is clear that a more robust system is needed to connect children and their families with the services and providers needed, prior to them entering the special health care needs or disability system. After extensive research, it was determined to pursue the Connecticut "Help Me Grow" model. Help Me Grow is a unique, comprehensive, and integrated statewide system designed to address the need for early identification of children at risk for developmental and/or behavioral problems, and then link to developmental and behavioral services and supports for children and their families.

Numerous meetings with internal Bureau of Family Health (BFH) partners and external early childhood partners have been held. From this, the core leadership team was established to begin building the Kansas system, with representation by key decision-makers from all sectors of the early childhood system. It is noted that behavioral and developmental problems in children can dramatically impact the lives of children and families. The costs to the overall system and the family are greater when these problems remain undetected or untreated, particularly with regard to mental health, education, and juvenile justice costs. The system is being developed for children birth through age eight.

There are four main core components of a comprehensive Help Me Grow system.

1. Centralized telephone access point for connection of children and their families to services and care coordination
2. Community and family outreach to promote the use of Help Me Grow and to provide networking opportunities among families and service providers
3. Child health provider outreach to support early detection and early intervention
4. Data collection and analysis to understand all aspects of the Help Me Grow system, including the identification of gaps and barriers

By following this model, Kansas is better able to assure early screening, diagnosis, and treatment for those who need services and provide opportunities to engage families with children of all ages. Additionally, this provides opportunities to engage both medical and community providers in the provision of coordinated and comprehensive services during those early development stages, thus supporting optimal outcomes for when children reach adulthood. This system is intended to be expanded over time to address the needs of all maternal and child health populations.

The Wichita State University Community Engagement Institute has been identified as the project facilitator to assure the initiative moves forward. Additionally, the University of Kansas Center for Public Partnerships and Research is involved to support the data management needs of the system. The core leadership team has identified and approved the use of the Integrated Referral Information System (IRIS) as a computer-based/online referral system. IRIS is currently under pilot for the Maternal, Infant and Early Childhood Home Visiting (MIECHV) communities and is the system pursued by Help Me Grow in Kansas. A contract is being developed with the "Help Me Grow" National Center at the Connecticut Children's Hospital for technical assistance through implementation.

Developmental Evaluation Clinics: The Kansas Special Health Care Needs program (KS-SHCN), in partnership with the Kansas State Department of Education (KSDE) and the University of Kansas Medical Center – Center for Child Health and Development (KU-CCHD), supports specialty clinics designed to assist in the assessment and diagnosis of development delay. These outreach clinics are held in multiple areas of the state where the child and family meets with a multi-disciplinary team of professionals, including (but not limited to) a developmental pediatrician, early intervention and childhood providers, speech/physical/occupational therapy, and others in the child's community who may support the child and family after diagnosis. Some clinics are held onsite at the military base to support families who may find it difficult to get a diagnosis due to short term residency. In FY17, outreach clinics were held in six (6) locations throughout the state, including two active military bases and Native American reservations. A total of 40 children and their families were served through these clinics. Prior to the appointment, families complete a patient information form that asks about patient history and developmental issues to support the clinic team at the time of the appointment. One clinic was specifically organized for Native American children and held on the reservation in partnership with tribal leaders to identify children with developmental delays and to assist in connecting them to the appropriate services and supports. Developmental and hearing screenings were done for Native American children in the Kickapoo and Prairie Band Pottawatomie Nation locations. Leadership Education in Neurodevelopmental Disabilities (LEND) students participate in these diagnostic clinics to gain valuable insight into conducting evaluations and how to effectively communicate with the families who have children with special health care needs.

Tribal Developmental Health Needs Assessment: Child Development Summits and Community Forums were held on two reservations to help Native American families and community members understand about developmental milestones and the need for developmental screenings. These events were attended by 115 family and community members.

KS-SHCN and Newborn Screening Collaboration: The KS-SHCN program partners with the Kansas Newborn Screening (NBS) and Newborn Hearing Screening (NBHS) programs to make sure infants are identified at birth and referred to the KS-SHCN

program for long term services and supports. A referral process was first implemented in 2015 with the NBS program and then with the NBHS program in 2016. KS-SHCN care coordinators immediately reach out to the families upon diagnosis to make sure children and families are getting their needs met. The care coordinators continue to work with families to make sure children receives routine KAN Be Healthy (KBH) visits, the Kansas Early Periodic Screening Diagnosis and Treatment (EPSDT) program, and any developmental screenings and evaluations that might be necessary. Upon completion of screenings, the care coordinators work with the family to identify next steps and action items. These are then listed in each child's KS-SHCN Action Plan to be followed-up on by the care coordinators in collaboration with the families.

*Title V CYSHCN and Medicaid Partnership:* KS-SHCN partners with the Medicaid Managed Care Organizations (MCOs) to receive data of dually enrolled Medicaid/Title V CYSHCN program participants. A monthly report is provided to the MCOs of enrolled Title V CYSHCN participants. The MCOs complete a report for KS-SHCN notifying of those under Medicaid case management and the status of the participants' KBH screening. If a child on the KS-SHCN program is "not current" on their KBH checkups, the care coordinator can reach out, reminding them of the importance of these and to encourage them to get an appointment scheduled. Families are provided assistance if needed. If a child is due for his/her next KBH it becomes an objective listed and worked on in the child's KS-SHCN Action Plan.

*Early Childhood Comprehensive Systems (ECCS/KIDOS):* From August 2013 through July 2016, KDHE administered the three-year Early Childhood Comprehensive Systems: Building Health Through Integration (ECCS) grant. Named the Kansas Initiative of Developmental Ongoing Screening (KIDOS), the project goal was to expand and effectively coordinate, improve, and track developmental screenings and referrals for infant and toddlers (birth to age three) across early childhood support systems at the state and local levels including home visiting and early education settings, pediatricians and medical homes, intervention services, and child care programs and families. A pediatrician-chaired state work group provided expertise and guidance for the KIDOS project. Using the Collective Impact framework, a comprehensive community toolkit was developed to provide resources, tools, and guidance to communities coordinating comprehensive developmental screening systems (see [screenearlystartstrong.org](http://screenearlystartstrong.org)). These tools and technical assistance were provided to community implementation teams. They were also disseminated at 5 regional summits conducted statewide in April and May 2016. Expansion of statewide capacity to provide quality training on the Ages and Stages Questionnaires (ASQ-3™ and ASQ: SE/SE2) occurred. The KIDOS project also enhanced data collection systems for developmental screenings and referrals, and evaluated system improvements.

Kansas was one of 12 states awarded the new ECCS Impact grant for up to 5 years starting August 1, 2016. The overall aim of ECCS Impact is to increase age-appropriate developmental skills of 3-year old children by 25% by 2021. KDHE has contracted with the KU-CPPR to assist with project coordination and evaluation. Entitled KIDOS 2.0 (Kansas Initiatives to Develop and Optimize Systems for early childhood), the ECCS Impact grant activities builds on KIDOS 1.0 with a continued a focus on developmental screening and referral processes, and promotion of developmental health for children birth to kindergarten entry. This work utilizes CoIIN and Collective Impact strategies to focus on building early childhood systems. KIDOS 2.0 has two place-based communities participating in this intensive work: Geary County, also a Healthy Start site, and Montgomery County, a MIECHV community. In early 2017, the Kansas team participated in an initial CoIIN learning session and the local community teams began PDSA (Plan-Do-Study-Act) projects focused on improving communication and engagement of parents with their child's developmental health.

Objective: Provide annual training for child care providers to increase knowledge and promote screening to support healthy social-emotional development of children.

The MCH Child and Adolescent Health consultant met with the MIECHV/ECCS and Infant-Toddler Services (Part C) program directors, to discuss what components of the *Screen Early Start Strong* resources are appropriate for child care providers. *Screen Early Start Strong* is part of Kansas Initiative for Developmental Ongoing Screening (KIDOS). In addition to gathering information about the KIDOS work and how it aligns with the MCH plan strategies, the MCH consultant attended the Association of Maternal & Child Health Programs (AMCHP) Conference in Kansas City and participated in a session on supporting and enhancing developmental screening initiatives through, family, professional, and state partnerships. At this session, the CDC's *Learn the Signs. Act Early* program was promoted. The program aims to improve early identification of children with autism and other developmental disabilities so children and families can get the services and support they need. The program/content is appropriate for child care providers and has three components.

The program is made up of three components:

1. Health education campaign
2. Act Early Initiative
3. Research and evaluation

After getting recommendations from the program directors, the consultant decided to move forward with *Learn the Signs. Act Early* resources as a starting point to distribute to child care providers. The materials selected as most appropriate include:

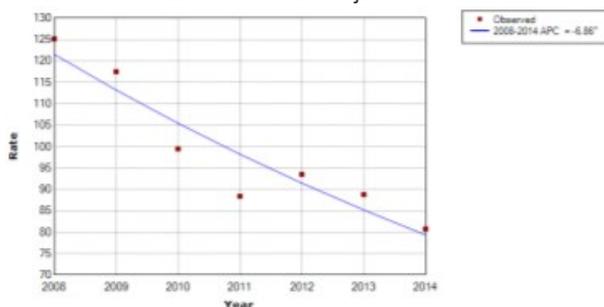
1. *Concerned About Development? How to Help Your Child and How to Talk with the Doctor* Fact Sheet
2. "Learn the Signs. Act Early." for Early Care and Education Providers
3. Milestones Brochure

An inquiry was also sent to CDC to gain access to the GroupSpaces site to begin customization of the materials to tailor them to Kansas. To address the state action plan strategy related to making available and providing training to child care providers on social-emotional development, milestones, and age-appropriate activities using the Kansas Early Learning Standards, a meeting was set up with the Child Care Licensing to discuss distributing customized materials to providers across the state. The MCH program plans to work closely with the *Learn the Signs. Act Early* Ambassador, as it pertains to the dissemination materials to child care providers, in particular licensed child care centers and day care homes (approximately 650 child care centers including head starts and 4,300 licensed day care homes).

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### NPM 7: Child Injury (0 to 9 years)

In Kansas between 2008 and 2014, rates of non-fatal injuries (a hospital admission with a primary diagnosis of unintentional or intentional) have significantly decreased, from 125.2 to 80.8 injuries per 100,000 children ages 0 through 9 (APC=-6.9, 95% CI=-9.6, -4.1). The following table illustrates the decline of non-fatal injuries.



There is still progress to be made. In 2014, rates of non-fatal injuries were highest among infants less than a year old (146.4 per 100,000), followed by children ages one to four (97.5 per 100,000), and children ages five to nine (55.1 per 100,000). Non-Hispanic white and non-Hispanic black children had nearly the same rates of non-fatal injury (71.4 vs. 71.7 per 100,000, respectively). Male children are more likely than female children to sustain non-fatal injuries. The 2014 rate among males was 91.2 per 100,000, while the rate among females was 69.8 per 100,000. Kansas' initiatives to continue to lower the nonfatal injury rate have centered on car seat safety, poison control resources, and accessibility to carbon monoxide and smoke detectors.

Objective: Increase by 10% the number of children through age 8 riding in age and size appropriate car seats per best practice recommendations by 2020.

Local MCH Agency Strategies: Child injury education is addressed during developmental screenings, immunizations, health assessments and home visits provided by local MCH agencies. Child injury education needs are based on age and development. Many local MCH agencies have staff that are Child Passenger Safety Technicians. For example, Morris County Health Department continues to have a strong Safe Kids Coalition. MCH program staff provide education and equipment/devices recommended by Safe Kids Kansas/Worldwide. There is also a Certified Car Seat Technician that installs and checks car seats. Seward County Health Department staff participated in the Children's Fun Fair. Information regarding car

seats was provided to attendees. Children were weighed and measured by the certified car seat technician and advised what type of car seat is recommended for each child. University of Kansas Medical Center Research Institute School of Medicine Wichita provides infant safety education related to car seat education and installation during Becoming a Mom® prenatal education sessions.

Objective: Increase the proportion of families receiving education and risk assessment for home safety and injury prevention by 2020.

Safe Kids Collaboration: Local MCH agencies collaborate with Safe Kids Kansas for injury prevention and program guidance on topics including water safety, sun safety, poison control, car seat safety, safe sleep, choking, fire, carbon monoxide, and preventing falls.

Home Safety Checklist/Tool: To enhance home safety information and education provided as part of prenatal and postnatal visits/sessions during infancy and early childhood, the MCH Child and Adolescent Health Consultant developed a standard tool for MCH home visitors to assess environments for potential harm or injury in the home environment. The MCH Child and Adolescent Health Consultant also met with the Director of Injury and Disability Prevention programs and Safe Kids Kansas to discuss if there was a tool related to home safety that would be appropriate for home visitors and prenatal education providers. Although, it was found that a home safety checklist existed at Safe Kids Worldwide, it wasn't comprehensive enough to cover the MCH state action plan priority areas around health and safety. Other discussions took place with the MCH Perinatal Consultant and Home Visiting staff to determine if there were any other resources to be utilized prior to developing something new. Local agency and state examples were reviewed for relevance and adaptation. After speaking with home visiting program coordinators in each region of the state, it became apparent that nothing comprehensive had been developed for home safety. A review of safety checklists began and after attending the AMCHP conference, a follow-up conversation with a Training and Technical Assistance Associate at Children's Safety Network was had. It was recommended to review the checklists and tools available by the American College of Preventive Medicine and Massachusetts Department of Health. The materials were found to be relevant to our work and comprehensive. A checklist was adapted from the home safety checklists from the American College of Preventive Medicine and Massachusetts Department of Public Health. Information from the Safe Kids checklist was also incorporated. The information was compiled and a revised checklist was shared for input with MCH staff as well as home visitors of our local grantees at the annual Governor's Public Health Conference on April 26, 2017. We hope to include the checklist into DAISEY and have it readily available to the home visitors and partners delivering the *Becoming a Mom*® education to provide home safety education during prenatal sessions.

Poison Dangers in the Diaper Bag: MCH and child care staff contributed to a collaboration with the University of Kansas and other partners to develop poison control resources, including the *Poison Diaper Bag* (available in English and Spanish <http://www.kumed.com/medical-services/poison-control/info-for-families>) (see image below). During 2016 and 2017 updates were made to the Kansas prenatal education curriculum in an effort to standardize. As part of the update, Poison Diaper Bag handout was incorporated, along with a handout on infant choking.

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## Poison Diaper Bag

Be wary of the danger you may carry

**Diapers, baby wipes and crayons**

May be a choking hazard.

**Diaper cream**

May cause stomach upset and diarrhea if large amount is swallowed.

**Hand sanitizer**

Contains alcohol, so may cause a child to vomit or appear drunk; may irritate eyes, skin and mouth.

**Baby powder**

May cause eye and throat irritation; if inhaled could cause serious breathing problems.

**Baby oil**

May cause stomach upset and diarrhea but can also easily go down the wrong way, into the lungs when swallowed, causing serious problems.

**Prescription and over-the-counter medicines**

May cause a wide variety of minor to serious problems, depending on product.

**Teething gel**

May cause serious harm if swallowed.



**Sunscreen**

May cause stomach upset and diarrhea; may cause eye and mouth irritation.

**Insect repellent**

May irritate eyes and mouth; possible seizures if swallowed.

**Lotion**

May cause stomach upset and diarrhea if large amounts swallowed.

Poison centers offer free, confidential medical advice 24 hours a day, seven days a week through the Poison Helpline at 1-800-222-1222.



Smoke Detectors for CYSHCN: KS-SHCN focuses on developing partnerships among programs statewide. Since children with special health care needs are children first, it is important that they learn the same safety skills as other children. The KS-SHCN partnership with Safe Kids Kansas provides free smoke and carbon monoxide detectors in homes of families of children with special needs. Safe Kids Kansas provides the detectors and specialized community partners to install the devices in the family's home and review safety tips with parents. KS-SHCN provides funding to cover the cost of any detectors that need to be customized due to the special health care need of the child or family. KS-SHCN program offers this service to all families identified as not having a smoke or carbon monoxide detector through care coordination. Care coordinators share safety tips with families per Safe Kids Kansas recommendations. Care coordinators work with families who rent their home, to advocate for their landlords to install smoke and carbon monoxide detectors in their rental homes. Many CYSHCN families who rent have been successful in getting detectors provided by their landlords. Protocols and procedures were developed and implementation began Summer 2015. A log is kept of all smoke and carbon monoxide detectors given out.

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### **SPM 3: Physical Activity (children 6 through 11; adolescents 12 through 17)**

The 2008 Physical Activity Guidelines for Americans recommend that children and adolescents ages 6-17 get 60 minutes or more of physical activity daily with most of the 60 minutes being either moderate- or vigorous intensity aerobic physical activity.

The revised National Survey of Children's Health (NSCH) will capture physical activity of at least 60 minutes per day with baseline NSCH data reflecting at least 20 minutes per day. The overall finding from the 2011/12 NSCH, based on parent-reported data, was that 28.2% of Kansas children ages 6-17 were physically active for at least 20 minutes seven days a week. The percentage of children who participated in at least 20 minutes of physical activity every day decreased as age increased, 36.0% for children ages 6-11, and 19.9% for adolescents ages 12-17. A higher percentage of non-Hispanic black children (31.6%) who participated in at least 20 minutes of physical activity every day compared to non-Hispanic white (29.2%) and Hispanic children (21.1%). In addition, 33.5% of males participated in at least 20 minutes of physical activity every day, compared to 22.6% of females.

The Kansas Youth Risk Behavior Surveillance System (YRBSS) data are self-reported by students in grades 9 through 12. In 2013, 28.3% of Kansas students had been physically active doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time for a total of at least 60 minutes per day on each of the 7 days before the survey (i.e., physically active at least 60 minutes per day on all 7 days). The prevalence of having been physically active at least 60 minutes per day on all 7 days was higher among male (37.1%) than female (19.1%) students. The prevalence of having been physically active at least 60 minutes per day on all 7 days was higher among 9th-grade (30.4%) than 10th-grade (27.0%), 11th-grade (28.8%) and 12th-grade (26.4%) students. The prevalence of having been physically active at least 60 minutes per day on all 7 days did not change significantly from 2011 (28.3%) to 2013 (30.2%).

Objective: Increase the percent of home-based child care facilities implementing daily routines involving at least 60 minutes of daily physical activity per CDC recommendations to decrease risk of obesity by 2020.

Made possible with MCH support, the Child Care Licensing (CCL) program collaborated with the KDHE Bureau of Health Promotion to develop a training with the *Let's Move* principles. This training is available to child care providers through the online learning portal, KS-TRAIN. Pre and post surveys are conducted to assess and measure a provider's understanding of what physical activity means per the CDC guidelines. The goal is to help children increase the number of minutes per day of physical activity, that raises their heart rate, performed while in out of the home settings. The ultimate goal being 60 minutes per day for each child. Training is offered to child care providers at no cost. To date, 84 child care centers and 70 family care providers have completed the course.

Objective: Increase the percent of children and adolescents (K-12 students) participating in 60 minutes of daily physical activity.

Local MCH Agency Strategies: Information was distributed to clients regarding the American Academy of Pediatrics' Healthy Habits along with importance of daily physical activity. Local MCH agencies encouraged and promoted physical activity among children and youth through counseling during developmental screenings, home visits, and WIC appointments. Families were educated at each visit about physical activity the entire family can focus on. Families were encouraged for children and adolescents to have at least 60 minutes of physical activity daily. Some local MCH agencies provided presentations to students in elementary/middle schools regarding physical activity.

Jefferson County Health Department worked in collaboration with the local school district to educate youth on the importance of daily physical activity. They jointly purchased the "Adventures to Fitness" subscription, which is an evidence-based tool used to take students on a fun exercise adventure. Students engaged in moderate to intense physical activity for 20-30 minutes in the school gymnasium before classes begin. A school committee was formed to plan and organize the morning activities, and middle/high school students, teachers and support staff assisted with leading and supervising wellness activities. The overall goal is to incorporate lifelong wellness into the students' everyday lives. Another goal was to gauge whether or not students were more attentive in class and if they were more eager to learn on the days they exercised compared to days they did not exercise. Students, administrator, teachers, and students were given questionnaires at the end of the year regarding success of the program. Overall responses were overwhelmingly positive. The school district and local health department are planning to launch the program every fall.

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#### **Other Activities Impacting the Child Population (relates to NPM 11 Medical Home, children with and without special health care needs)**

The Title V program partnered with the University of Kansas School of Medicine - Wichita and Kearny County Hospital in FY2016 to assess community members' perceptions, knowledge, attitudes, and desires related to health services in Kearny County in order to address gaps in needed care. The MCH Block Grant supports activities to assure access to quality care, especially for those with limited availability of care. The frontier nature of Kearny County results in limited availability of care for some residents, an issue that requires attention and creative strategies. MCH also supports efforts to increase the number of children receiving health assessments and follow-up diagnostic and treatment services and to provide and ensure access to preventive and child care services as well as rehabilitative services for certain children.

The project focused on working closely with the Pioneer Care Advocacy Team (PCAT) to develop plans to address health care, health information, and social services needs identified in the survey and focus groups. PCAT previously conducted interviews with Emergency Department (ED) visitors, or their parents if children or adolescents, over a 45-day period in September and October 2015. Data indicates that 39% of the 136 patients interviewed during ED visits during the data period were children and adolescents 0-18 years of age (23% 0-6 YO; 16% 7-18 YO). Interview data also indicates that over 70% of those interviewed had primary care physicians (PCP), yet only about 19% had contacted their PCP or a clinic to request to be seen prior to coming to the ED. Clearly, families that use ED services in lieu of PCPs are less likely to access and receive these important services than those having regular contact with their PCP.

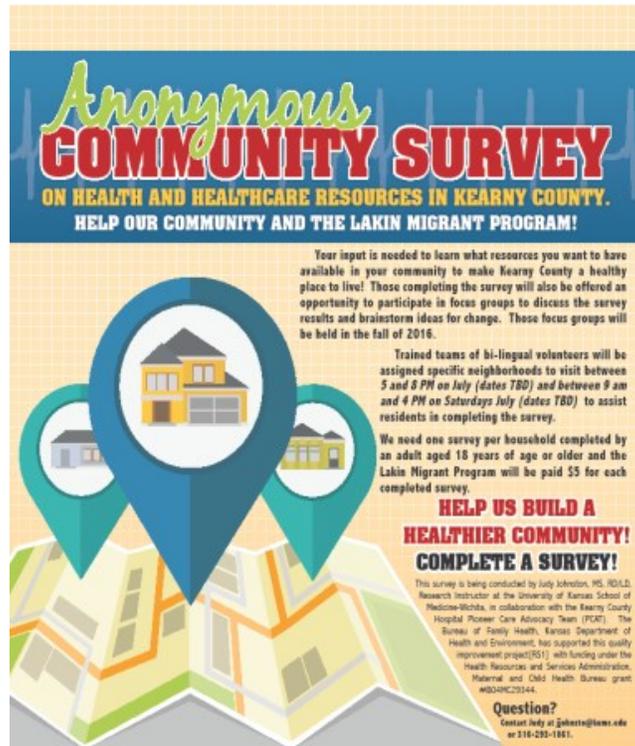
ED interviews, a community survey\* (see flyer below), and focus groups were conducted in Kearny County. The community survey July/August 2016 resulted in 865 useable surveys and data regarding health and wellness beliefs, perceptions and desires related to health and wellness resources in eight community sectors (healthcare, public health, daycare/preschool, public schools, worksites, faith communities, K-State Research & Extension, and the community environment) of that county. A total of 45 trained community volunteers collected surveys in Kearny County. Demographic information on respondents follows.

- **68.8% of survey respondents had children ≤ 18 years of age in the home**
- 48.7% of survey respondents were age 18-44 years of age
- 72.9% of survey respondents were female
- 30% of survey respondents reported annual household income of ≤ \$40,000

A poster presentation focused on the survey methodology, health/wellness beliefs, and healthcare sector data has been accepted at the Society of Behavioral Medicine (SBM) Annual Conference in San Diego in March 2017. In addition, the Kearny

County Hospital CEO and community partners presented survey results in multiple venues in Kearny County as well as in meetings with healthcare system planners in Harper County, hospital administrators in southwest Kansas, local and state elected officials from numerous southwest Kansas counties, and other community organizations throughout the state. A special presentation of study findings was provided to the faculty of the Department of Preventive Medicine and Public Health, KU School of Medicine-Wichita in November 2016. As a result of the findings and action in Kearny County, Kearny County Hospital received a Blue Cross Blue Shield Pathways to Healthy Communities grant.

*\*Kearny County/Southwest Kansas Health Assessment - Community Survey Flyer*



**Anonymous  
COMMUNITY SURVEY**  
ON HEALTH AND HEALTHCARE RESOURCES IN KEARNY COUNTY.  
HELP OUR COMMUNITY AND THE LAKIN MIGRANT PROGRAM!

Your input is needed to learn what resources you want to have available in your community to make Kearny County a healthy place to live! Those completing the survey will also be offered an opportunity to participate in focus groups to discuss the survey results and brainstorm ideas for change. These focus groups will be held in the fall of 2016.

Trained teams of bi-lingual volunteers will be assigned specific neighborhoods to visit between 5 and 8 PM on July (dates TBD) and between 9 am and 4 PM on Saturdays July (dates TBD) to assist residents in completing the survey.

We need one survey per household completed by an adult aged 18 years of age or older and the Lakin Migrant Program will be paid \$5 for each completed survey.

**HELP US BUILD A HEALTHIER COMMUNITY!  
COMPLETE A SURVEY!**

This survey is being conducted by Jody Johnston, MS, RD, LD, Research Instructor at the University of Kansas School of Medicine-Wichita, in collaboration with the Kearny County Hospital Pioneer Care Advocacy Team (PCAT). The Bureau of Family Health, Kansas Department of Health and Environment, has supported this quality improvement project (QI) with funding under the Health Resources and Services Administration, Maternal and Child Health Bureau grant #50249C20344.

**Question?**  
Contact Jody at [jjohnst@kumc.edu](mailto:jjohnst@kumc.edu) or 316-235-1861.

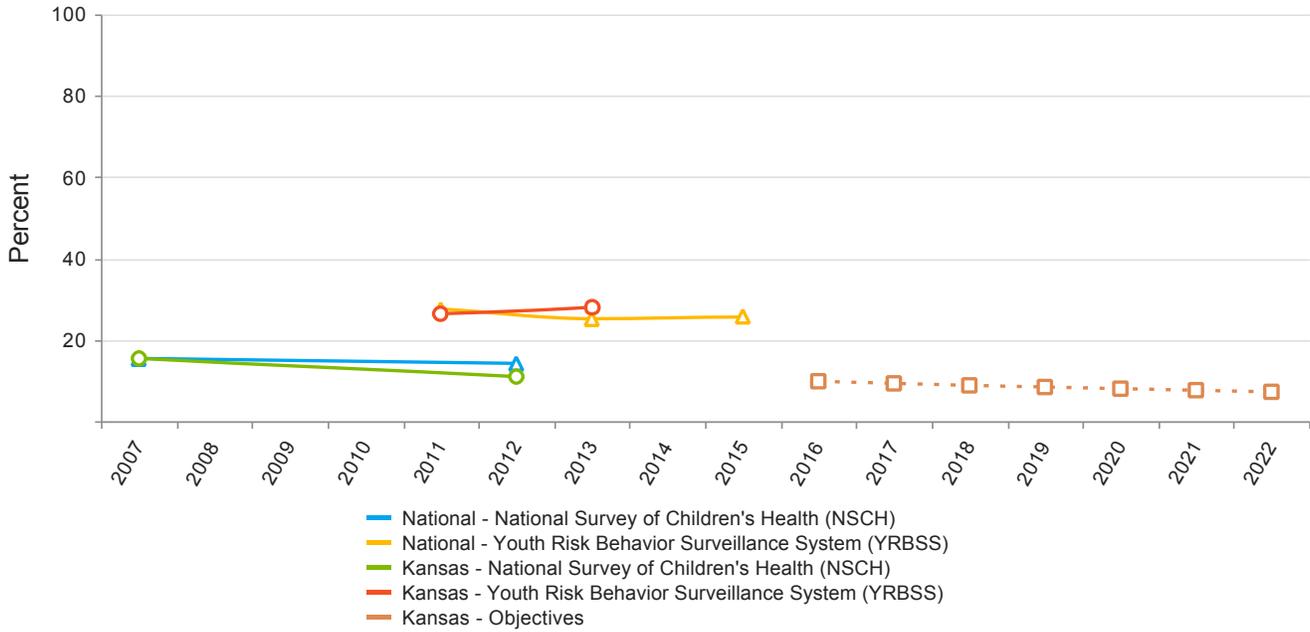
## Adolescent Health

### Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000	NVSS-2015	30.7	NPM 9 NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000	NVSS-2013_2015	14.0	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000	NVSS-2013_2015	11.0	NPM 9 NPM 10
NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling	NSCH-2011_2012	72.6 %	NPM 10
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	86.8 %	NPM 10
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	NSCH-2011_2012	30.2 %	NPM 10
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	WIC-2014	29.7 %	NPM 10
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	YRBSS-2013	28.9 %	NPM 10
NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza	NIS-2015_2016	55.6 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISF-2015	50.9 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISM-2015	36.0 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2015	87.3 %	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2015	63.7 %	NPM 10

National Performance Measures

NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others  
Baseline Indicators and Annual Objectives



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	9.9
Annual Indicator	11.0
Numerator	25,495
Denominator	231,663
Data Source	NSCH
Data Source Year	2011_2012

Federally Available Data	
Data Source: Youth Risk Behavior Surveillance System (YRBSS)	
	2016
Annual Objective	9.9
Annual Indicator	27.9
Numerator	39,871
Denominator	142,707
Data Source	YRBSS
Data Source Year	2013

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	9.4	8.9	8.5	8.1	7.7	7.3

**Evidence-Based or –Informed Strategy Measures**

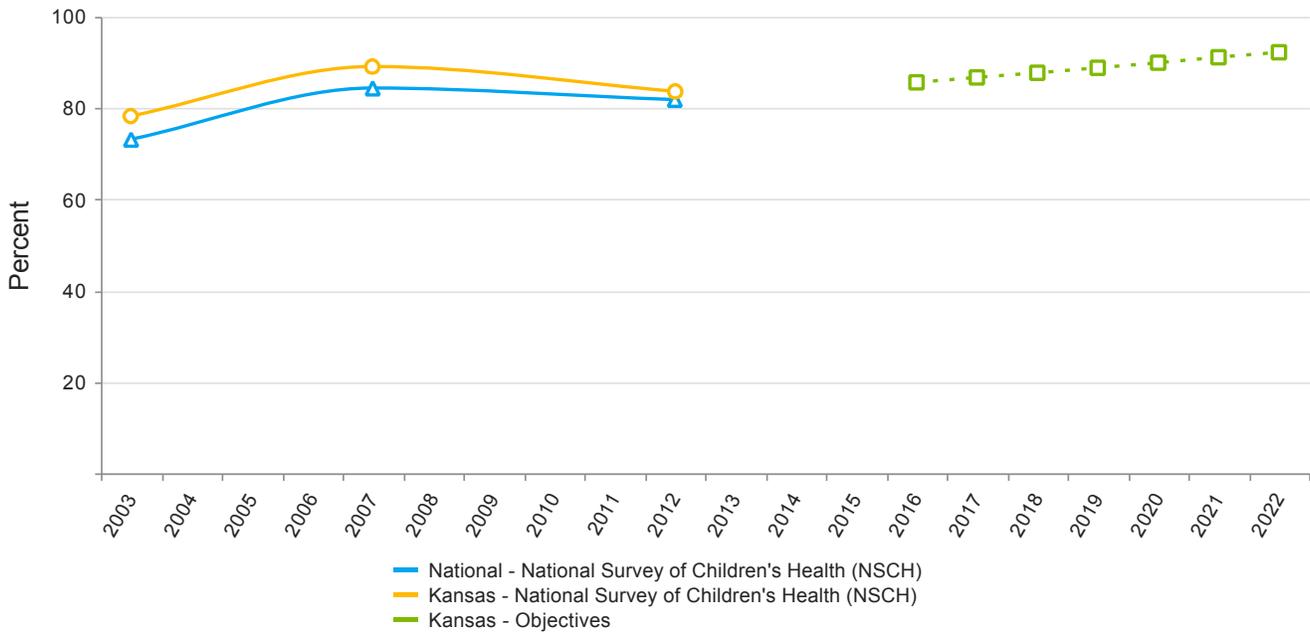
**ESM 9.1 - Number of schools implementing evidence-based or informed anti-bullying practices and/or programs**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	12
Numerator	
Denominator	
Data Source	Second Step Schools
Data Source Year	2015-2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	12.0	12.0	24.0	24.0	24.0	24.0

**NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.  
Baseline Indicators and Annual Objectives**



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	85.5
Annual Indicator	83.4
Numerator	191,615
Denominator	229,749
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	86.6	87.6	88.7	89.8	91.0	92.1

**Evidence-Based or –Informed Strategy Measures**

**ESM 10.1 - Percent of adolescent program participants (12-21 years) that received education on the importance of a well-visit in the past year**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	17.3
Numerator	744
Denominator	4,297
Data Source	DAISEY
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	30.0	40.0	50.0	60.0	70.0	80.0

**State Action Plan Table**

State Action Plan Table (Kansas) - Adolescent Health - Entry 1

Priority Need

Communities and providers support physical, social and emotional health.

NPM

Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Objectives

- 4.1 Develop a cross-system partnership and protocols to increase the proportion of adolescents receiving annual preventive services by 2020.
- 4.2 Increase the number of adolescents receiving immunizations according to the recommended schedule by 2020.

Strategies

4.1.1 Engage health care providers, Medicaid and Managed Care Organizations to promote annual well-child visits through adolescence into adulthood. 4.1.2 Engage school nurses to identify and refer children and adolescents with an Individualized Healthcare Plan (IHP) who have not had a well visit in the past year. 4.1.3 Partner with schools to evaluate the capacity and infrastructure to provide school-based services for physical, social, and emotional health needs.

4.2.1 Increased awareness of, access to, and utilization of the Vaccines for Children (VFC) program. 4.2.2 Provide parent education on immunizations, including schedules, and the importance to child and adolescent health. 4.2.3 Identify and promote existing vaccination programs and campaigns. 4.2.4 Work with Immunize Kansas Coalition (IKC) to increase HPV vaccination completion for youth ages 13-17 years.

ESMs	Status
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ESM 10.1 - Percent of adolescent program participants (12-21 years) that received education on the importance of a well-visit in the past year	Active
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## NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000

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NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

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NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

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NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling

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NOM 19 - Percent of children in excellent or very good health

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NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

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NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

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

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

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

State Action Plan Table (Kansas) - Adolescent Health - Entry 2

Priority Need

Communities and providers support physical, social and emotional health.

NPM

Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Objectives

4.3 Increase the number of schools that are implementing programs that decrease risk factors associated with bullying by 2020.

4.4 Increase the number of adolescents aged 12 through 17 years accessing positive youth development, prevention, and intervention services and programs by 2020.

4.5 Increase access to programs and providers serving adolescents that assess for and intervene with those at risk for suicide.

## Strategies

4.3.1 Identify evidence-based programs in partnership with the Bureau of Health Promotion (BHP) that decrease risk factors associated with bullying through parental involvement, curriculum integration, and school staff-wide training. 4.3.2 Work with BHP to help schools improve school-based bullying policies to meet best practices. 4.3.3 Provide information to school nurses and counselors on how to respond to bullying. 4.3.4 Partner with school nurses and counselors to provide access to behavioral health services in schools. 4.3.5 Explore options for educating and reporting unsafe social media and digital content.

4.4.1 Provide annual training on Adverse Childhood Experiences (ACEs) and trauma-informed responses and approaches for MCH staff, grantees, and partners working with adolescents and their families. 4.4.2 Partner with communities to connect adolescents with supports and mentors in safe, accessible environments to reduce risky behaviors and promote protective factors and healthy relationships including abstinence. 4.4.3 Support public awareness campaigns to prevent adolescent self-injury. 4.4.4 Make accurate, age appropriate information on reproductive health and healthy relationships, including the benefits of abstinence and avoiding risky behaviors more easily available to youth and their families. 4.4.5 Identify methods to increase adolescent awareness of services and programs available to them in their community.

4.5.1 Develop follow-up protocols for families to be referred for behavioral health services and offer additional support as needed to assure services are received. 4.5.2 Behavioral health awareness days with free screenings across the state. 4.5.3 Provide school-based access to confidential mental health screening, referral and treatment that reduces the stigma and embarrassment often associated with mental illness, emotional disturbances and seeking treatment. 4.5.4 Increase access to substance abuse screening, treatment and prevention services through co-locating screening, treatment and prevention services in schools and/or facilities easily accessible to adolescents in out of school time. 4.5.5 Promote the yellow ribbon initiative and accessible crisis services through school and out-of-school activities.

## ESMs

## Status

ESM 9.1 - Number of schools implementing evidence-based or informed anti-bullying practices and/or programs Active

## NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

## Adolescent Health - Plan for the Application Year

**PRIORITY:** Communities and providers support physical, social and emotional health

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

**NPM 10:** Adolescent well-visit (12 through 17)

*Local MCH Reach:* Based on 2017-2018 MCH Aid to Local applications received, 47 of 70 (67%) of grantees plan to provide services to the Adolescent population

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### **NPM 9: Bullying (12 through 17, who are bullied or who bully others)**

Resources, including websites and tools, related to bullying will be reviewed and shared, as appropriate, with MCH grantees, schools, and "ready" communities across the state prior to launching efforts.

- Landscape Assessment, Community Action Toolkit ([www.stopbullying.gov](http://www.stopbullying.gov))
- Preventing Bullying Through Science, Policy, and Practice (<http://www.nap.edu/23482>)
- Measuring Bullying Victimization, Perpetration, and Bystander Experiences: A Compendium of Assessment Tools ([www.cdc.gov/violenceprevention](http://www.cdc.gov/violenceprevention))
- School Climate Survey Compendium (<http://safesupportivelearning.ed.gov/topic-research/school-climate-measurement/school-climate-survey-compendium>)
- Mental Health Community Conversations Toolkit (<http://www.samhsa.gov/community-conversations>)

*Local MCH Agency Strategies:* Local agencies (70%) are focusing efforts on the bullying measure and related state action plan objectives and strategies. Specifically, they collaborate with local school districts in providing anti-bullying campaigns, information, education, and counseling. Local agencies are also participating in local coalitions that provide education to first-line providers, educators and parents on mental health and bullying. Bullying is also addressed during adolescent well visits conducted in local MCH clinics using Bright Futures materials.

Objective: Increase the number of schools that are implementing programs that decrease risk factors associated with bullying by 2020.

MCH aims to continue facilitating collaborations among organizations leading bullying prevention efforts including the Kansas State Department of Education (KSDE), Kansas Department of Health and Environment's Injury Prevention Program, schools, community agencies, and coalitions.

*School-Based Policy/Program Development and Improvement:* Bullying is related to the climate of the school and is most strongly and significantly related to the respect that students feel in the school, especially among their peers. Thus, where there is a respectful environment, bullying is less likely to exist in schools. The KDHE Bureau of Health Promotion (BHP) contracted with 15 schools in 2016 to implement the Second Step Program, an evidence-based anti-bullying prevention program. Title V is exploring partnership opportunities with the Bureau of Health Promotion, Injury Prevention to increase the number of schools implementing programs that promote social-emotional and character development (SECD). SECD is an evidence-based strategy that integrates the intellectual, emotional, and social facets of learning. The benefits of SECD are improved attitudes about self, others, and school as well as positive classroom behavior.

MCH plans to work closely with the Bureau of Health Promotion to improve school-based bullying policies to meet best practices. A survey was adapted from the teacher version of the Authoritative School Climate Survey to assess school personnel's perspectives of bullying. The survey will be sent out during the upcoming 2017-2018 school year and will advance our bullying prevention efforts by providing baseline data for the measure which will be used to figure out the prevalence and monitor the effect our efforts are having. We hope to disseminate the survey via the listserv maintained by the KSDE School Counseling Program Consultant.

The BHP Sexual Violence Prevention and Education Coordinator oversees the local school programs and coordinates the Second Step program and has been helpful in connecting the MCH Child and Adolescent Health Consultant with leaders of bullying prevention including the Executive Director of a local Secondary Trauma Resource Center that provides training to schools and organizations on secondary trauma. Conversations took place about how to collaborate around the work that MCH does with schools and communities. The MCH consultant has also worked closely with the Kansas State Department of Education (KSDE) School Counseling Consultant and Social-Emotional Character Development Coordinator to learn more about state bullying laws and the impact on schools as well as policies in place and activities supported by school counselors.

*Kansas State Department of Education Family & Consumer Sciences Partnership:* Ongoing conversations have been taking place with the KSDE Family and Consumer Sciences (FCS) Consultant who has access to more than 400 FCS teachers in school districts across Kansas. We are also exploring partnership opportunities with FCS teachers and engaging youth in Family, Career and Community Leaders of America (FCCLA). Family and Consumer Sciences Education body of knowledge is focused on improving the quality of life of the individual who in turn influences family strength and community wellness, ultimately impacting our society's wellness. The FCS philosophy and practice is based upon the theories of Maslow's Hierarchy of Needs and Bronfenbrenner's Ecological Model, both focusing upon the needs of the individual. In Kansas, the term "life literacy" has been adopted to explain the knowledge and skills an individual needs to hold to make intelligent life decisions. Standards have been set for the FCS classroom which focuses upon the younger adolescent (middle level) and the older adolescent (secondary level). Each comprehensive standard has content standards which better illustrates the knowledge and skills to be addressed. Local coursework aligns to these standards. The middle level courses are usually designed to meet local needs in the life literacy arena. The secondary level FCS offerings includes courses which specify course competencies as part of the Career and Technical Education program as these life literacy skills are the foundation to human services and family and consumer sciences careers. We hope to insert and/or create curricula related to Title V measures and priorities based on the needs of the students and community.

An alignment of the FCS Standards/FCCLA activities and the Title V Adolescent Health priorities/objectives revealed an abundance of opportunity for the future! Additionally, the FCS Consultant presented to the adolescent domain group of the Kansas Maternal & Child Health Council on April 5, 2017, to discuss recommendations including:

- Training students and teachers in Youth Mental Health First Aid and training FCS Sciences teachers in Positive Youth Development.
- Adding Adverse Childhood Experiences (ACES) and Mental Health First Aid training to the annual Kansas School Nurse Conference (added and reflected in the 2017 conference brochure).
- Presenting information at the annual Kansas School Nurse Conference related to strategies for partnership between nurses and FCS teachers/FCCLA leaders (on prevention education and planning to improve health outcomes and advance the MCH state action plan) (added and reflected in the 2017 conference brochure with the following objectives:
  - Understand how the Family and Consumer Sciences (FCS) Body of Knowledge, real work experiences and inquire based strategies of the FCS classroom promote healthy decision making in today's youth.
  - Learn how FCS teachers are collaborating with school nurses.
  - Identify how partnerships with your local FCS teacher can assist your work.

Discussions have also involved the Kansas State University (KSU) Associate Professor and Extension Specialist/Youth Development Associate Director with the School of Family Studies and Human Services to assure alignment with the adolescent health needs assessment conducted as part of the broader MCH 5-year needs assessment. The KSU program led implementation of the needs assessment and compiled the recommendations (below) and proposed strategies.

- RECOMMENDATION 1: Address the highest priority adolescent health issues.
- RECOMMENDATION 2: Help families support the health and well-being of their adolescents.
- RECOMMENDATION 3: Provide educational environments that prepare youth for healthy adulthood.
- RECOMMENDATION 4: Encourage collaborations and increase community support for those working for and with youth.
- RECOMMENDATION 5: Improve the responsiveness, availability and access of health care to youth.

Objective: Increase the number of adolescents aged 12 through 17 years accessing positive youth development, prevention, and intervention services and programs by 2020.

Kansas Youth Leadership Summit: We are exploring partnering to either present or assist with sponsoring the Kansas Youth Leadership Summit in July 30-August 1 2017. We hope increase the number of adolescents aged 12 through 17 years accessing positive youth development, prevention, and intervention services and programs

(<http://www.kansasfamily.com/programs/kansas-youth-leadership-summit/#get-involved-with-kansas-youth-leadership-summit>).

Care Coordination Trainings: Youth with special health care needs will continue to be encouraged to participate in the Family Care Coordination Trainings held by the KS-SHCN team. Youth participation will continue to be monitored and evaluated to see if a training for youth needs to be conducted separately from parents/caregivers. Referrals will continue to be made to the Faces of Change program through the Kansas Youth Empowerment Academy (KYEA) for those who are qualified.

CYSHCN, ACEs, and TIC: The Special Health Services Family Advisory Council (SHS-FAC) has exhibited an increased interest in trauma informed care/approaches. These family members have developed a one-page information sheet to help educate providers about this important topic. In the coming year, the members of the TIC Work Group will continue to refine their ideas around educating on this topic, including the development of a dissemination plan for the developed materials. Additionally, trauma informed care will be an ongoing area of interest for the KS-SHCN program, including providing additional trainings to the Satellite Offices and Aid to Local grantees. The 2017 Satellite Office training with the existing and new care coordinators will include opportunities for role playing with parents and youth who exhibit a high ACE's score, have experienced trauma, or are currently experiencing a traumatic event.

Objective: Increase access to programs and providers serving adolescents that assess for and intervene with those at risk for suicide.

Mental Health First Aid: The MCH program has been involved in ongoing discussions related to increasing access to mental health first aid training, for school personnel/teachers/nurses, MCH local agency staff including home visitors, and any other community level partner providing services for adolescents. Plans involve promoting mental health first aid training (and leveraging those already trained across the state in multiple sectors/settings), more involvement with school mental health initiatives at the state and local levels, distribution of resources via counselor and MCH local agency listservs, and updating websites and social media sites with relevant resources and information, including professional development/training opportunities.

Yellow Ribbon Program: The MCH Child and Adolescent Health consultant is exploring information about the Yellow Ribbon program/campaign. Yellow Ribbon is a suicide prevention program that empowers people (of all ages) to raise awareness about and to prevent youth/teen suicide. Kansas Family Partnerships (KFP) coordinates statewide drug awareness campaigns, provides youth drug prevention programs, provide substance abuse prevention materials and resources, education for prevention professionals and advocacy for sound drug policy. The MCH program intends to work with all local Kansas Yellow Ribbon Chapters in some way.

Youth Mental Health Awareness: The Title V MCH Director was invited by the Kansas Department on Aging and Disability Services (KDADS) to participate in the *Proclamation of Child Mental Health Awareness Day*, with an official signing by Governor Brownback on April 27, 2017. The signing was also attended by the Department for Children and Families (DCF), State Department of Education (KSDE), community mental health centers, consumers, and more. We look forward to continued work with KDADS, DCF, KSDE, and partners to increase awareness and do more together to address the mental health needs of infants, children, adolescents, women, and their families.



## NPM 10: Adolescent well-visit

Objective: Develop a cross-system partnership and protocols to increase the proportion of adolescents receiving annual preventive services by 2020.

Local MCH Agency Strategies: Local agencies provide adolescent well visits along with behavioral health screening in accordance with Bright Futures standards and guidelines. Smaller agencies that do not provide clinic-based services educate parents and adolescents about the importance of a yearly preventative visit and refer them to their Family Planning clinic or local providers in their community.

Thirty percent of the local MCH grantees are focusing efforts on increasing access to the adolescent well visit. The Community Health Center of Southeast Kansas (CHC/SEK) (MCH grantee and Federally Qualified Health Center) health assessments and internal reporting indicates that the adolescent population is in need of greater interventions especially in the area of preventive health. Efforts to address this are underway with CHC/SEK working directly with one of the MCOs to identify their participants in this age cohort who are in need of an annual exam and encourage them to follow up. A program to accomplish this has been developed through our Communication Center; coordination of this effort is now under the direction of the MCH Coordinator who is responsible for eliminating any barriers that are keeping adolescents from accessing this care (e.g. transportation, lack of insurance coverage, etc.).

National MCH Workforce Development Center School-Based Health Initiative: Adolescence is a crucial time for preventive interventions, because it's a period of significant physical, behavioral and emotional growth. In an effort to increase access to preventive health services and comprehensive well-visits for adolescents, Title V along with key partners is developing a model for the establishment of school-based health centers in Kansas with technical assistance provided by the National Maternal & Child Health Workforce Development Center, University of North Carolina (UNC), Chapel Hill. We applied to participate in the National MCH Workforce Development Center Cohort 2017 to develop a model for school-based health centers that, once piloted, can be replicated in schools across the state to improve the rate of adolescent well-visits. Desired outcomes for the project include:

- develop a model or structure to provide well visits for youths in school settings;

- reduce barriers in obtaining preventative services;
- provide opportunities for adolescents to obtain routine yearly exams; and
- increase youth/family understanding of the importance of making a well medical visit a yearly routine.

The project will involve partnering with schools and medical providers along with community partners to evaluate the capacity and infrastructure to provide school-based services, followed by development of best practices, existing policies, and effective procedures that address components identified as key to successful development and implementation of a school-based health center. The model will provide guidance and information for stakeholders and partners to support local implementation of the model. Capacity in the MCH workforce will be developed in the following areas: effective cross-sector collaboration and systems integration, quality improvement, and evidence-based implementation strategies.

Despite consensus among providers, community partners, and well-established guidelines for adolescent preventive care, delivery of annual preventive visits and services is consistently below recommended levels. One potential measure of adolescents' access to annual well visits could be the percent of children with a medical home. In Kansas, the percent of children who receive care that meets the American Academy of Pediatrics (AAP) definition of a medical home is steadily declining. Additionally, survey data collected as part of a statewide adolescent health needs assessment conducted in 2015 by Kansas State University highlights a number of barriers to adolescents accessing services. Lack of knowledge and cost/affordability were identified as the top barriers. Other prevalent barriers noted during the needs assessment process include: embarrassment or shame associated with accessing health services, a lack of understanding of the need for health services, and a lack of available transportation to access needed services. This project will address barriers by building community capacity to provide preventive health services where the adolescents attend school, reducing the need for transportation and improving access to services. Additionally, provision of services in the school setting can support adolescents seeking medical advice related to questions and concerns that might be considered embarrassing if they had to request their parents take them to the doctor. With an emphasis on prevention, early intervention, and risk reduction, school-based health centers are intended to provide the support youth need to enter adulthood healthy. Additionally, school-based health centers can bridge the divide between health and education by incorporating public health approaches to achieve population health and equity. All of this is likely to increase the percent of well-visits or preventive services received by adolescents.

*WDC School-Based Health Project Team Roster*

Name	Title	Agency
Rachel Sisson	Bureau Director/ Title V MCH Director	KDHE Bureau of Family Health (BFH)
Heather Smith	Section Director/Title V CYSHCN Director	KDHE BFH, Special Health Services Section
Traci Reed	Section Director	KDHE BFH, Children & Families Section
Kayzy Bigler	SHCN Program Manager	KDHE BFH Special Health Services Section
Tamara Thomas	Child & Adolescent Health Consultant	KDHE BFH, Children & Families Section
Elaine Johannes	Associate Professor and Extension Specialist	Kansas State University Extension
Kari Harris	Assistant Professor and Physician	University of Kansas – Wichita Pediatrics
Cassandra Sines	Consumer rep – family member	Parent, Family Advisory Council Member
TBD	Consumer rep – youth	
Chris Steege	Executive Director	American Academy of Pediatrics, KS Chapter
Krista Postai	President & CEO	Community Health Center of Southeast Kansas
Jason Wesco	Executive Vice-President	Community Health Center of Southeast Kansas
Annie Wallace	President	Kansas School Nurse Organization
Sharon Johnson	Management Systems Analyst II	KDHE Division of Health Care Finance
Kasey Sorell	Clinical Initiatives Nurse	KDHE Division of Health Care Finance
Warren Hays	School Health Program Manager	KDHE Bureau of Health Promotion

WDC School-Based Health Initiative Flyer & Adolescent Health Fact Sheet (page 1 of 2)

## KANSAS ADOLESCENT SCHOOL-BASED HEALTH INITIATIVE



**Goal:** Increase access to preventive health services and comprehensive well-visits for adolescents by developing a model for the establishment of school-based health centers\* in Kansas.

- In phase 1, the Title V Maternal & Child Health (MCH) program leads development of the model. The model will provide guidance and information for stakeholders and partners to support local implementation of the model.
- Capacity in the MCH workforce will be developed in the following areas: effective cross-sector collaboration and systems integration, quality improvement, and evidence-based implementation strategies.

This project aligns with the National MCH Performance Measure #10:

- Percent of children aged 12 to 17 who had a well-visit in the past 12 months.

\*School-based health centers represent multiple sectors: all comprehensive health, oral, and behavioral services. With support of national technical experts, the model developed for the establishment of comprehensive school-based health centers will address the needs of children and youth receiving an annual well visit, and will expand access to all health care services. Services that may be provided at schools are based on local needs and are supported as part of Kansas' Title V MCH state plan, which receives an annual re-approval.

### PHASE 1: DEVELOPMENT 2017

**Key Partners\***

- Kansas Department of Health & Environment (Public Health and Medicaid)
- Parents and Families
- Youth (adolescents/students)
- University of Kansas – Wichita Pediatrics
- Community Health Center of Southeast Kansas
- Kansas State University Research & Extension
- American Academy of Pediatrics, Kansas Chapter
- Kansas School Nurse Organization

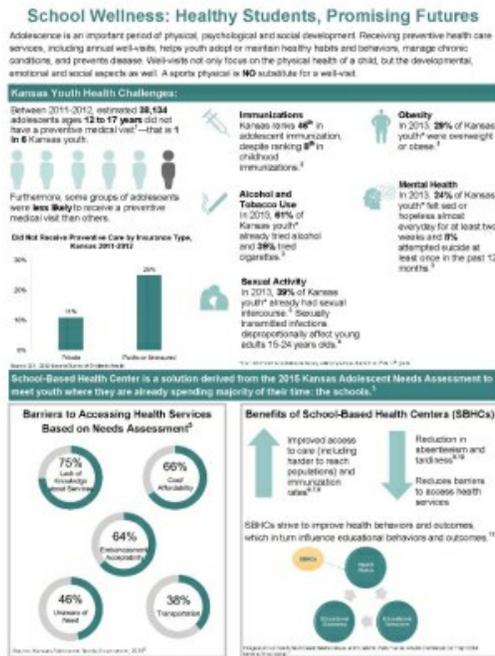


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**Care Coordination for Adolescent Well-Visit:** KS-SHCN care coordinators will continue in SFY18 to work with adolescents to make sure they receive their routine KAN Be Healthy (KBH) exams, the Kansas Early Periodic Screening Diagnosis and Treatment (EPSDT) program.

KS-SHCN has expanded community-based services through increasing the number of KS-SHCN Satellite Offices over the past few years. This expansion not only continues in the number of SO's, but also in the level of responsibility and activities the SO will oversee. In SFY18 KS-SHCN will be adding an additional 6 SO's, bringing the total to 14. Each SO has agreed to provide care coordination services at the community level. This includes all care coordination activities that have historically taken place at the KS-SHCN Topeka Administrative Office. In July 2017, KS-SHCN SO care coordinators will receive training on transition tools, resources and transition planning to be tracked within the youth's Action Plan goals. Care coordinators will begin talking to parents/caregivers early in a child life and request that the youth participate in the transition conversation on or before the youth reaches a developmental age of 14 years. More details on the plan are provided in the report section, however a new partnership with the Children's Mercy Hospital Transition Program will enhance these activities dramatically. Through this collaboration, KS-SHCN will be better positioned to readily share transition tools and resources, as well as jointly develop new ones as the need is identified. All tools and resources will be vetted through the Special Health Service Family Advisory Council (SHS-FAC) and Kansas Youth Empowerment Academy (KYEA) prior to implementation. Youth will continue to be encouraged to participate in youth leadership programs such as the Kansas Youth Leadership Summit and the FACES of change program through KYEA. They will also be encouraged to attend transition workshops conducted by Families Together, Inc. and the KS-SHCN Family Care Coordination Trainings to continue to improve their self-awareness and self-advocacy skills (please refer to the CYSHCN Domain Report for more details on these trainings).

**Teen Pregnancy Targeted Case Management (TPTCM):** For FY18 ten local agencies across the state, including eight agencies who also provide MCH services, will provide services to pregnant and parenting teens up to age 21 years through the Teen Pregnancy Targeted Case Management program. Based on applications received for FY2018, the projected number of TPTCM participants to be served is 330. One of the objectives of the program is that all adolescents served, and their children, will access well child/adolescent programs such as early and periodic screenings and immunizations. In addition to ensuring adolescents receive prenatal medical care, TPTCM case managers educate adolescents on routine healthcare services, prevention of illness and injury, and available healthcare resources in the community. When an adolescent does not have an identified healthcare home the TPTCM case managers provide linkages to community healthcare providers. Other services the participants receive through the program either directly or through referral to other providers, include behavioral health assessment and treatment, substance abuse assessment and treatment, and domestic abuse services. All adolescents served

in TPTCM programs are Medicaid eligible. If an adolescent loses Medicaid eligibility when their pregnancy and post-partum period ends, TPTCM case managers assist them in identifying and accessing other healthcare coverage options. Helping ensure these adolescents have adequate healthcare coverage increases their ability to access needed health services, including adolescent well visits and behavioral health services on an ongoing basis.

*Title V Abstinence Education Program:* The Kansas Abstinence Education project will continue through a contract with The Children's Alliance of Kansas to coordinate abstinence education training to foster/adoptive/kinship parents and children/youth in foster care and out-of-home placement (residential care) as well as other at-risk youth through partnerships with Kansas child welfare providers and foster and adoptive family organizations. Additionally, with supplemental funding for the project period ending September 30, 2018, we propose to expand and integrate abstinence education activities through maternal and child health services in local health departments and agencies. To determine proposed targeted service areas for the supplemental funding, we first reviewed the 5-year (2011-2015) county pregnancy rates for females aged 10-19 years to identify counties above the state rate. Secondly, we cross-referenced with locations of local MCH grantees taking into consideration their identified needs and service objectives related to the adolescent population as well as their capacity and performance. As a result, grantees covering 9 counties have been identified as potential locations for the supplemental abstinence education program. All locations receive limited MCH funding to support various MCH services, and all are frontier, rural, or densely-settled rural counties along with one semi-urban county in various geographic areas statewide. Each of these local health agencies have identified adolescent health as a priority and provide services to the adolescent population such as preventive well-visits or physicals, family planning/reproductive health, education on alcohol/drug use, sexuality and risky behaviors, and collaborate with schools, juvenile justice, law enforcement, and other community services on initiatives such as suicide prevention, human trafficking, bullying, depression or other social-emotional health issues. A number of these sites have indicated a great need and interest to do more to improve outcomes for adolescents in their communities. Additional resources are needed to build their capacity to do so. To determine final locations, KDHE will conduct a request for proposals (RFP) process in early summer 2017 for implementation in FY2018. While the supplemental funding is time limited, we believe that the investment in these selected communities toward evidence-based curricula, related training, and implementation during this one year will reap longer term benefits. In addition to the youth that are reached and positively impacted during the year, the local grantees will be encouraged to align and integrate this work with their other community initiatives and future MCH services to adolescents. Linking with MCH programs in local health departments and agencies will provide a framework for sustainability after the award project period.

Objective: Increase the number of adolescents receiving immunizations according to the recommended schedule by 2020.

*Strengthening the MCH-Immunization Program Partnership:* The MCH Program plays a key role in assuring preventive interventions such as immunizations to improve the health and quality of life for women, infants, children, and adolescents. MCH programs promote routine health screenings for all children that include assessment of immunization status, assure administration of immunizations and establish systems and referral networks that link low-income children to state immunization programs. In addition to serving as Vaccines For Children (VFC) sites, local MCH agencies provide education about the importance of well visits and immunizations during all services, including home visits.

Immunizations are one of the most cost effective tools for preventing disease, and major benefits of MCH and immunization program collaboration include reduced health care costs and improved wellness. In response to the state plan objective, the MCH program at the state level is working more closely with the state Immunization Program to align measures and strategies for collective impact. Shared/joint messaging and alignment efforts are resulting in more collaboration and efficiency at the local level. The most recent MCH state plan clearly reveals the crossover between MCH and immunization as services/programs. The programs merged aid to local support for special immunization projects with MCH awards (effective FY18) to remove barriers and funding silos/limitations and promote coordination and collaboration based on the idea that MCH supports immunizations as a core function/essential public health service.

The MCH program delivered a presentation at the 2017 Immunization Conference to provide more information, specifically to enable participants to: 1) Describe how Maternal & Child Health supports immunizations as a core function/essential public health service; 2) Understand how and why the Maternal & Child Health (MCH) and Immunization Program aligned State Aid to Local funding and activities to achieve maximum impact; and 3) Identify at least one way local immunization programs can align

and integrate services with maternal and child health programs.

## Adolescent Health - Annual Report

**PRIORITY:** Communities and providers support physical, social and emotional health

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

**NPM 10:** Adolescent well-visit (12 through 17)

*Local MCH Reach:* During FY16, 50 of 80 (63%) local agencies provided services to the Adolescent population.

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### **NPM 9: Bullying (12 through 17, who are bullied or who bully others)**

According to the 2011/12 National Survey of Children's Health (NSCH), the **parent/guardian reported** prevalence of Kansas adolescents aged 12-17 years who always/usually/sometimes bullied or were cruel or mean to others in the past month was 11.0%. (The revised NSCH will also capture bullying victimization.) In Kansas, adolescents with special health care needs were more likely to be a bully than adolescents without special health care needs (19.0% and 8.4%, respectively). Hispanic adolescents (16.8%) were more likely to be a bully compared to non-Hispanic white adolescents (10.7%). Compared with adolescents whose parents had a college education, some college education or a high school education, adolescents whose parents had less than a high school education were more likely to be a bully (7.9%, 10.0%, and 11.6% versus 24.8%, respectively). Adolescents living in low-income families were more likely to be a bully than adolescents living in higher-income families. The highest percent of adolescents who were a bully were adolescents living in households with incomes below 100 percent of poverty (15.6%), followed by adolescents in households with incomes of 200-399 percent of poverty (13.5%), adolescents from households with incomes of 100-199 percent of poverty (12.3%), and adolescents in households with incomes 400 percent or more of poverty (4.2%). Adolescents without insurance coverage and with Medicaid/CHIP coverage were more likely to be a bully than adolescents with private health insurance (17.8%, 14.2% versus 8.5%, respectively). Adolescents of immigrant parents (born outside the United States) were more likely to be a bully than adolescents of American-born parents (24.2% and 8.6%, respectively). Similarly, adolescents living in non-English language households were more likely to be a bully than living in English language households (29.7% and 9.4%, respectively). Adolescents living in non-Metropolitan Statistical Areas (MSAs) and MSA, Central City were more likely to be a bully than adolescents living in MSA, Non-Central City (13.0%, 12.8% and 5.2%, respectively). There was no difference in the prevalence of being a bully between adolescents living in two-parent married households and those living in unmarried, separated, cohabiting households. There was no gender difference in the prevalence of being a bully.

The Kansas Youth Risk Behavior Surveillance System (YRBSS) data are **self-reported** by students in grades 9 through 12. In 2013, 27.9% of Kansas students had been electronically bullied (including being bullied through e-mail, chat rooms, instant messaging, websites, or texting) or who were bullied on school property, during the 12 months before the survey. The prevalence of having been electronically bullied or bullied on school property was significantly higher among female (34.6%) than male (21.6%) students. The prevalence of having been electronically bullied or bullied on school property was significantly higher among 9th-grade (36.7%) than 11th-grade (24.3%), and 12th-grade (20.2%) students.

*Local MCH Agency Strategies:* Local MCH agencies provided education and counseling on bullying during physicals and adolescent well visits from Bright Futures and the CDC. Referrals were made to mental health services, crisis centers and suicide hotlines for additional resources and to report bullying. Some local MCH agencies worked in collaboration with their local school districts and local law enforcement in educating students on bullying prevention during Red Ribbon Week as well as throughout the school year. Many local MCH agencies offered educational awareness about healthy relationships and defining what constitutes a healthy relationship is critical to understanding physical, social and emotional health. Examples include:

- Community Health Center of Southeast Kansas (CHC/SEK) (MCH grantee and Federally Qualified Health Center) employs the majority of the school nurses in the school district and has implemented standardized policies related specifically to bullying and other social pressures.
- Nemaha County Community Health Services provides materials from the Kansas Children's Service League to parents during KAN Be Healthy assessments on bullying: "Is Your Child Bullying Others," "Cyberbullying," and "Is Your Child

Being Bullied?”

- Public Health of Labette County and Wilson County Health Department staff collaborated with the local school district counselors and social workers to implementing the anti-bullying campaign, Rachel's Challenge, an evidence-based program.

*MCH Bullying Prevention Professional Development:* The Child and Adolescent Health Consultant attended the annual International Bullying Prevention Association Conference on November 6-8, 2016, in New Orleans, Louisiana. The purpose of the conference was to:

- Learn strategies for positive school climate
- Receive tools to create or enhance your student engagement efforts
- Design an inclusive school community program
- Discuss strategies to reduce social-emotional barriers to increase student learning
- Network with like-minded youth serving partners
- Gain access to a resource room packed with solutions

The conference provided new research, practices, and knowledge from outstanding leaders working around the world. Specifically, information on strategies and solutions for schools and communities to address bullying prevention and intervention were provided. Moreover, the sessions presented by experts and colleagues provided current information on challenges and solutions that are impacting adolescents today. This event was a great way for the newly hired Child and Adolescent Health Consultant to make connections and be more effective in her position. Moreover, meetings were held with Dr. Anne Williford to learn about her bullying prevention efforts. Dr. Williford's research primarily deals with understanding characteristics associated with bullying and peer victimization among children and adolescents, and identifying strategies to prevent such behaviors in school settings. She is also one of the leaders in the Kansans Against Bullying Project sponsored by the Kansas Department of Education (KSDE), the project seeks to connect cutting-edge evidence to anti-bullying policy development by providing training, online resources, and technical assistance to K-12 Kansas schools.

*HRSA's National Bullying Prevention Initiative:* The MCH Child and Adolescent Health Consultant participates in HRSA's National Bullying Prevention Initiative, an implementation work group that involves quarterly calls with state agencies that are pursuing bullying prevention.

The consultant is currently piloting HRSA's *Bullying Prevention Self-Assessment Instrument* and accompanying user guide before these get disseminated more broadly. The Instrument is an aid for planning and implementation of efforts to work with other agencies and with communities to prevent bullying. It has been developed to provide State Health Departments and other agencies, organizations, or interests with a resource they can adapt to their own needs for strengthening bullying prevention. The pilot entails:

- Reviewing and completing the self-assessment instrument;
- Reading the accompanying user guide; and
- Answering a brief questionnaire.

Objective: Increase the number of schools that are implementing programs that decrease risk factors associated with bullying by 2020.

*School-Based Bullying Prevention Event:* The Bureau of Family Health and Title V program are committed to implementing strategies targeted to prevent and reduce bullying, suicide, and other adolescent risky behaviors. The MCH program partnered with Kearny County hospital and Garden City (western Kansas) to host community events related to bullying prevention. *Time for Three*, a group nationally known for bullying prevention efforts, musical performances, and speaking engagements. *Time for Three* performs for schools, telling personal stories of being bullied as youngsters. The group appeared in both Lakin and Garden City high schools with support from MCH in FY16. The cause directly aligned with the Kansas MCH priorities and measures.

The events were an overwhelming success. The students raved about the school assemblies, cheering loudly throughout the programs. School leadership from Lakin and Garden City have committed to meet together in the near future to consider collaborative initiatives to reduce the frequency of bullying behavior among their students (targeted schools for expansion of

Second Step). The schools and hospital (common partner) are eager to meet with the state Title V staff to talk more about tools and/or programs for the schools to consider.

Objective: Increase the number of adolescents aged 12 through 17 years accessing positive youth development, prevention, and intervention services and programs by 2020.

Care Coordination Trainings: Youth with special health care needs (YSHCN) have been encouraged to participate in the Family Care Coordination trainings held by KS-SHCN staff each quarter, where they learn more about how to navigate the system of care. Topics covered in this are medical home, advocacy, partnering with providers, accessing insurance coverage, self-care and peer support. Youth participation was monitored and evaluated to see if a training for youth needs to be conducted separately from parents/caregivers. Two youth participated and were very engaged with the group in sharing how things were different for them as youth trying to navigate the systems of care. At this time, it is decided to continue evaluating for the need to offer a youth-only training, however some of the basic components and key messages have been integrated into the Faces of Change program through the Kansas Youth Empowerment Academy (KYEA). Evaluation reports showed that they enjoyed the training and learned new skills to use when navigating the systems of care in the future.

CYSHCN, ACEs, and TIC: KS-SHCN conducts an annual training with the Satellite Office staff. In 2016, a special presentation was provided regarding Adverse Childhood Experiences (ACEs) and trauma informed care (TIC). This training provided staff with an understanding of how lived experiences can and often does affect how youth might react to past trauma and why some engage in risky behaviors. As part of this activity they played “The Brain Architecture Game” (<https://dev.thebrainarchitecturegame.com/>), a tabletop experience that builds understanding of the powerful role of experiences on early brain development. The goal was to provide staff an opportunity to learn how experiences and resiliency play a factor in how youth (and adults) respond to various circumstances and experiences. The training allowed staff to increase awareness that CYSHCN may experience trauma at various levels, many with moderate to high ACEs scores and develop some strategies for working with them in a collaborative, non-threatening way.

Objective: Increase access to programs and providers serving adolescents that assess for and intervene with those at risk for suicide.

Yellow Ribbon Program (<https://yellowribbon.org/>): A meeting was held with Kansas Family Partnerships (KFP) to learn more about the Yellow Ribbon Program and other programs that promote healthy youth and communities regarding substance abuse prevention through education, networking and advocacy. It was learned that Kansas Family Partnership serves all of Kansas and that there are 150 Students Against Destructive Decisions (SADD) chapters in Kansas as well as various Yellow Ribbon trainers they work with. This led to the meeting with the Yellow Ribbon Program Coordinator of Unified District 259 in Wichita.

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## **NPM 10: Adolescent well-visit**

The 2011/2012 National Survey of Children’s Health showed that 83.4% of Kansas adolescents, 12–17 years of age, had a preventive medical visit in the past year. Adolescents without health insurance coverage were significantly less likely than adolescents with coverage to have received a preventive medical visit in the past year (57.1% versus 85.4%, respectively). Of those who had health insurance, adolescents covered by public health insurance (Medicaid/CHIP) were less likely to have received a preventive medical visit than those with private insurance (78.4% and 88.7%, respectively). Hispanic and non-Hispanic black adolescents were less likely than non-Hispanic white adolescents to receive a preventive medical visit. About 68.3% non-Hispanic black and 77.3% of Hispanic children received a preventive medical visit, compared with 86.7% of non-Hispanic white adolescents. Girls were significantly more likely to have received a preventive medical visit than boys (90.1% versus 77.4%, respectively). Adolescents with special health care needs were more likely to have received a preventive medical visit than adolescents without special health care needs (88.7% and 81.7%, respectively). Adolescents with parents who had more education were more likely to receive a preventive medical visit. Adolescents whose parents had a bachelor’s degree or more were most likely to have received a preventive medical visit (91.3%), followed by those whose parents had some college and adolescents whose parents had only a high school diploma (78.7% and 79.9%, respectively), and

adolescents of parents with less than a high school degree (68.6%). Adolescents living in low-income families were less likely to receive a preventive medical visit than adolescents living in higher-income families. The lowest percent of adolescents who had received a preventive medical visit were adolescents living in households with incomes below 100 percent of poverty (74.3%), followed by adolescents from households with incomes of 100-199 percent of poverty (76.7%), adolescents in households with incomes of 200-399 percent of poverty (83.9%), and adolescents in households with incomes 400 percent or more of poverty (93.8%).

Objective: Develop a cross-system partnership and protocols to increase the proportion of adolescents receiving annual preventive services by 2020.

Local MCH Agency Strategies: Local MCH agencies provided adolescent well-visits in conjunction with KAN Be Healthy screenings and sports physicals. Information regarding adolescent well-visits were trained from Bright Futures and provided as a resource to the client.

The majority of the local MCH agencies, including Morton County Health Department, Reno County Health Department and Unified Government of Wyandotte County Health Department collaborate with the local school districts and/or school nurses to provide school-based services for physical, social and emotional health needs.

Sedgwick County Health Department works with adolescents on Adverse Childhood Experiences (ACEs). Through this they are able to connect the adolescents with community resources, so they can move forward and become happy, healthy, productive adults.

Riley County Health Department offers educational awareness about healthy relationships and defining what constitutes a healthy relationship. This is critical to understanding physical, social and emotional health of the adolescent. Riley County also focuses on the persistent inequalities in the health and well-being of adolescents and how the interplay of risk and protective factors at critical points of time can influence the adolescent's health across his/her lifespan.

Greeley County Health Department sends letters to parents of 11 year olds and high school seniors providing immunization education, schedules and encouraging parents to have their children vaccinated. The letters target Tdap, MCV4, and HPV vaccinations; the high school senior letters target MCV4 booster, MenB series, and catch-up of other vaccinations their children may need before heading to college.

Unified Government of Wyandotte County provides required adolescent immunizations to include HPV, TDAP and meningococcal with assessment of a medical home and makes referrals if necessary.

National MCH Workforce Development Center (WDC) School-Based Health Initiative: The Title V program submitted a proposal that was accepted by the WDC to receive technical assistance to develop a model and resource manual for school-based health centers. Our primary goal for this project is to organize/compile essential guidance materials and resources a school/community could use to establish in-school preventive health services (ex: comprehensive well visit including physical assessment, screening, guidance, and referral as needed). The work ties directly to advancing the MCH adolescent health measure and state plan strategies. As part of phase 1 (existing/current), the Title V MCH program is facilitating team discussions and assisting with development of the model. During the development, the team has participated in monthly webinars provided by the National MCH Workforce Development Center as well as monthly team meetings hosted by the KDHE MCH Team Lead and Co-lead. As part of phase 1, the team conducted an environmental scan for school-based health center readiness in Kansas by disseminating a survey to identify current school-based health services being provided as well as evaluate the interest and capacity/infrastructure to provide school-based services for physical, social, and emotional health needs. The Kansas School Nurse Organization has agreed to help distribute the survey to reach hundreds of school nurses. The goal is to conduct a pilot project with a local school to begin during the 2017-2018 school year. Read more about the project in the Adolescent Health Application Section.

Care Coordination for Adolescent Well-Visit: The KS-SHCN care coordinators work with adolescents and their families to make sure they receive their routine KAN Be Healthy (KBH) screenings and assessments. KBH is the Kansas Early Periodic

Screening Diagnosis and Treatment (EPSDT) program. Upon completion of the KBH, the care coordinators work with the adolescent identify next steps and their transition goals. These are then listed in the adolescents KS-SHCN Action Plan to be followed-up on by the care coordinators in collaboration with the youth and their families along with transition goals are designed to help them understand and learn how to independently navigate the systems of care.

KS-SHCN has worked to expand transition resources and services through this new care coordination program. The focus of these efforts is to assure youth understand the importance of receiving preventive care through the adolescent well visit and to develop skills to support effective transitions into the adult health care system. Through work completed as part of a previous D-70 grant and from input and feedback received through the Title V Needs Assessment and existing D-70 state work plan, KS-SHCN has developed a plan where youths with a developmental age or 14 work with care coordinators, parents/caregivers and identified community members to work towards an effective health care transition. This model utilizes tools and resources developed through a previous HRSA Integrated Community Systems grant and resources from the "Got Transition" website. Tools include a youth self-assessment to determine where the youth feels most confident in the skills needed to accomplish their goals. Transition activities are noted on the youth's Action Plan. Youth are encouraged to participate in youth leadership program such as the Kansas Youth Leadership Forum and the FACES of change program through the Kansas Youth Empowerment Academy.

*Teen Pregnancy Targeted Case Management (TPTCM):* In FY16, ten local programs received TPTCM funding and served 238 pregnant or parenting teens. Of the ten local TPTCM programs, nine also provided MCH services. The co-location of both programs within an agency increased opportunities to collaborate to ensure adolescents received coordinated care and supports across programs. Local TPTCM programs provided individualized, intensive case management services to assist adolescents in the identification and attainment of goals in the areas of daily living, education or vocational training, employment, finances, health, interpersonal relationships, and parenting. TPTCM screening data are collected and monitored in DAISEY to identify areas for quality improvement.

*Title V Abstinence Education Program:* KDHE continued the Kansas Abstinence Education Project funded by an ACF Title V Abstinence Education Program grant. The KDHE contracted partner, The Children's Alliance of Kansas, coordinated abstinence education training to foster/adoptive/kinship parents and children/youth in foster care and out-of-home placement (residential care) as well as other at-risk youth through partnerships with Kansas child welfare providers and foster and adoptive family organizations. The education and training utilizes abstinence-based, evidence-informed curricula regarding health relationships, decision-making, and youth development in accordance with federal grant requirements. From October 1, 2015 – March 31, 2017, trained providers conducted All Stars, Choices, HEART (Healthy Empowering Adolescent Relationship Training) and Healthy Relationships trainings and programs reaching 1110 youth ages 10-19 and 311 parents/adults statewide.

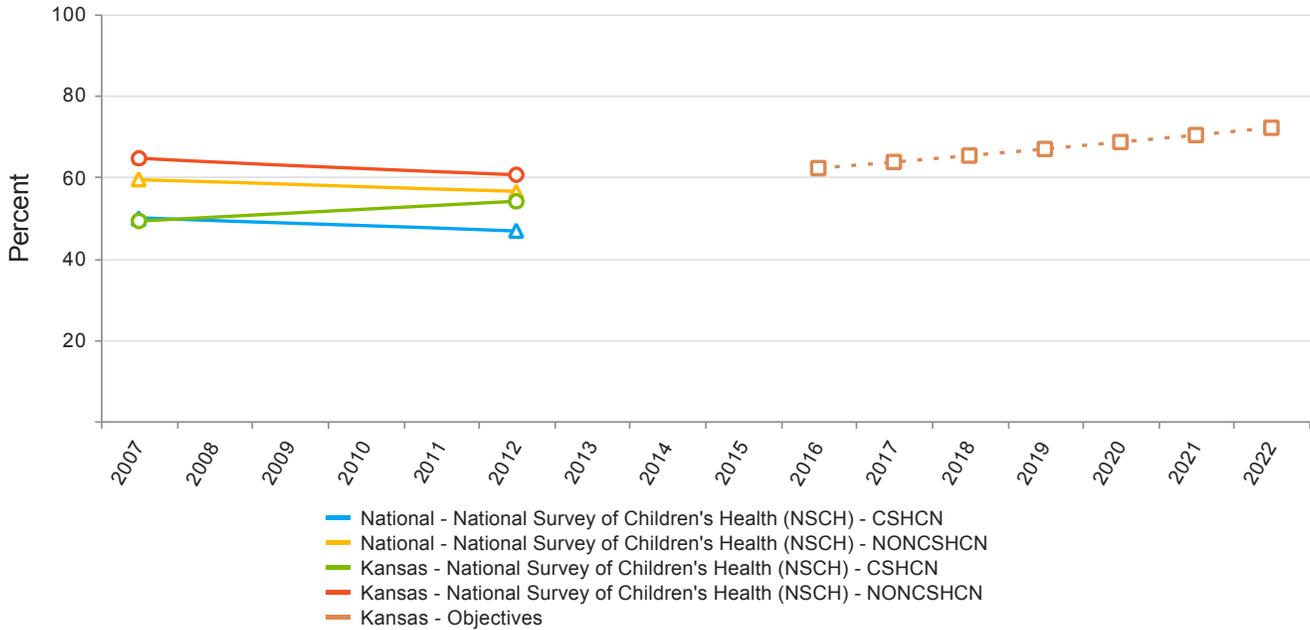
## Children with Special Health Care Needs

### Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system	NS-CSHCN-2009_2010	22.8 %	NPM 11
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	86.8 %	NPM 11
NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)	NIS-2015	75.2 %	NPM 11
NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza	NIS-2015_2016	55.6 %	NPM 11
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISF-2015	50.9 %	NPM 11
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISM-2015	36.0 %	NPM 11
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2015	87.3 %	NPM 11
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2015	63.7 %	NPM 11

**National Performance Measures**

**NPM 11 - Percent of children with and without special health care needs having a medical home  
Baseline Indicators and Annual Objectives**



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2016
Annual Objective	62.1
Annual Indicator	53.8
Numerator	74,319
Denominator	138,094
Data Source	NSCH-CSHCN
Data Source Year	2011_2012

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	63.6	65.2	66.8	68.5	70.2	72.0

**Evidence-Based or –Informed Strategy Measures**

**ESM 11.1 - Percent of families who experience an improved independent ability to navigate the systems of care**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Kansas Special Health Services
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	5.0	10.0	15.0	20.0	25.0	30.0

## State Action Plan Table

### State Action Plan Table (Kansas) - Children with Special Health Care Needs - Entry 1

#### Priority Need

Services are comprehensive and coordinated across systems and providers.

#### NPM

Percent of children with and without special health care needs having a medical home

#### Objectives

5.1 Increase family satisfaction with the communication among their child's doctors and other health providers to 75% by 2020.

5.2 Increase the proportion of families who receive care coordination supports through cross-system collaboration by 25% by 2020.

5.3 Develop an outreach plan to engage partners, providers, and families in the utilization of a shared resource to empower, equip, and assist families to navigate systems for optimal health outcomes by 2020.

#### Strategies

5.1.1 Support family-centered medical homes through increased awareness among families, including communicating with their doctors and building effective health advocacy skills. 5.1.2 Provide professional development opportunities to health care providers to increase family-centered medical home supports. 5.1.3 Implement communication and referral protocols for SHCN Care Coordinators and providers.

5.2.1 Explore new and existing partnerships that promote collaboration between primary care and behavioral health providers. 5.2.2 Expand KS-SHCN to have care coordinators located in all six Kansas public health regions. 5.2.3 Engage Managed Care Organizations and primary care providers in collaborative coordination for SHCN clients. 5.2.4 Provide support to agencies working with foster homes and the foster care system in serving CYSHCN in foster care. 5.2.5 Develop, monitor and evaluate a patient-centered care coordination action plan for all SHCN clients and BAM participants.

5.3.1 Complete the online navigational toolkit to provide resources and services, including expansion to Help Me Grow. 5.3.2 Increase access to primary and specialty care in underserved areas. 5.3.3 Increase utilization of Medicaid, CHIP, and Health Insurance Exchange services through education and referrals. 5.3.4 Connect SHCN care coordinators with foster care and Managed Care Organization case managers to provide technical assistance and support for SHCN clients. 5.3.5 SHCN providers will have access to care coordinators for support and assistance in their community (in-person or remote access).

ESMs	Status
ESM 11.1 - Percent of families who experience an improved independent ability to navigate the systems of care	Active

NOMs
NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system
NOM 19 - Percent of children in excellent or very good health
NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)
NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

## Children with Special Health Care Needs - Plan for the Application Year

**PRIORITY:** Services are comprehensive and coordinated across systems and providers

**NPM 11:** Medical home (Percent of children with and without special health care needs having a medical home)

**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

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Transformation of The Title V CYSHCN Program: KS-SHCN will continue to seek opportunities to align with the MCH programs and services across the state. A huge part of this includes a shared message that CYSHCN are children first and that infants, children, and adolescents served through MCH services may also have a special health care need, even if not connected to the KS-SHCN program or served by a specialty clinic. Therefore, efforts to educate MCH staff and grantees and align KS-SHCN and MCH services will continue to be a focus of the coming year. In partnership with the Maternal and Child Health Aid-to-local process, the KS-SHCN program is again expanding satellite offices (SO) with the addition of 6 new offices in FY18 to better meet the needs of clients across Kansas. All satellite office staff will provide care coordination services for clients on the KS-SHCN program in their communities beginning in October '17. Through this integration, the KS-SHCN will expand from 10 offices to 14 in FY18.

Of the previous ten SO's, seven were located in local health departments, one in an Infant-Toddler/MCH partner program (Hay), one in a hospital system (Sedgwick county), and the administrative office in Topeka served the remaining regions. The SO's serve as the entry-point into KS-SHCN, working directly with families throughout the application process, and assisting them with their application, and answering questions. The SO's have been assessed for capacity and staffing needs and will be expanding their role to include care coordination services for FY18. With the integration into the MCH ATL application, 14 SO's will be in place across the state starting in July 2017. This includes a total of 6 new local health department partners, covering a range from 1 to 16 counties, depending on the geographic area. This expansion supports care coordination services across all six public health regions in Kansas. During the coming year, further assessment will be done to identify if additional SO will be needed in the future to better accommodate care coordination services.

CYSHCN is leading collaborative efforts to establish community-based Help Me Grow models specifically designed to coordinate developmentally appropriate comprehensive services among providers. The Help Me Grow model is, at its core, a framework for coordinating MCH and early childhood services across systems and providers. Combined with communities that use the web-based referral and intake tool IRIS, Title V is poised to drive a coordinated and integrated system and the network of providers that serve families, children, and CYSHCN.

Direct Assistance Programs (DAPs): DAP's continue to be monitored with yearly evaluations to take place in August of each year to see if any further changes need to be made, especially due to the ever changing insurance industry. Additional DAP's are being researched and may be added in the future per funding availability. Beginning in July '17 KS-SHCN satellite offices will receive training on DAPs as part of their care coordination training, so they will be able to assist families in their DAP selections.

Aid-To-Local Funding Process: The KS-SHCN program will continue to use the Aid-to-Local process in future years. Each year the application and review process is evaluated and updated to improve the process for the applicants, reviewers and the KS-SHCN staff. Significant changes to the application, guidance, and review process will be implementing in the coming year. Primarily, the SHS-FAC is assisting to develop guidance and criteria around what an eligible project must include. This will be included in the guidance and serve as the basis for developing the review materials. In the future, any project submitted that does not directly align with at least one of the KS-SHCN priorities AND meet the criteria set forth by the SHS-FAC, will not be considered for funding. Additionally, completion of the review process will result in the applicant receiving an overall "score," which is an average of all reviewers' scores. Applicants who do not receive an overall score of 75% or more will not be considered for funding. Lastly, applicants are encouraged to identify sustainability plans for long-term funding needs. If they submit a project that will require multi-year funding, they will be expected to submit a multi-year budget with an incremental reduction in funding requested by KS-SHCN each year in order to be eligible for funding.

**KS-SHCN Contract Partnerships:** The KS-SHCN program entered year two of the ATL process. Through the ATL process applicants were provided access to the online application and reporting system, Catalyst, for ATL grant. The applicants were provided the KS-SHCN Priorities and Objectives, and asked to share the “problem” or “community need” as related to the Objective. For each objective the applicant was interested in addressing, they were then asked to share strategies or activities to implement, anticipated health outcomes, and long-term sustainability needs. KS-SHCN received 20 separate projects from a total of 10 partnering entities.

A review team consisting of the following was developed to review all applications: Special Health Services/Title V CYSHCN Director; KS-SHCN Program Manager; KS-SHCN Care Coordinators; and SHS-FAC Members. This resulted in at least 3 or 4 separate reviewers for each project proposal. A scoring rubric was provided and the responses were compiled and calculated. Internal (KDHE) reviewers met to discuss each proposal and make one of the following recommendations: Do Not Fund; Fund with Conditions; or Fund as Written. Of the 20 proposed initiatives, 2 were funded “as written,” 9 were not recommended for funding, and the remaining 9 were recommended “with condition.” All applications were from existing partners. At the time of this application, one applicant who was offered funding declined after receipt of funding notice. Accepted proposals included specialty and outreach clinical services, parent trainings and supports, care coordination, community services, and youth leadership and development.

<p><b>Specialty and Outreach Clinical Services</b></p> <ul style="list-style-type: none"> <li>• <b>Kansas City clinics:</b> PKU (only for established patients), Cystic Fibrosis, and Cleft/Lip Cleft Palate</li> <li>• <b>Wichita clinics:</b> PKU, Cerebral Palsy/Medical Complexities, and Wheelchair Seating</li> <li>• <b>Outreach clinics:</b> Wheelchair Seating (four communities in Western KS and Developmental Evaluation/Diagnostic Clinics)</li> <li>• <b>Dental Hygienist Services:</b> Oral Health Kansas provided support for a dental hygienist as part of the multi-disciplinary team in select clinics, providing oral health education, oral screenings, and fluoride varnishes to patients seen in clinic.</li> </ul>
<p><b>Parent Training and Supports</b></p> <ul style="list-style-type: none"> <li>• <b>Wheelchair Specialty Clinic Care Coordination:</b> In addition to the wheelchair seating services, the applicant incorporated a patient navigator to provide additional education and support services to those served through clinic.</li> </ul>
<p><b>Care Coordination Activities</b></p> <ul style="list-style-type: none"> <li>• <b>Hospital-to-Home Transition Program:</b> A community-based transition to home program, following a hospitalization for medically fragile patients. This project included increased education and coordination (both initially and ongoing) to caregivers and families, increased surveillance and support in the home following discharge, and increased coordination and partnership with the discharging institution and insurers.</li> <li>• <b>Connecting the Docs:</b> Support for a full-time Care Coordinator in the FQHC in Southeast Kansas to provide serves to low-income special needs children. This is in its second year and the protocols and tools developed will be used for development of a replicable model to implement Phase 2 of the KS-SHCN Care Coordination program.</li> </ul>
<p><b>Community Services</b></p> <ul style="list-style-type: none"> <li>• <b>Northeast Kansas Tribal Developmental Disability Services Improvement Plan:</b> This plan will share the results of the regional needs assessment conducted in FY16, through community education events and structured technical assistance. Dissemination of will be targeted at Kansas tribal leadership, lead education agencies, Indian Health Services, county and state health offices, the University of Kansas Medical Center and affiliates, and the Kansas Department of Health and Environment (KDHE). Other activities include, community presentations of the findings, trainings on cultural competency, the development of a strategic plan.</li> </ul>
<p><b>Youth Leadership Development</b></p> <ul style="list-style-type: none"> <li>• <b>FACES of Change:</b> A seven-month leadership program for youth with disabilities was designed to foster attitudes of civic engagement and services through the development of leadership skills. Implementation began in April of 2016 with the first session series concluding in November 2016. The second series began in April of 2017.</li> </ul>

**KS-SHCN Enhanced Data System:** Development will begin for the new KS-SHCN data system in early FY18. It is anticipated that the system will be completed by the end of the fiscal year. This new system will be designed to meet the changing needs of the program and include components needed for care coordination services such as client demographics, applications, supporting documentation, financial calculation, Authorizations, Action Plans, budget (both individual client and program), Direct Assistances Programs, letters, clinic information, follow up reminders for care coordinators, etc. This new system will include a family portal so families can access their Action Plans, Authorizations, update their application and send message directly to their care coordinator. This new data system will allow for improved and timely services for clients and a better coordination in workflow for KS-SHCN care coordination staff.

**Family Engagement Initiatives:** Family involvement within the CYSHCN population has been and will continue to be a top priority. No program changes will or should be made without consulting families who use the services provided by the program. For this reason, the SHS-FAC was developed and continue to be strong in advising and assisting the KS-SHCN program. The

statement “nothing about us without us” is the foundation of the programs philosophy, so the family voice is critical in moving the program forward.

The KS-SHCN program staff believe that family involvement is more than just advising on program changes but being part of making that change occur. It is important for the program to gain knowledge from the families’ perspective, but it is equally as important for the program to support the SHS-FAC members by educating and equipping them for involvement in all aspects of their lives. That means helping them develop the skills and knowledge to effectively advocate for their child and family. This is why family caregiver health is a high priority for the program and KS-SHCN staff. This is an independent focus area that is being integrated into the care coordination service and addressed through the Family Care Coordination Trainings where caregivers learn the importance of taking time to care for themselves and address their own health needs in order to better equip them in taking care of their child with special health care needs.

During FY18 the caregiver initiative will be advanced with the completion of the Family Caregiver Assessment modified from the University of Kansas Beach Center on Disability Family Needs Assessment (developed and researched as a model for the Kansas Early Intervention/Part C program). The SHS-FAC and Kansas Family Delegate have been and will continue to be actively engaged in determining what needs to be addressed in the assessment and assisting in identifying appropriate referrals and resources related to the health of the whole family that can be used. As part of the KS-SHCN Care Coordination Program, the family caregiver(s) will complete the assessment and the Care Coordinator will provide resources, referrals and supports to assist caregivers with their identified needs.

Objective: Build MCH capacity and support the development of a trained, qualified workforce by providing professional development events at least four times each year through 2020.

Increasing Awareness of KS-SHCN: An overview presentation of the KS-SHCN program is being developed and will be put on the KS-SHCN website for viewing by families and partners. This was requested by partners to help them better explain the services and supports offered by the program. This is also being used by Families Together as part of supporting parent training for their Parent-to-Parent program. This will be reviewed and updated as needed.

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#### **NPM 11: Medical home**

Objective: Increase family satisfaction with the communication among their child’s doctors and other health providers to 75% by 2020.

Care Coordination Training: In FY18 KS-SHCN program will hold two one-day parent/caregiver care coordination trainings to assist parents/caregivers to increase their knowledge of medical homes, community services and supports, obtaining insurance coverage, understanding shared plans of care, advocacy and to develop skills to better partner with their child’s providers. These trainings will continue to be held by KS-SHCN staff who are also parent of children with special health care needs. Each training will begin with staff sharing their personal story to help families feel comfortable in knowing that they are in a non-judgmental environment where they are free to openly share their hopes, dreams and daily struggles of being a parent of a child with special health care needs. Participants will be asked to complete a pre-, post-, and one-year evaluation that can then be used to improve future trainings. These trainings have received positive feedback from participants. Currently, one is scheduled in Pittsburg, Kansas for September in collaboration with the programs local FQHC partner.

Local MCH Agency Strategies: Morton County Health Department will ensure that all children and adolescents with special health care needs are screened for a medical home and receive all services available through the health department to improve their capacity and help them achieve maximum potential.

Saline County Health Department is increasing access to specialty clinics through comprehensive and coordinated care. The satellite office has provided an additional outreach option to families through Telehealth. Implementation of this program will decrease the financial and transportation hardships families’ face when trying to maintain services with specialty clinics and providers located outside of their county. Telehealth will increase the accessibility of specialty clinics and providers for the

clients with special health needs.

OBJECTIVE: Increase the proportion of families who receive care coordination supports through cross-system collaboration by 25% by 2020.

KS-SHCN Care Coordination Program: The ongoing KS-SHCN care coordination pilot will continue taking place with the Topeka Staff until all tools, processes and procedures have been tested and refined through PDSA cycles. In January of '17, the pilot first began with those clients who are uninsured, then moved to those with KanCare (Medicaid) and will conclude with those clients who have private insurance. It was decided to do the pilot in three different population groups since they have such a wide variance of needs depending on if they have insurance and if so, whether it is public or private. The KS-SHCN team wanted to make sure that all development of protocols, documentation tools/forms, training, and evaluation methods worked well with all clients/families before training satellite office team members across the state.

Once clients are determined eligible for the KS-SHCN program an initial assessment is done by the lead care coordinator using tools modified from the Boston's Children's Hospital Care Coordination training. Once the lead care coordinator determines the client's level of need a care coordinator within their region will be assigned. The lead care coordinator will conduct an introductory call between the client/family and their care coordinator. The assigned care coordinator will then work collaboratively with the family to choose their DAP's, determine authorizations needed and develop the clients Action Plan (level 2 & 3 only). Follow up will occur with each client/family based on goals within the Action Plan but will occur no less frequently than every 3 months. Clients who are identified with level 1 care coordination needs will be followed up with no less than every 6 months.

As part of care coordination services clients/families are supported in working collaboratively with their doctors and other service provider to best meet the client's needs using a holistic approach. Providers will have access to the client's care coordinators for support and assistance when needed to provide the best health outcomes for the client. Families are reminded about the need for their child's yearly Kan-Be-Healthy appointment and assisted in scheduling the appointment if necessary. This is monitored as part of the client's Action Plan. If a client is uninsured the client/family is assisted in identifying and applying for insurance to best meet their needs. For youth (14 & up) transition activities are included within their Action Plan. Youth are encouraged to work collaboratively with their parent/caregiver and the care coordinator to develop and follow their Action Plan. All client needs are addressed in a holistic way within their individual Action Plan.

The Kansas Special Health Care Needs (KS-SHCN) program will continue to support multi-disciplinary clinics in Kansas City and Wichita, which include activities to assist youth around transition to adulthood. Clinic teams and coordinators work with patients and families to assist and assure services are identified and obtained prior to aging out of the program. Transition services will continue to expand with the addition of care coordination services provided by KS-SHCN satellite offices throughout the state. Care coordinators will work with youth to help them identify where they are in the transition process and assist the youth in developing Action Plan goals to address transition activities in order to prepare them in successfully learning how to navigate the systems of care.

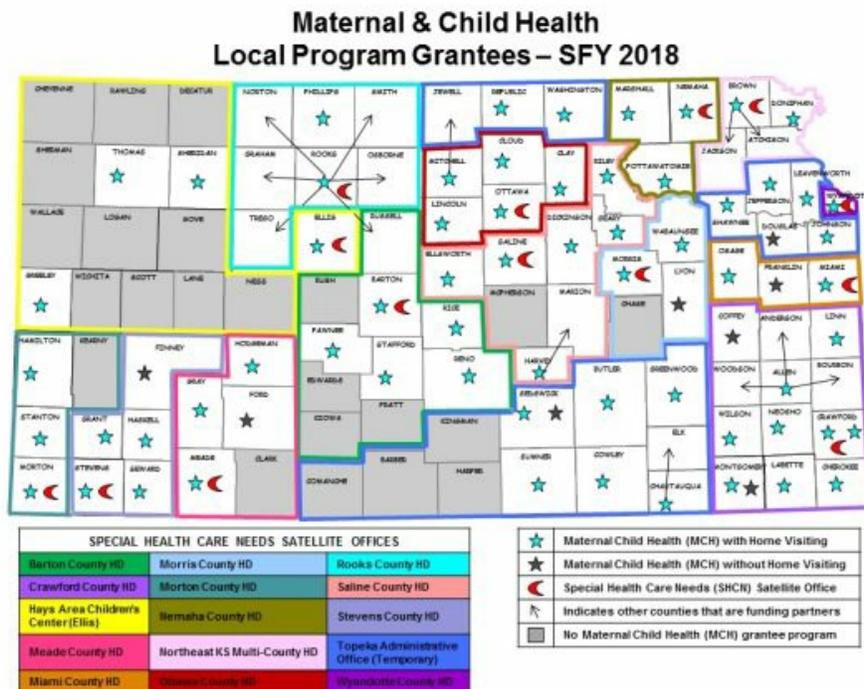
Satellite Office Expansion: For the State Fiscal Year (SFY) 2018 aid to local application process, the MCH and CSHCN teams continued to work closely together to integrate the funding request for Kansas Special Health Care Needs (KS-SHCN) Satellite Offices (SOs) into the MCH application, allowing local agencies the opportunity to learn more about services for SHCN and to become SOs. A total of 14 local agencies will serve as a satellite office and provide services at the local level. Satellite Office responsibilities include:

- Provide assistance with the application process to families interested in or needing KS-SHCN services;
- Assist families in compiling necessary medical and financial information to KS-SHCN and other state and federal financial assistance programs;
- Follow up with families regarding referrals made to ensure support, collaboration and integrated service delivery across systems;
- Maintain proficiency in using the KS-SHCN web-based data system to enter intakes and applications on clients;
- Monitor client status and communicate needs to families, as applicable;
- Input client notes into web-based data system regarding interactions and communications made with KS-SHCN families;

- Run update and reminder reports on a weekly basis to identify families that need updated applications, information or follow-up;
- Participate in one in-person 2-day training in July. This training will cover basic satellite office work including Care Coordination;
- Participate in one hour long webinar/conference calls weekly until December 2017, tapering to bi-weekly or monthly as determined by SO staff; and
- Provide Care Coordination services for clients in your area as assigned by the Lead Care Coordinator.

Care Coordination training for satellite offices will begin July FY17, beginning with onsite data systems training for new satellite offices the first two weeks of July, statewide in-person training to be held in Salina on July 12 & 13, 2017, and weekly webinars from the third week of July through the end of September. Beginning the first of October, clients will begin being assigned by the Lead Care Coordinator to the local satellite offices in their region for care coordination services. Beginning in October, hour weekly brainstorming conference calls will be conducted until the end of December '17 for all satellite office staff to present their new client cases and to work as a collective group to identify strategies and resources to best assist the client/family. This offers another level of ongoing training utilizing knowledge from all care coordinators across the state. Satellite office staff will be surveyed in December '17 to see if they would like to move these brainstorming calls to twice a month or monthly for the remained of SFY18. All care coordinators across the state will have access to TA anytime from the Topeka office to support them in provide quality care coordination.

The SOs serve as the entry-point into KS-SHCN, working directly with families throughout the application process, and assisting them with their application, and answering questions. The SO's are being assessed for capacity and staffing needs to expand their role to include care coordination services in the coming year. A total of 14 SO's will be in place across the state starting in July 2017 for State Fiscal Year 2018, up from 7 in State Fiscal Year 2017. This includes a total of 6 new local health department partners, covering a range from 4 to 22 counties, depending on the geographic area. See map below for the SFY18 KS-SHCN Satellite Offices.



This expansion will support future plans for growth of the KS-SHCN Care Coordination program into the local communities, to be done at the SO level with the Administrative Office serving as the training and technical assistance to the statewide KS-SHCN Care Coordination system. KS-SHCN will continue to seek opportunities to align with the MCH programs and services

across the state. A huge part of this includes a shared message that CYSHCN are children first and that infants, children, and adolescents served through MCH services may also have a special health care needs, even if not connected to the KS-SHCN program or served by a specialty clinic.

*KS-SHCN and Infant-Toddler Services Partnership:* The KS-SHCN program will continue to collaborate with the Infant-Toddler (IT) program over the coming years using the Interagency Agreement (IAA) as a structural support to move this partnership forward. The IAA includes a referral process and training opportunities for both programs. The IAA will be reviewed and updated yearly as new collaboration activities are identified.

The Infant-Toddler Program Coordinator will develop and conduct an informational webinar for all KS-SHCN staff to learn more about the Infant-Toddler program. This webinar will help KS-SHCN staff understand the services and supports families can receive and how they can work collaboratively with the child's IT services provider to make sure the family and child are getting what they need, with no duplication of effort by either program. All KS-SHCN staff will be trained on when and how to refer families to the IT program.

The KS-SHCN Program Manager will conduct presentations for IT Family Service Coordinators and IT Primary Service Providers, so that they understand the special health care needs program and the service and supports a family can receive from the program. As part of this training they will learn about the KS-SHCN Decision Scheme and how to use it to identify families who may qualify for services and how to refer them.

*KS-SHCN and Medicaid Partnership:* The KS-SHCN program will continue to work collaboratively with our Medicaid and MCO partners to make sure clients are receiving the appropriate services. Care Coordinator will continue to review the monthly MCO reports so they know what services the MCO has authorized for the client and work with the client to assist them in getting appointments scheduled, fill prescriptions, and effectively communicating with providers, etc. Partnerships between the MCO case managers and the KS-SHCN care coordinators will continue to be nurtured and grown over the next year in order to provide quality services for the special health care needs population.

KS-SHCN program will conduct presentations for the MCO case managers regarding the KS-SHCN program, so they have a better understand of our program and how we can complement what they are doing and not duplicate. Monthly reports will continue to be sent to the MCO's from the KS-SHCN program that contain a copy of the authorization and Action Plans for each shared client. This allows the MCO case manager to know what the KS-SHCN care coordinator is doing to assist the client.

Additionally, the KS-SHCN program will continue to collaborate with the SHCN Medicaid Liaison to make sure services are not duplicated and identify any gaps or barriers that can be addresses between the programs to improve services for the children with special health care needs in Kansas. This partnership continues to strengthen each year with improved outcomes for children.

*KS-SHCN and Birth Defects:* In FY17, protocols and procedures were developed to assist any family who had a child born with conditions related to the exposure from the Zika virus. Any child identified with a condition due to Zika will immediately be contacted about the services and supports the KS-SHCN program can provide. At this time no babies born in Kansas have been identified with a medical condition related to Zika, but this will continue to be in place for any identified in the future.

Over the next year, the KS-SHCN program will be working collaboratively with the new Birth Defects Program to make sure a referral process is implemented immediately upon diagnosis of a birth defect. It is expected that this new referral process will mirror the process already in place for both newborn screening programs.

Objective: Develop an outreach plan to engage partners, providers, and families in the utilization of a shared resource to empower, equip, and assist families to navigate systems for optimal health outcomes by 2020.

*Shared Plan of Care (SPoC):* As part of the D-70 grant work a Shared Plan of Care (SPoC) was developed and will continue being piloted in a large pediatric office. The intent of this project was to develop a replicable model that includes the SPoC document, protocols, policies and procedures that can be offered to other interested pediatric offices across the state.

Providers identified through the KS-SHCN provider application identifying as wanting assistance in the development and usage of a SPoC will be offered the SPoC replicable model that will include the protocols, policies and procedures. The KS- SHCN program will assist them in modifying the model to fit their office needs. This can also include modified training modules for care coordination that were developed and used for the KS-SHCN Satellite office care coordination training.

Through the development of the SPoC work a need was identified for “Lunch and Learns” to inform providers on a variety of topics in order to better assist their patients. The KS- SHCN staff has developed one “Lunch and Learn” around the Family Care Coordination Training the program provides to families across the state. Two additional trainings will be developed in FY18. One on waiver services and another on Individualized Health Care Plans in schools. More will be developed based on requests from providers.

The KS-SHCN team will be developing SPoC fact sheets for both providers and families. A SPoC video will also be developed and located on the Navigational Tool Kit and available to be played in pediatric office waiting or patient rooms. This video will explain what a SPoC is, how it can be used, who it can be shared with and how it will benefit children. It is the intent of the program to engage the assistance of the Family Advisory Council (FAC) in the development of the video.

System Navigation Activities: The KS-SHCN program in collaboration with other Bureau of Family Health programs will continue to answer the KRG 800 phone number and e-mail in an effort to provide a quality resource and referral system for consumers. The follow up tracking protocol will continue to be use to make sure that consumers are getting the services and resources they are looking for with the eventual goals of folding this into the new resource and referral system (modeled after “Help Me Grow”) that is currently being developed (more can be found on this new system under the child domain).

The Navigational Tool Kit was added to the KS-SHCN website in December of '16 and contains 11 different categories of national, state and local resources available to Kansas consumers. New resources are added quarterly as identified.



Respite Care: During the KS-SHCN strategic planning process one of the areas identified under the family caregiver health priority was to seek partnership and funding opportunities for a sustainable respite pilot project. This was identified by families as something that would help decrease their stress level and give them some time to address their own health needs. Beginning in FY18, the KS-SHCN program will gathering data around current respite services happening in Kansas. Information will be gathered on who provides these services, how they are funded, how the process works, training requirements for respite workers, how families access the services, eligibility requirements and what other agencies are currently doing around respite

services. This information will be used to help the program develop a plan for a pilot project and in building collaborative partnerships.

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**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**

Objective: Incorporate information regarding changes to the health care system into existing trainings and technical assistance by 2020.

Standards for Systems of Care for CYSHCN: In FY18 the KS-SHCN program will complete the state plan meetings as part of the D-70 grant, this process will continue to build infrastructure and capacity for increased services for all CYSHCN in Kansas. Two additional phases will be held with each covering two remaining domains from the “Standards for System of Care for Children and Youth with Special Health Care Needs”. One phase will take place in the fall of '17 with the final phase being held in the Spring of '18. Each phase will consist of 6 regional meetings (one in each public health region) across the state to gather information from families, providers and community partners on what we are doing well and where we need to better align. Each phase will have an accompanying survey one for providers and one for families to assist with gathering more information from the public. Once all information has been gathered and compiled for each phase a final stakeholder meeting will be held to review the findings and to identify next steps leading to a shared vision

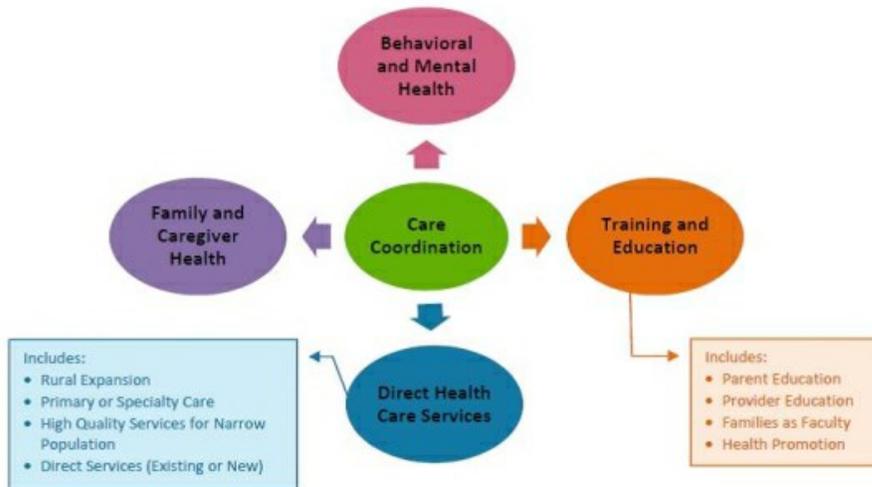
## Children with Special Health Care Needs - Annual Report

**PRIORITY:** Services are comprehensive and coordinated across systems and providers

**NPM 11:** Medical home (Percent of children with and without special health care needs having a medical home)

KS-SHCN promotes the functional skills of persons, who have or are at risk for a disability or chronic disease. The program is responsible for the planning, development, and promotion of the parameters and quality of specialty health care in Kansas in accordance with state and federal funding and direction. KS-SHCN provides specialized medical services to infants, children and youth up to age 21 who have eligible medical conditions. Additionally, the program provides services to persons of all ages with metabolic or genetic conditions screened through the Newborn Screening. Services may include diagnostic evaluations, treatment services or care coordination. This program assures that medical specialty services were accessible through a contractual system and provided diagnostic evaluation, case management, treatment services, and financial assistance to over 5,764 individuals with qualifying conditions and income, and their families, across the state.

Transformation of The Title V CYSHCN Program: KS-SHCN continued to focus on activities identified during the 2015 strategic planning and 5-Year Plan development. The KS-SHCN plan consists of 14 objectives and 31 total strategies. The KS-SHCN five year plan focuses on the five priorities as follows: (1) Care Coordination focuses on empowering families, improving communication among providers and systems, and stronger cross-system collaboration; (2) Family Caregiver Health focuses on promoting health and wellness among family caregivers, increasing awareness of and access to respite services, and family leadership and peer supports; (3) Behavioral Health focuses on collaboration to support integrated care, community education and referrals, and screening and assessments for KS-SHCN families; (4) Training and Education focuses on advocacy, youth leadership and self-determination, and training for professional in integrated care of people with disabilities; and (5) Direct Health Services is focused on gap-filling services such as oral health, access to adequate insurance coverage, and telehealth. These strategies are re-assessed each year by the SHS-FAC to monitor progress and make recommendation for changes, as needed. A diagram of the priorities is below.



The objectives and strategies align nicely with the Title V plan and the transformation of the Block Grant, with many of the KS-SHCN priorities and strategies integrated into the Title V state action table: not only in the priority selected for the CYSHCN domain, but in many of the overall state priorities and a variety of different objectives. This reflects the integrated and cross-systems approach to the Kansas work while allowing the KS-SHCN program, opportunities to address broader needs of the child and their family and focus on stronger collaboration and integration across systems of care.

Through quality improvement and strategic planning, the program worked to develop a model that would best meet the needs of those served. A more holistic approach to providing care coordination and efforts to provide more of a wrap-around service

delivery model similar to that found in a medical home have been developed. The KS-SHCN program also determined the need existed to continue to focus on filling service gaps for uninsured and underinsured families, until a long-term solution could be found. However, the families expressed a need for the program to also focus on assisting with non-medical needs, that would also better support families in meeting their top health concerns and the unmet needs. Additionally, the program continues to review funding allocations and support for direct clinical services, including multi-disciplinary clinics, and make modifications as needed. Throughout this process an increased need for outreach clinics and telehealth services was identified.

Direct Assistance Programs (DAPs): As part of the strategic planning, an analysis of how KS-SHCN provides services was conducted, leading to significant change. Ultimately, the largest change was due to the inability for KS-SHCN to monitor and track the level of funding available or authorized at any given time. This was unsettling as the funds to cover direct services is limited and the program was on the verge of making cuts to services if a solution was not found, as each year the program funds would be depleted earlier and earlier in the year. This prompted a change to a “Direct Assistance Program (DAP)” model. This ultimately changed the way services were authorized, not which services were authorized. This allowed the program to set limits per authorization and per year to better track and monitor the funds that were ultimately already spent. This change resulted in better accountability and an ability to identify when funds are running low and cease authorizations for that DAP until funds are released. Each of the DAPs have eligibility criteria and annual maximum assistance amounts.

DAP’s began in the summer of ’15 and were re-evaluated in the summer of ’16. Internal DAP tools to assist staff and clients were also developed to make the DAP structure flow smoothly. A tracking form was developed and used to track client concerns/issues with DAP’s and a review process was put into place to evaluate if changes to the DAP(s) were needed. Small adjustments were made based on information gather with the tracking form, feedback from families, staff and the availability of funds resulted in an increase of funding assistance for DAP-MP (metabolic product). This DAP now has a higher annual maximum amount and an additional change to increase the monthly and yearly maximum for pregnant or nursing women who have PKU. Once we experienced the first pregnant woman with PKU and saw that her need for formula increase due to her pregnancy we made the appropriate policy adjustments to better accommodate her and all future pregnant and nursing mother. Upon evaluation of the other DAPs some minor policy adjustments were made. Families have adapted well to the program changes and are comfortable with the DAP process. Due to the implementation of DAPs and the structure put in place to support it the KS-SHCN team has established better communications with the clients allowing for a smoother move to care coordination services. This process has led to more program accountability, increase in client/staff communication and a better understanding of previous service gap barriers. The 8 DAPs that were developed are reflected in the following chart.

DAP	Support Available	Support Available (within a 365 day period)	
		General Guidelines (100% Coverage)	Genetic/Heritable Conditions (50% or 25% sliding fee scale coverage)
Medication (DAP-Rx)	Prescribed Medication ***The client must pay a \$5 co-pay for every \$100 of medication at the time of pick-up.**	Up to \$10,000	50% Coverage = Up to \$5,000 25% Coverage = Up to \$2,500
	Nutritional Supplements, Vitamins, or OTC medications (limited to individuals with Cystic Fibrosis) ***The client must pay a \$5 co-pay for every \$100 of medication at the time of pick-up.**	Up to \$500	50% Coverage = Up to \$250 25% Coverage = Up to \$125
Medical Equipment and Supplies (DAP-ME/S)	Prescribed Durable Medical Equipment (DME)  The client must pay a co-pay or follow: \$25 co-pay for DME under \$500 \$50 co-pay for DME \$501 to \$1,000 \$100 co-pay for DME over \$1,000	Up to \$5,000  Includes a minimum of one (1) or up to four (4) KS-SHCN Clinic appointments	50% Coverage = Up to \$2,500 25% Coverage = Up to \$1,250
	Medical Supplies: Up to a maximum of \$1,200 for up to 12 boxes of catheters. Up to a maximum of \$600 for ostomy supplies. Up to a maximum of \$1,500 for diabetic testing equipment and supplies (only for Cystic Fibrosis-related diabetes). Up to a maximum of \$500 for diapers or pull-ups (only for age 5-21). Up to a maximum of \$250 for special bottles or feeding supplies. Up to a maximum of \$500 for hearing aid molds, repairs, and batteries. Up to a maximum of \$1,000 for glasses, lens replacement, or prosthetic eyes. Other medical supplies, not otherwise identified, up to \$250.	Up to \$2,000	50% Coverage = Up to \$1,000 25% Coverage = Up to \$500
Travel (DAP-T)	Reimbursement at current state rate.	Up to \$500	50% Coverage = Up to \$250 25% Coverage = Up to \$125
Co-Payments and Deductibles (DAP-C/D/CI)	Co-Pays	Up to \$1,000	50% Coverage = Up to \$500 25% Coverage = Up to \$250
	Deductibles/Co-insurance  Must have private insurance with a co-payment and/or deductible limit.	no more than 50% of Deductible/Co-insurance Up to \$5,000	no more than 50% of deductible 50% Coverage = Up to \$2,500 25% Coverage = Up to \$1,250
Medical Services (DAP-MS)  Must be uninsured, or ineligible for KanCare and/or insurance through the health insurance marketplace.	Medical Appointments: One (1) well-child/well-adolescent, or preventive care appointment, with established provider. Up to six (6) specialty care appointments ***Client must pay a \$15 co-pay per appointment**	Up to \$500	50% Coverage = Up to \$250 25% Coverage = Up to \$125
	Medical Testing: Laboratory Tests X-rays	Up to \$500 Up to \$500	50% Coverage = Up to \$250 25% Coverage = Up to \$125
	Specialty tests	Up to \$1,500	50% Coverage = Up to \$750 25% Coverage = Up to \$375
	Hospitalization/Surgery Hospital Bill ***Client must pay \$500 towards hospital bill**	Up to \$4,500  Up to \$2,500	50% Coverage = Up to \$2,250 25% Coverage = Up to \$1,125
	Hospital/Surgery Related Services		50% Coverage = Up to \$1,250 25% Coverage = Up to \$625
	Other Services Physical, Speech, Occupational Therapy ***Client must pay a \$15 co-pay per appointment**	Up to \$1,200	50% Coverage = Up to \$600 25% Coverage = Up to \$300
	Interpreter Services (limited to authorized appointments)	Up to \$700	50% Coverage = Up to \$350 25% Coverage = Up to \$175
Other specialty care services, not listed	Up to \$800	50% Coverage = Up to \$400 25% Coverage = Up to \$200	
Orthodontic Treatment Services (DAP-OTS)  Must be diagnosed with a craniofacial anomaly, such as Cleft Lip/Cleft Palate	KS-SHCN CL/CP Clinic: A minimum of one (1) or up to four (4)		
	Orthodontic Evaluation	Up to \$300	50% Coverage = Up to \$150 25% Coverage = Up to \$75
	Orthodontic Treatment Plan	Up to \$5,000	50% Coverage = Up to \$2,500 25% Coverage = Up to \$1,250
Hemophilia (DAP-H)  Must be diagnosed with hemophilia disorder, or other bleeding disorder, requiring treatment of factor	One (1) comprehensive treatment center visit		
	Factor (limited to \$2,500 per authorization)	Up to \$7,500	50% Coverage = Up to \$3,750 25% Coverage = Up to \$1,875
Metabolic Products (DAP-MP)  Must be diagnosed with PKU, or other amino acid disorders, requiring treatment with metabolic products	Formula (limited to \$750 per month) ***PKU clients who are pregnant or nursing (limited up to \$1000.00 per month)***	Up to \$9,000	50% Coverage = Up to \$4,500 25% Coverage = Up to \$2,250
	Low-Protein Food Items (limited to individuals 18 or younger)	Up to \$1,500	50% Coverage = Up to \$750 25% Coverage = Up to \$375

**Aid-To-Local Funding Process:** In FY16, the KS-SHCN program transitioned the request for funding process to be more in line with the MCH process by integrating within the agency's Aid-to-Local (ATL) system. Through this integration, partners were provided the outline of the KS-SHCN 5-year plan, and they were asked to identify the community needs related to the priorities and objectives and submit proposals on how they felt they could best address those needs. The applicants were able to demonstrate need, identify anticipated health outcomes of services, and show evaluation measures that would be used. Clinical

service requests were required to outline how they will provide, and bill for, services. Those seeking funding support for clinical services were required to complete an exemption request form, showing how the services are either non-billable or non-reimbursable, supporting a stronger accountability for funding.

Partnerships have been strengthened and cost-savings have been abundant allowing for the addition of new partnerships. The process supported partners by providing them opportunities and an avenue for recommending systems change, or advocating for additional support to promote higher quality services. Partners were asked to think outside the box and consider the true needs of families served through their funding. Another component of the funding request process includes an expectation of matching funds to assure the applicant is financially committed to the services provided or activities to be completed.

The KS-SHCN program also joined the Maternal Child and Health ATL process to expand satellite offices across Kansas for FY17. Five new satellite office were added with the goal to add more in FY18. All new satellite offices are Maternal and Child Health sites leading to better coordination of care for children with special health care needs. This expansion is needed in order to provide quality care coordination services to clients/families in their local communities.

*KS-SHCN Contract Partnerships:* KS-SHCN joined the ATL process in FY16. Through the ATL process applicants were provided access to the online application and reporting system, Catalyst, for ATL grant. The applicants were provided the KS-SHCN Priorities and Objectives, and asked to share the “problem” or “community need” as related to the Objective. For each objective the applicant was interested in addressing, they were then asked to share strategies or activities to implement, anticipated health outcomes, and long-term sustainability needs. Of the 20 proposed initiatives, 5 were funded “as written,” 3 were not recommended for funding, and the remaining 12 were recommended to “Fund with Conditions”.

A review team consisting of the following was developed to review all applications: Special Health Services/Title V CYSHCN Director; KS-SHCN Program Manager; KS-SHCN Care Coordinators; and SHS-FAC Members. This resulted in at least 3 or 4 separate reviewers for each project proposal. A scoring rubric was provided and the responses were compiled and calculated. Internal (KDHE) reviewers met to discuss each proposal and make final funding recommendations: Accepted proposals included specialty and outreach clinical services, parent trainings and supports, care coordination, community services, and youth leadership and development.

Of the 20 applicant proposals, 50% were entirely new project initiatives, which were not solicited by the KS-SHCN program. Of the 17 funding recommended proposals: 7 were from entirely new partners; 4 were from existing partners, but new initiatives; and 6 were continuation funding requests from existing partners. Contracted projects included specialty and outreach clinical services, parent trainings and supports, care coordination, community services, and youth leadership and development. Refer to the chart of services in the CYUSHCN Plan Section.

The majority of these programs were pilot programs, intended to provide the most financial support during the initial development and first year of implementation, with a gradual reduction in funding until the initiative is self-sustaining or other funding has been secured. Evaluation and sustainability plans were integrated into the proposal process to support effective data collection and long-term sustainability of the initiative.

*KS-SHCN Enhanced Data System:* The existing data system currently does not meet the needs of the KS-SHCN program, which has become increasingly more challenging since the strategic planning and shift in programmatic activities. This past year, a formal Request for Proposal (RFP) was developed for a new data system that could meet all the program needs and be enhanced through the development of a family portal so families can access their Action Plans and Authorizations, update their application, and send messages directly to their care coordinator. This new system will have all the features needed for care coordination services, correspondence with families and providers, data tracking and evaluation, budget, auto-calculation of financial eligibility, develop Action Plans and Authorizations and more. Four quality bids were received and the review is being finalized at this time. It is expected to begin contracting with the awarded vendor in Summer 2017 and a new system in place by January 2018. This new system will allow the KS-SHCN program to better streamline workflow and be more efficient in meeting the client’s needs.

*Family Engagement Initiatives:* Family involvement within the CYSHCN population has been a priority for many years. This was

a primary focus of the strategic planning and embodied throughout the process. Every priority, objective, strategy and outcome measure of the KS-SHCN 5-Year Plan was either developed by, with, or with approval of the SHS-FAC. This is one way the program supported family involvement as decision and policy makers.

Family involvement also goes beyond decision- and policy-making needs for the state. Another focus of KS-SHCN is to educate and equip families for involvement in all aspects of their own lives. This includes parents or caregivers advocating for their children, but also advocating for their own needs or to support the overall functioning of their family. This is why Family Caregiver Health was identified as a high priority during the strategic plan. While this focus was integrated into the care coordination program, this is an independent initiative and focus area. This priority was selected from family input, sharing they find it difficult to take the time to care for themselves and address their own health needs, due to increased responsibilities related to taking care of their child with special health care needs.

The Family Caregiver Health initiative began with identifying and reviewing existing assessments, such as the University of Kansas Beach Center on Disability Family Needs Assessment (developed and researched as a model for the Kansas Early Intervention/Part C program). It was identified this most closely aligned with the vision of the program and the wishes of the SHS-FAC. The SHS-FAC was actively engaged in identifying what needs to be addressed in the assessment that will be used, with the Kansas AMCHP Family Delegate working collaboratively with KS-SHCN staff to adapt this assessment. The goals will be to identify areas of caregiver need and provide appropriate referrals and resources related to the health of the whole family. As part of the KS-SHCN Care Coordination Program, the family caregiver(s) will complete the assessment and the Care Coordinator will provide resources, referrals and supports to assist caregivers with their identified needs. This project remains under development, and was selected as one of two SHS-FAC projects for FY17. As part of this work the SHS-FAC developed a fact sheet on Trauma Informed Care to help give families better understanding on how trauma could be effecting them and those around them.

Local MCH Agency Services and Supports: Across the state, 31 of 80 (39%) MCH local agencies/grantees provided services to the Children and Youth with Special Health Care Needs population during State Fiscal Year 2016. At the present time (State Fiscal Year 2017), 30 of 71 (42%) grantees are providing services. Local agencies evaluate and screen children for a patient centered medical home to establish continuity of care for children with special health care needs. Resources and local provider lists are provided to families during visits if they do not have an established medical home. Local agency staff screen for medical home during KAN Be Healthy visits (Medicaid's EPSDT program), immunization visits, home visits, and any other service visit at the agency.

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#### **NPM 11: Medical home**

The Medical Home consists of six core components: accessible, patient/family-centered, continuous, comprehensive, coordinated, and compassionate. Each of the new KS-SHCN priorities address one of the six components of the medical home, as this is a foundational concept for building stronger systems of care for CYSHCN in our state. The Special Health Services Family Advisory Council (SHS-FAC) provided significant input and expertise in developing the new direction of the KS-SHCN Program, therefore the new priorities expand beyond the medical home approach and focus on an even more coordinated and holistic approach to providing services in Kansas. For example, care coordination addresses all six of the core components. Family caregiver health addresses the family-centered care and comprehensive nature of a medical home. The focus on behavioral health is intended to support continuous, comprehensive, coordinated supports. Training and education activities revolve around each component in some way, with a particular focus on the accessible and compassionate components. Lastly, direct health services ultimately address all five components.

Accessible Care: Ultimately, the focus for accessible care includes families understanding where to go for services, availability of providers in the community, and assurance of health insurance coverage. KS-SHCN provides this through partnerships and contracts with several health systems in Kansas to provide clinics, outreach diagnostic services and wheelchair management services, telehealth/telemedicine, and appropriate referrals to public and private insurance.

Patient/Family Centered Care: Nearly all activities provided by KS-SHCN are designed to be patient/family-centered. Families

are recognized as the expert, providing strength, knowledge, and support for the individual. In this model, the family voice is valued. In Kansas, this could not be more accurate. The Special Health Services Family Advisory Council (SHS-FAC) provides valuable insight and expertise to assure each program with SHS abide by this core component of a medical home, most specifically the Title V CYSHCN program. KS-SHCN adopts the mantra, "Nothing about us, without us" from the disability movement as services are planned for and provided. Therefore, consumers and families are engaged at all levels and central to the success of any initiative.

*Continuous Care:* With continuous care, ideally the same health care professionals would be available from infancy through adolescence. However, if this is not possible, smooth and successful transitions are critical to the process. This would also include assuring that the transition to adult health care system is calculated, planned, and the youth are prepared for what to expect next.

Additionally, KS-SHCN supports multi-disciplinary clinics in Kansas City and Wichita, which include activities around transition to adulthood. Clinic teams and coordinators work with patients and families to assist and assure services are identified and obtained prior to aging out of the program. Transition services are being expanded through the implementation of the KS-SHCN care coordination program. Care coordinators work with youth to help them identify where they are in the transition process and assist the youth in developing Action Plan goals to address transition activities to prepare them in learning how to navigate the systems of care.

*Comprehensive Services and Supports:* KS-SHCN continues to focus on comprehensive supports and care, assuring the child and family's needs are identified and addressed. The new KS-SHCN Care Coordination program is very comprehensive in terms of coordination and assistance, with the goal to support families in receiving comprehensive medical care.

*Coordinated Care:* The new KS-SHCN care coordination program is focused heavily on this component of the medical home. This includes not only the care coordination that will be provided by the program, but also within the activities with our provider partners in the development and utilization of a shared plan of care (SPoC). The goal is regardless of where the initial plan of care is developed, it will be developed with the patient or family engaged and at the center of the plan. The plan will be shared with all primary and specialty care providers involved with that patient's care and be made available to community service providers and external care coordinators (as identified and requested by the patient) to assure coordinated care across all sectors and to assure all needs are addressed.

*Compassionate Care:* KS-SHCN has engaged in a variety of activities to support this component of the medical home, most notably in the work done around adverse childhood experiences, trauma informed care/approaches, and resiliency. Ultimately, all of this is to support staff and providers in better understanding and empathizing with the patient and their family.

*Culturally Responsive Care:* Staff are trained in how to be culturally sensitive to the patient and family backgrounds. Staff have attended the Bridges Out of Poverty training and have been encouraged to learn more about the Social Determinants of Health and culturally-competent care.

Objective: Increase family satisfaction with the communication among their child's doctors and other health providers to 75% by 2020.

*Care Coordination Training:* In FY17, KS-SHCN continued to implement one-day parent/caregiver care coordination trainings to assist parents/caregivers and increase their knowledge of medical homes, community services and supports, obtaining insurance coverage, understanding shared plans of care, advocacy and to develop skills to better partner with their child's providers. The response to this program by participants has been very favorable.

KS-SHCN conducted four of these trainings across Kansas. The trainings are facilitated by KS-SHCN staff who are parents of children who have special health care needs. Trainings begin with the staff sharing their personal story to help families feel comfortable in knowing that they are in a non-judgmental environment where they are free to openly share their hopes, dreams and daily struggles of being a parent of a child with special health care needs. Participants complete a pre-, post-, and one-year evaluation, providing information that can then be used to improve the training. For FY18, KS-SHCN will conduct 2

parent/caregiver care coordination trainings across the state. One is already scheduled for September in Pittsburg, KS as a collaborative effort with the local federally qualified health center (FQHC).

Objective: Increase the proportion of families who receive care coordination supports through cross-system collaboration by 25% by 2020.

Local MCH Agency Strategies: Community Health Center of Southeast Kansas CHC/SEK continues to focus on expanded services with the addition of a full-time case manager/care coordinator for special needs children. The local agency joined KU Medical Center's Project Echo (Telehealth Rocks) that is bringing specialized education and case consultation service for children with special health care needs to provide parent support and education. On-site physical therapy services were added to services provided by a pediatric specialist two to three days a week. Clinic space is also provided to Children's Mercy staff to provide specialty clinics at CHC/SEK.

Nemaha County Community Health Services employs the school nurse for the school district. The nurse provides services to children with special health care needs on a daily basis and makes referrals when needed. The nurse also attends Individualized Education Plan meetings as requested by school staff.

KS-SHCN Care Coordination Program: KS-SHCN evaluated several care coordination models across the nation to develop a program for those served by the program in Kansas. After extensive research, planning, preparation, and development, the resulting program is a multi-phase, tiered coordination approach that will take several years to fully implement. Phase 1 of the program includes implementation of a robust Care Coordination program for KS-SHCN clients and families. Phase 2 of the program includes training and supports for community and medical providers who provide Care Coordination services. This would include assistance with workforce development and staff training needs. Phase 3 of the program includes supporting community-based Care Coordinators who would be placed in a medical providers' office, most likely part-time, and provide Care Coordination to CYSHCN in the practice.

The planning for Phase 1 was completed in late 2016 with the development of protocols, documentation tools/forms, training, and evaluation methods. The planning concluded and staff training began in early 2017 with an accompanying pilot phase. The development team consisted of staff in both administrative, social work, and nursing capacities from various hospital systems and the state agency. This provided robust conversation and a comprehensive approach to development of the overall plan, something that would work for various systems. Staff identified the primary needs KS-SHCN families encounter, particularly learning how to navigate healthcare and other systems to best meet their child's needs. With this program, care coordination does not mean doing everything for families – rather partnering with them to learn systems and supporting them to feel comfortable and skilled at finding supports to meet their child's needs. A robust training plan has been developed and is set to begin in July 2017 with the existing and new satellite offices care coordinators, with statewide implementation in October 2017.

Satellite Office Expansion: Efforts to educate MCH staff and grantees and align KS-SHCN and MCH services has been the focus since January 2016 when the KS-SHCN Satellite Offices (SO) were integrated as part of the MCH ATL process. Through this integration, the KS-SHCN expanded from 6 offices in SFY 16 to ten in SFY17. Of the previous six SO's, three were located in local health departments (Crawford, Ellis, and Saline counties), two in hospital systems (Wyandotte and Sedgwick counties), and the administrative office served the North Central and Southwest regions (Shawnee county). Currently, the roles of the SO has simply been to provide an access point for families and consumer interested in KS-SHCN program services. This included information, referral, and assistance in completing an application. The regional offices were the first contact the families experienced with the program. This model worked to support a significant reduction in staffing within the Topeka Administrative office, due to an incentivized early retirement opportunity.

While the supports provided by the regional offices were valuable, the outcomes of the strategic planning efforts and resulting priority area for a robust care coordination model, it was quickly realized that additional capacity would be needed. The KS-SHCN program has been understaffed since those retirements in 2012, without the opportunity to obtain additional staffing. Therefore, a community-based approach was considered. Through partnership with the Bureau of Family Health, Children and Family Section, the KS-SHCN Satellite Offices were integrated into the Maternal and Child Health (MCH) Aid to Local (ATL) grant application for SFY16. At this time, the program increased from seven regional offices to the Satellite Office (SO) model, with 9 offices covering 11 regions. In SFY17, no new offices were added, however increased interest was seen in provision of

care coordination services at the local level. In SFY18, there will be a total of 14 SOs, in addition to the Topeka Administrative Office. More detail about the SO responsibilities can be found under the CYSHCN Domain Plan.

*KS-SHCN and Infant-Toddler Services Partnership:* To support stronger coordination, KS-SHCN and the Kansas Infant-Toddler/Early-Intervention program has partnered to begin the development of a formal Intragency Agreement (IAA). Both programs have worked collaboratively in past years but are strengthening that relationship with an IAA. The IAA addresses cross training opportunities for both programs and contains a formal reciprocal referral process to make sure all children received the appropriate referral and services. As part of this process the KS-SHCN team has developed a program decision scheme to assist the Infant-Toddler providers to know when to refer families to the KS-SHCN program. Additionally, the Kansas Infant-Toddler and KS-SHCN program have co-presented several times for early childhood providers throughout the last year and plan to continue to do that in the coming years.

*KS-SHCN and Medicaid Partnership:* The KS-SHCN program works collaboratively with our Medicaid and MCO partners to make sure clients are receiving the appropriate services. Care Coordinator review the monthly MCO reports so they know what services the MCO has authorized for the client and works with the client to assist them in getting appointments scheduled, fill prescriptions, and effectively communicating with providers, etc. They communicate with the MCO care coordinators to let them know if there are any gaps or barriers in the client's services they may not be aware of. One area where this collaboration has really shown a benefit is for clients with cleft lip/palate conditions. Many times this service was being denied or delayed due to miscommunication. With the assistance of the KS-SHCN Lead Care Coordinator clients are moving through the MCO approval process quicker and with positive results. The program also assist, if needed, the MCO's in working with the orthodontic providers who are able to treat these clients' unique needs. Since the KS-SHCN program has had a long standing history with the orthodontic providers assisting with this partnership has been an easy thing for the program to do to make sure the services happen in a timely fashion.

*KS-SHCN and Birth Defects:* The KS-SHCN program began working on protocols and procedures to assist families who have a child who have been born with complications due to exposure to the Zika virus. Once the program is notified about a child born with Zika exposure the staff immediately reaches out to the family to let them know about the program and what assistance they might be eligible for, including care coordination. This is being done in partnership with the new Birth Defect program. As the Birth Defect program continues to be developed the KS-SHCN program will develop protocols and procedures to assist those children and families, as well.

Objective 7.3: Develop an outreach plan to engage partners, providers, and families in the utilization of a shared resource to empower, equip, and assist families to navigate systems for optimal health outcomes by 2020.

*Shared Plan of Care (SPoC):* As part of the D-70 grant work a Shared Plan of Care (SPoC) has been developed and is currently being piloted in a large pediatric office. The intent of this project is to develop a replicable model that includes the SPoC document, protocols, policies and procedures for its use that can be offered to other interested pediatric offices across the state.

The KS-SHCN team began by researching a variety of SPoC and provided several versions to the partnering pediatric team for their review. Once reviewed, the pediatric clinic team then identified which components they would like in their SPoC document and the KS- SHCN staff formatted it and sent it to a Family Advisory Team member for parent input before sending it to the pediatric team to begin piloting. The SPoC has undergone several PDSA cycles and been refined to its current state. Piloting has occurred with 66 children who have asthma or obesity issues. It will continue to be piloted with these two populations, as well as, ADHD in the coming months. Protocols and procedures are being refined by the clinic staff until they are ready for it to be used in other facilities. Through this process a need was identified for clinic staff to receive training on a variety of topics in order to better assist their patients. From this need "Lunch and Learns" were developed. The KS- SHCN staff has held one "Lunch and Learn" to share information with the clinic staff on the Family Care Coordination Training that is provided to families across the state by the KS-SHCN program. Two additional ones have been requested and are currently being developed around waiver services and Individualized Health Care Plans in schools. More will be developed based on requests from providers.

As part of the SPoC work the KS-SHCN provider application was modified to determine if providers are already using a SPoC in their practice, and if not, would they like assistance from the KS-SHCN program to begin implementing a SPoC in their practice.

The KS-SHCN team is developing SPoC fact sheets for both providers and families. A video is also being developed that will be located on the Navigational Tool Kit and can be run in pediatric offices. It is the intent of the program to engage the assistance of the Family Advisory Council (FAC) in the development of the video.

System Navigation Activities: KS-SHCN continued to house the Kansas Resource Guide (KRG) in an effort to support access to community resources and service systems. Over the last year a follow up tracking protocol was developed and implemented to identify if those who call KRG for assistance receive the services they were looking for, if not, additional assistance is given to help them find what they are seeking. PDSA cycles were used to determine if additional changes needed to occur.

In the fall of FY17, The KS-SHCN program was informed by the KRG website vendor that beginning in July '17 they would no longer support the KRG website. Fortunately, there were already plans in place due to the D-70 State Implementation Grant (SIG) to develop a new system for Kansas modeled from the "Help Me Grow" system in Connecticut. As this new system is being developed the 800 phone line and e-mail address will continue to be answered Monday-Friday from 8:30-4:30.

Once the new system is developed and expanded it is expected that the KRG service will fold into that system providing even more services and supports to families, providers and community members across Kansas. In the interim, beginning in December of '17 a Navigational Tool Kit was developed and is located on the KS-SHCN website. This user friendly tool kit covers 11 different categories (education, health, insurance, community services, transportation, benefits, housing, parenting, transition, technology, and employment) and contains national, state and local resources. Family Advisory Council members were key contributors to the Navigational Tool Kit with new resources added as they are identified.

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**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**

Objective: Incorporate information regarding changes to the health care system into existing trainings and technical assistance by 2020.

Standards for Systems of Care for CYSHCN. The program continues to build infrastructure and capacity for increased services for all CYSHCN in Kansas. KS-SHCN has been aligning program services and contractual supports with the "Standards for System of Care for Children and Youth with Special Health Care Needs". Over the last year, with the award of the D-70 Systems Integration Grant (SIG) and the requirement to develop a "state plan" the KS-SHCN team has been working to align the program with the "National Standards for Systems of Care for Children and Youth with Special Health Care Needs". This process was already in the works prior to the grant award, but assisted in moving the process forward more rapidly. Rather than developing a plan specific to the grant, the team decided it would be most worthwhile to develop a plan around the overall system of care in place for CYSHCN. The "Kansas State Plan for Systems of Care for CYSHCN" was submitted as part of the D-70 Grant Progress Report in 2016, however is being expanded to include the second and third phase information.

To date, three phases of the state plan have been completed with an addition two to be finalized by the Spring of 2018. Each phase has consisted of two system domains, with each domain consisting of 6 regional meetings (one in each public health region) across the state to gather information from families, providers and community partners on what we are doing well and where we need to better align. Each phase has an accompanying survey one for providers and one for families to assist with gathering more information. Once all information has been gathered and compiled a final stakeholder meeting is held to review the findings and to identify next steps through a shared vision. Though this process the need for the new resource and referral system was identified.

Now that the KS-SHCN program has begun implementing strategic plan activities, it is expected that the program will grow and provide improved services to individuals served by KS-SHCN. Many of these goals and strategies will take a few years to develop, but provide opportunities for steady improvements in services and supports for CYSHCN and their families.



## Cross-Cutting/Life Course

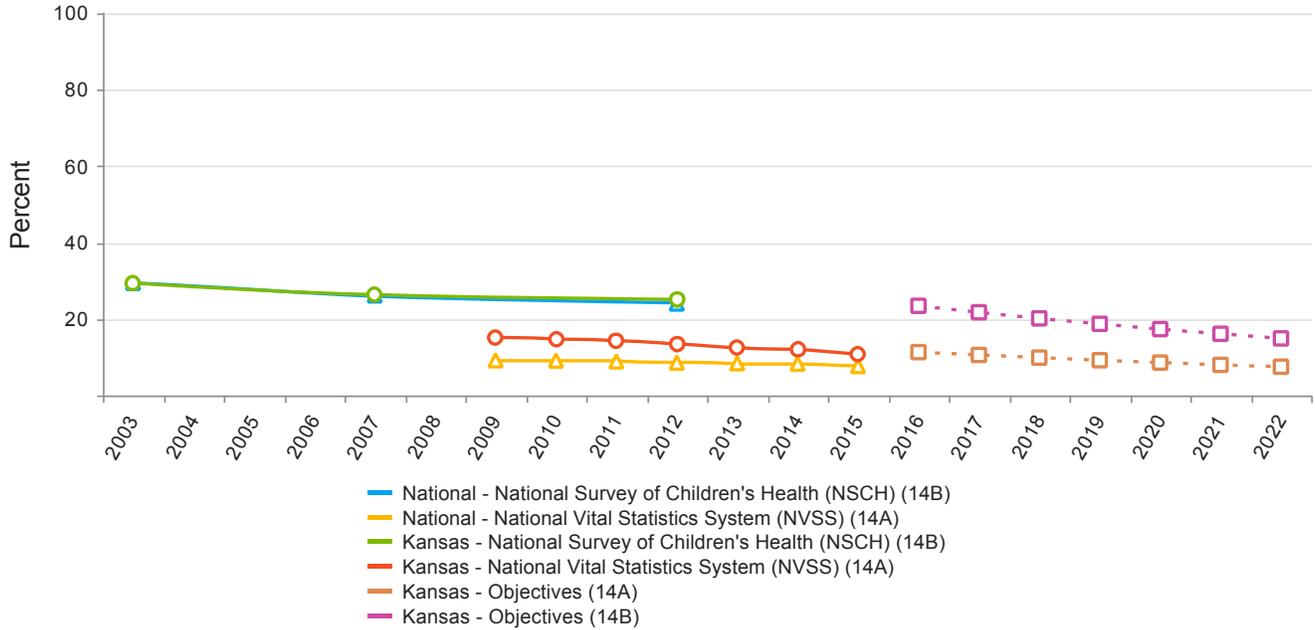
### Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2014	111.2	NPM 14
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2011_2015	17.8	NPM 14
NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2015	6.8 %	NPM 14
NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)	NVSS-2015	1.2 %	NPM 14
NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)	NVSS-2015	5.6 %	NPM 14
NOM 5.1 - Percent of preterm births (<37 weeks)	NVSS-2015	8.8 %	NPM 14
NOM 5.2 - Percent of early preterm births (<34 weeks)	NVSS-2015	2.4 %	NPM 14
NOM 5.3 - Percent of late preterm births (34-36 weeks)	NVSS-2015	6.3 %	NPM 14
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2015	24.1 %	NPM 14
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2014	6.1	NPM 14
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2014	6.2	NPM 14
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2014	4.5	NPM 14
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	1.7	NPM 14
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2014	211.6	NPM 14
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2014	89.2	NPM 14
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	86.8 %	NPM 14

**National Performance Measures**

**NPM 14 - A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes**

**Baseline Indicators and Annual Objectives**



**NPM 14 - A) Percent of women who smoke during pregnancy**

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2016
Annual Objective	11.4
Annual Indicator	11.0
Numerator	4,298
Denominator	39,083
Data Source	NVSS
Data Source Year	2015

State Provided Data	
	2016
Annual Objective	11.4
Annual Indicator	11
Numerator	4,294
Denominator	39,052
Data Source	Kansas Vital Statistics
Data Source Year	2015
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	10.7	10.0	9.3	8.7	8.1	7.6

**NPM 14 - B) Percent of children who live in households where someone smokes**

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	23.5
Annual Indicator	25.3
Numerator	180,387
Denominator	713,663
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	21.8	20.2	18.8	17.4	16.2	15.0

**Evidence-Based or –Informed Strategy Measures**

**ESM 14.1 - Percent of pregnant women program participants who smoke referred to the Tobacco Quitline and enrolled/accepted services**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	13.3
Numerator	13
Denominator	98
Data Source	DAISEY
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	15.0	17.5	20.0	22.5	25.0	27.5

**State Performance Measures**

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

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	91.5
Numerator	657,320
Denominator	718,755
Data Source	NSCH
Data Source Year	2011_2012
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	92.4	93.3	94.3	95.2	96.2	97.1

**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**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	47
Numerator	987,775
Denominator	2,101,649
Data Source	Kaiser Family Foundation
Data Source Year	2008
Provisional or Final ?	Provisional

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	44.7	42.4	40.3	38.3	36.4	34.5

## State Action Plan Table

### State Action Plan Table (Kansas) - Cross-Cutting/Life Course - Entry 1

#### Priority Need

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

#### NPM

A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

#### Objectives

7.1 Increase the proportion of smoking women referred to evidence-based cessation services to 95% or higher by 2020.

7.2 Increase abstinence from cigarette smoking among pregnant women to 90% by 2020.

7.3 Implement collaborative oral health initiatives, identify baseline measures, and expand oral health screening, education, and referral by 2020.

7.4 Build MCH capacity and support the development of a trained, qualified workforce by providing professional development events at least four times each year through 2020.

7.5 Deliver annual training and education to ensure that providers have the ability to promote diversity, inclusion, and integrate supports in the provision of services for the Special Health Care Needs (SHCN) population into adulthood.

## Strategies

7.1.1 Promote provider training on tobacco use and smoking with focus on pregnancy, identifying resources and interventions available including Nicotine Replacement Therapy (NRT). 7.1.2 Expand education and utilization of the Tobacco Quitline (including reminder and fax referral system). 7.1.3 Promote referral to the Baby & Me Tobacco Free program, SCRIPT, and other evidence-based interventions where available. 7.1.4 Increase the number of communities implementing the SCRIPT program, including motivational interviewing techniques.

7.2.1 Place toolkits (screening, referral, resources, and programs) in the hands of providers. 7.2.2 Facilitate referrals to Baby & Me Tobacco Free and other evidence-based programs for smoking cessation counseling and support based on family risk and need. 7.2.3 Standardize smoking history and screening forms. 7.2.4 Enlist support of pediatricians to inquire about smoking, counseling, and referrals postpartum. 7.2.5 Leverage consistent, repeat messages about tobacco and nicotine across all systems and services, using media, social media, texting, videos, peer-to-peer mentoring. 7.2.6 Engage women and families to collect input on additional interventions to support cessation.

7.3.1 Integrate oral health education and referral into prenatal and infant health education through BAM programs, well visits, dental visits, home visits. 7.3.2 Promote oral health in all programs targeted towards CYSHCN through care coordination activities. 7.3.3 Repeat on-site oral health screenings at child care facilities through the Healthy Smiles initiative in three years. 7.3.4 Continue offering the existing training and develop level 2 and 3 courses to build on education through Healthy Smiles. 7.3.5 Educate health care professionals regarding the child care home population for ongoing screenings and oral health education.

7.4.1 Increase knowledge of providers, partners, and consumers, including families, as it relates to Kansas Maternal and Child Health: purpose, scope, target populations, programs, services, and more. 7.4.2 Develop a system to capture increases in MCH staff and grantees completing trainings, such as the MCH navigator self-assessment. 7.4.3 Incorporate MCH competencies more intentionally into MCH position descriptions. 7.4.4 Train paraprofessionals working with families on strategies to address risk of immediate harm to support safe, stable and nurturing environments.

7.5.1 Offer information and training to child care and education providers to support inclusion within those settings and assure higher quality care for CYSHCN. 7.5.2 Host webinars and online trainings for health providers on caring for CYSHCN, adapting from the Caring for People with Disabilities course. 7.5.3 Partner with the National Alliance on Mental Illness (NAMI) to offer youth and adult education programs to KS-SHCN clients.

## ESMs

## Status

ESM 14.1 - Percent of pregnant women program participants who smoke referred to the Tobacco Quitline and enrolled/accepted services	Active
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## NOMs

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

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NOM 3 - Maternal mortality rate per 100,000 live births

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NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

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NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

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NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

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NOM 5.1 - Percent of preterm births (<37 weeks)

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NOM 5.2 - Percent of early preterm births (<34 weeks)

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NOM 5.3 - Percent of late preterm births (34-36 weeks)

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NOM 6 - Percent of early term births (37, 38 weeks)

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

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

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

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NOM 9.3 - Post neonatal mortality rate per 1,000 live births

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

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

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NOM 19 - Percent of children in excellent or very good health

Priority Need

Services and supports promote healthy family functioning.

SPM

Percent of children living with parents who have emotional help with parenthood

Objectives

6.1 Increase opportunities to empower families and build strong MCH advocates by 2020.

6.2 Increase the number of providers with capacity to provide trauma-informed care by 2020.

6.3 Increase the number of families receiving home visiting services through coordination and referral services by 5% annually.

Strategies

6.1.1 Provide family and sibling peer supports for those interested in being connected to other families with similar experiences (e.g., Foster Care, Children and Youth with Special Health Care Needs (CYSHCN), others). 6.1.2 Conduct "Care Coordination: Empowering Families" trainings for parents of CYSHCN. 6.1.3 Increase the number of fathers and male support persons that are engaged in family health activities. 6.1.4 Identify options to provide supports (e.g., making healthy choices, positive coping mechanisms, violence, substance abuse, and mental health issues) to parents of adolescents, such as home visiting and peer-to-peer networks.

6.2.1 Increase MCH state staff and partner capacity around trauma-informed care. 6.2.2 Conduct an environmental scan to identify the types of trauma-informed care occurring in the state and the providers offering it. 6.2.3 Provide training for MCH grantees including home visitors on trauma-informed care.

6.3.1 Develop and utilize strategies for MCH home visitors to improve effective outreach and engagement of families in universal home visiting services. 6.3.2 Enhance and expand coordinated intake and referral systems across the state to support appropriate referrals and levels of services for families. 6.3.3 Partner with Healthy Start; Maternal, Infant and Early Childhood Home Visiting (MIECHV); and Becoming a Mom (BAM) communities to ensure coordination and referral for home visiting services.

Priority Need

Information is available to support informed health decisions and choices.

SPM

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

Objectives

8.1 Increase the proportion of MCH grantees that provide health information education to clients to improve health decision making among women, pregnant women, children, adolescents, and children and youth with special health care needs annually.

8.2 Partner with Health Literacy Kansas (HLK) to provide training to improve the knowledge of parents and teens as to the importance of making informed health decisions by 2020.

8.3 By 2020, create and disseminate a toolkit for preschool through school-aged providers with a curriculum and activities designed to teach children and adolescents about healthy habits and choices.

8.4 Increase youth-focused and youth-driven initiatives to support successful transition, self-determination, and advocacy by 2020.

8.5 Incorporate information regarding changes to the health care system into existing trainings and technical assistance by 2020.

## Strategies

8.1.1 Identify a baseline proportion of MCH grantees using DAISEY who are providing health information education. 8.1.2 Provide resources to increase education and knowledge of healthy decision making. 8.1.3 Work with partners to ensure that well visits incorporate best practices.

8.2.1 Emphasize the importance of health insurance literacy with HLK. 8.2.2 Identify target populations and/or regions that require increased health literacy support. 8.2.3 Promote distribution and use of "What to do when your child gets sick."

8.3.1 Identify effective age-appropriate approaches to assist children ages 6 to 11 years with making informed decisions about health and wellness. 8.3.2 Work with schools to incorporate information about healthy choices into school enrollment and orientation materials. 8.3.3 Work with child and youth programs (Child Care, Girl Scouts, Boy Scouts, Boys and Girls Club, YMCA, etc.) to provide health and wellness information. 8.3.4 Distribute The Future is Now THINK BIG – Preparing for Transition Planning workbooks to schools for distribution to children and adolescents as part of orientation.

8.4.1 Implement the youth leadership program, Faces of Change. 8.4.2 Implement Plan It Live It to support effective transition planning. 8.4.3 Explore opportunities for increased youth leadership. 8.4.4 Provide opportunities for parents to improve their skills in seeking out quality health-related information.

8.5.1 Educate MCH staff regarding ongoing changes to the health care system. 8.5.2 Identify opportunities to optimize changes in the health care system to maximize service delivery to families. 8.5.3 Sponsor and/or host regional training on health transformation. 8.5.4 Provide training and technical assistance to local health departments on MCH service planning and delivery. 8.5.5 Support connection between local health departments and Navigators to increase families' access. 8.5.6 Review and identify steps to incorporate information from the Peer-to-Peer Technical Assistance for State Title V MCH Programs on Implementation of the ACA. 8.5.7 Review and incorporate Standards for Systems of Care for CYSHCN.

## **Cross-Cutting/Life Course - Plan for the Application Year**

NOTE: All eight of the Kansas priorities are tied to an MCH population domain as required. Five priorities are tied directly to one population domain, covering Women and Maternal, Perinatal and Infant, Child, Adolescent, and Children and Youth with Special Health Care Needs. Three priorities are tied to one domain--Cross-cutting/Life Course. The three priorities are outlined in this section (State MCH Priority 2, 6, 8).

*Local MCH Reach:* Based on FY2018 applications, 47 of 70 (67%) MCH grantees plan to provide services to support the Cross-Cutting/Life Course domain.

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## **PRIORITY 2: Services and supports promote healthy family functioning**

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

Objective: Increase opportunities to empower families and build strong MCH advocates by 2020.

*Parent Support Network:* Based on feedback throughout the KS-SHCN strategic planning process and the Title V Needs Assessment, a need for a family mentor program – where families who have children with similar special health care needs can communicate with each other and gain support from one another – was identified. In a collaborative partnership the Special Health Services (SHS) programs are working together to develop the Family Support Network. A mentor/mentee data system has been identified to assist with connecting parents, caregivers, or siblings who have similar experiences or needs, including matches based on the child or youth with special health care needs condition or services. Newborn Hearing Screening (NBHS) is currently piloting the program and plans to expand to Newborn Screening (NBS) and KS-SHCN in the coming year. A mentee parent information form has been developed and approved by the Special Health Services-Family Advisory Council (SHS-FAC) for use. Policies, protocols, tools, recruitment and trainings for SHS staff and mentee parents will be developed over the next year and offered as part of care coordination services.

*Special Health Services Family Advisory Council (SHS-FAC):* During the 2017 Annual Retreat, on June 24-25, 2017, members were provided an overview of the SHS programs, individual grant or program work plans, information about how programs are aligned, funded, and organized across the state. This activity supported the members in making recommendations for the SHS programs, as well as strategically planning the groups' upcoming project, or area of focus.

In the past, the group has organized into two or three small groups and worked on different initiatives. This year, the group consensus was to work as one group on a larger initiative. They selected to work on Objective 2.3.2. of the KS-SHCN Action Plan, to “provide family and sibling peer supports for those interested in being connected to other families with similar experiences.” The coming year will be dedicated to developing an expanded peer-to-peer family support program, building from the existing Parent Support Network developed by the NBHS program and learning from similar programs across the country and within Kansas. The family members will lead this work through implementation, with support from KDHE and the SHS Director and Program Managers.

Additionally, the SHS-FAC provided a recommendation to the SHS programs to engage in cultural and linguistic competency initiatives, beginning with the identification or development of a training for the family leaders on the council, the program staff, and external partners. An existing training has been promoted throughout the agency and will be the starting point for this work.

*Care Coordination:* The KDHE Bureau of Family Health's Special Health Care Needs program spent the last year developing and piloting a new holistic care coordination model for children and youth with special health care needs. The program officially launches in July 2017 within the Topeka office. Training is planned for the satellite offices throughout the summer and into the fall. Full statewide implementation is planned for October 2017. The Care Coordination model addresses the needs of the entire family to assure Children and Youth with Special Health Care Needs are supported in all aspects of their lives. The program has also provided care coordination training to families across the state over the last two years. The goal of this

training is to help families learn how to better communicate with their medical providers and advocate for their child's health needs. *Training flyer:* [http://www.kdheks.gov/shcn/care\\_coordination.htm](http://www.kdheks.gov/shcn/care_coordination.htm)

*Teen Pregnancy Targeted Case Management (TPTCM) and Pregnancy Maintenance Initiative (PMI) Programs:* All ten TPTCM agencies and nine PMI agencies will continue to incorporate parenting education as a fundamental part of their service model. Educational material will be presented individually through one-on-one sessions and in group settings when appropriate to facilitate peer support networks. Fathers will be encouraged to participate in activities alongside the mother when appropriate to increase knowledge, skills and resources. Home visiting allows case managers the opportunity to assess living situations and provide support to further engage families in healthy choices.

*Prenatal Program Support (Becoming a Mom® (BaM) classes/sessions):* Plans for 2018 include the expansion of such integration components, including those of cross-cutting nature, into the BaM curriculum. Conversations with current KPCC have indicated the desire for the development of a 7<sup>th</sup> BaM session, targeted in the immediate postpartum period. In this 7<sup>th</sup> session, program participants who have delivered could return to the group setting with their new baby and support person to receive additional information that could not be covered during the traditional 6 prenatal sessions due to time constraints. This would also provide an opportunity for staff to follow-up with participants in that vulnerable postpartum period, in the supportive group environment they became accustomed to during the prenatal period. Communities where home visitation programs are not as readily available have expressed interest in such an opportunity.

Objective: Increase the number of providers with capacity to provide trauma-informed care by 2020.

The Kansas MCH team has been working with Wichita State University and partners including the Kansas Power of the Positive (KPoP) Task Force focused on Adverse Childhood Experiences (ACEs) and Trauma Informed Care/Systems of Care (TIC/TISC). We have completed review and training of the research and are moving on to the journey around review application in practice. A contract exists between KDHE and WSU's Community Engagement Institute (CEI) to assist with meeting this objective. Specifically, CEI will: 1) work with up to three public health organizations (including but not limited to: LHDs, FQHCs, and Safety Net clinics) who serve Medicaid beneficiaries to embed trauma-informed care, leadership, and treatment into all aspects of their organizational identity and practice; 2) respond to requests for technical assistance which could include facilitated discussions for groups exploring TISC but not yet ready for a formal training/presentation, individuals or groups working to implement TIC into their work, or those who may be interested in incorporating TISC into a funding proposal or other similar document, trying to make the case for bringing TISC into their work."

State MCH staff are looking to learn more from the Geary County Healthy Start/*Delivering Change* model related to the implementation of the *Lemonade for Life* ACEs protocol, developed by experts at the Iowa Department of Health and the University of Kansas. This information and program implementation plan will then be shared with other local grantees, to be adapted for incorporation into other community partnerships and programs. This, along with concentrated efforts around fatherhood involvement, are key areas of focus and planning for inclusion in the BaM program across the state in the upcoming year. State MCH staff dedicated to the development and expansion of this model will be working closely with BaM program sites and the Geary County Healthy Start/*Delivering Change* program, to ensure that successful models do not remain in isolation, but instead are shared and replicated in other communities across the state of Kansas.

In the fall of 2017, the MIECHV home visitors will receive trauma informed care, grief and loss training that the MCH home visitors will also be invited to attend. An initial assessment tool has been developed for MCH home visitors that includes an assessment of the emotional support of the mothers' life circumstances.

Objective: Increase the number of families receiving home visiting services through coordination and referral services by 5% annually.

*Home Visiting:* During the current reporting period, a Universal Home Visiting protocol was developed through a pilot project with Geary County Healthy Start/*Delivering Change*. The protocol was presented at the Governor's Public Health Conference, and materials have been made available at [www.kshomevisiting.org](http://www.kshomevisiting.org). Effective July 1, 2017, the MCH home visiting redesign will be implemented and local MCH home visiting programs will be expected to implement updated standards/guidelines. MCH

monitoring visits will include a review of records to ensure compliance.

MCH home visitors will follow these guidelines related to program outreach/recruitment:

- The home visiting program will develop a written outreach plan for submission in the annual MCH grant application (outreach plan requirements will be included in the fall 2017 home visiting training).
- Program monitoring visits will include a review of the written outreach plan and evidence it is being implemented.
- The home visiting program will conduct internal and external outreach and promotion of the home visiting services. Internal outreach will include each of the local health agency's programs delivering service to prenatal and post-natal women. External outreach will include physicians, hospitals, county social services programs, and early childhood education partners. In small counties without such local service providers, outreach will include these service providers in larger neighboring counties where prenatal and post-natal women receive such services.
- Outreach methods will go beyond brochures and flyers posted in the community and will include such approaches as letters, on-site visits, and participation in coalitions of other service providers, media information, health fairs and other community events.

MCH home visitors will follow these guidelines related to coordinated intake and referral systems:

- Referrals to other service providers that may meet a parent's needs will be made. When such referrals are made, there will be follow-up with the service provider to determine if the contact was achieved.
- When contact with the referral provider is achieved, the MCH Home Visitor will further follow-up to determine if the desired service was or is being delivered. The Home Visitor will seek signed consents for information sharing with other service providers, as appropriate.
- In the event the parent has multiple home visit service providers (such as Healthy Families America, Parents as Teachers, Early Head Start, Part C, etc.), the MCH Home Visitor will make efforts to conduct conferences with those providers in order to coordinate service delivery.
- Referrals and subsequent contacts as well as signed consents will be documented and maintained in the parent file/chart.

MCH home visitors are expected to record service and referral information in DAISEY; referral will be moved to IRIS following the IRIS implementation schedule across the state. KDHE will continue to promote the use of the Kansas Home Visiting website (<http://kshomevisiting.org>) to MCH home visitors. MCH home visitors will be invited to participate in MIECHV-hosted training and professional development opportunities.

The MIECHV Program will continue to support 500 caseload slots and services for pregnant women and families with infants and young children in Wyandotte County and Southeast Kansas (Cherokee, Labette, Montgomery, Neosho, and Wilson counties) through evidence-based and promising approach home visiting models, as well as local coordinated outreach and referral (central intake) programs.

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## **PRIORITY 6: Professionals have the knowledge and skills to address the needs of maternal and child health populations**

### **NPM 14: Smoking during Pregnancy and Household Smoking**

Objective: Increase the proportion of smoking women referred to evidence-based cessation services to 95% or higher by 2020.

Objective: Increase abstinence from cigarette smoking among pregnant women to 90% by 2020.

Refining our multi-tiered approach which includes universal screening and referral, education, counseling and medical interventions will continue to be a priority. Improvements in Quitline tools and processes will be pursued and expanded partnerships with the Bureau of Health Promotion and specifically Chronic Disease Risk Reduction (CDRR) grantees will be a priority. Kansas will also explore other intervention programs and strategies including Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT®) to begin moving beyond single intervention reliance. The MCH Health Program Analyst had a

call with SOPHE, the makers of SCRIPT®, in June 2017 to plan for a Kansas implementation training (one day train-the-trainer) to take place in Fall 2017. After the training, participants will be able to promote SCRIPT®, assess pregnant women for smoking, conduct SCRIPT® counseling session, plan the implementation of the program, organize and train staff, and evaluate effectiveness of the program. A comprehensive approach is being planned so the program is integrated into MCH, WIC, Home Visiting, and other existing programs as an additional evidence-based approach.

Incorporating medical interventions such as nicotine replacement therapy (NRT) can significantly improve Quit success rates so partnerships with Medicaid and clinical providers will be pursued in FY18 to improve coordination. Provider education on NRT for pregnant women will be featured at the Delivering Change Perinatal Conference in July 2017 with follow-up webinars planned by year-end. Promotion of Medicaid reimbursement for patient NRT and the provision of cessation counseling services will be promoted extensively in an effort to increase utilization among all stakeholders.

MCH Local Agency Strategies: Local agency staff will assess all pregnant women of smoking status and educate them about the dangers of smoking during pregnancy including home visitors. Tobacco use after pregnancy is also assessed during clinic visits as well as during home visits. Information and resources are given related to smoking during pregnancy, and second- and third-hand smoke exposure. Referrals will be made to the Kansas Tobacco Quitline. There are 38 grantees (81% of those that have chosen to provide Cross-Cutting/Life Course domain services) that are providing information and referring clients to KanQuit, the Kansas Tobacco Quitline. Local agencies will report client level data into DAISEY and will be able to track the smoking rates in their community. Education regarding tobacco use and exposure to tobacco/smoking (both while pregnant and after baby is born) is provided across many of the sessions of the BaM Prenatal Education classes.

Tobacco use and exposure will continue to be an important component of the BaM curriculum to address on birth outcomes and safe sleep. In addition to providing education on tobacco, there are currently 6 sites that serve as Baby and Me Tobacco Free (BMTF) sites, providing individual, prenatal smoking cessation counseling sessions, monthly follow-up sessions after baby is born, and incentives to encourage participation and completion. All pregnant women and support persons that chose to participate in BMTF are also referred to KanQuit to further support smoking cessation.

Local MCH program staff who screen for smoking and/or work directly with participants who smoke are required to complete *Addressing Tobacco Use in Kansas: Brief Tobacco Intervention Online Training* ([kstobaccointervention.org](http://kstobaccointervention.org)), an interactive, online course for health care providers demonstrating a “brief tobacco intervention” providers can use with patients who use tobacco products.

*Addressing Tobacco Use in Kansas: Brief Tobacco Intervention Online Training\**

- Free training available online 24/7 ([kstobaccointervention.org](http://kstobaccointervention.org))
- Takes about 30 minutes to complete
- Based on national clinical guidelines
- Appropriate for any member of the health team including front office staff and clinical care staff
- Learn how to effectively talk to your patients about tobacco cessation in 3 minutes.

\*Funded by the KDHE Bureau of Health Promotion

Infant Mortality CollN Efforts: Although the Infant Mortality CollN initiative will officially come to a close at the national level effective July 2017, Kansas intends to continue work related to both networks, including smoking cessation. From concept in 2014 to reality, the state has worked to integrate CollN activities into existing public health systems and programming to provide the mechanism to achieve current success and future expansion of programs. This integration extends to the inclusion of all CollN efforts in the Title V MCH State Plan and Aid-To-Local grant application process with collective impact and sustainability in mind.

The Kansas IM CollN Team met on May 22, 2017, to reflect, celebrate, and plan. The agenda for the day included plenty of time to reflect on the last few years, discuss successes and challenges, and plan for the future, with emphasis on sustainability, expansion/scale up, and health equity.

Special focus over the next year will be on the following:

- Refine pilot site cessation efforts (Saline and Crawford Counties); launch phase 2 sites in 3-5 targeted communities
- Develop Daisey evaluation system interface to track CollN data in statewide system
- Monitor BAM integration (toolkit, BTI, 5A's/3A's, BMTF, and SCRIPT®); and
- Develop programmatic and site recommendations based on ATL applications; BHP/CDRR partnerships; Implement and provide TA for new sites.

The Kansas smoking cessation aim, drivers, and change ideas are outlined below.

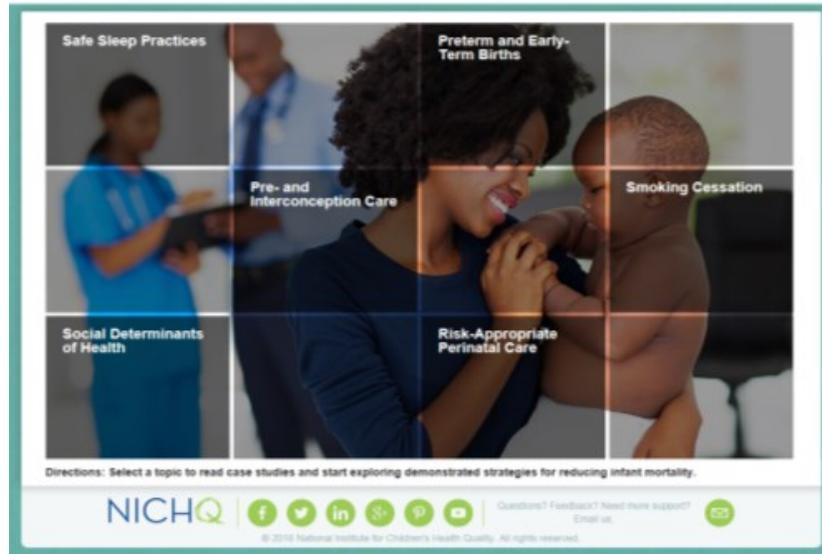
<p><b>Aim/Goals</b></p>	<p>By July 2017, we will reduce the rate of smoking in women in their reproductive years by 10% with emphasis on before, during, and after pregnancy.</p> <ul style="list-style-type: none"> <li>• Increase the percentage of women who stop smoking during pregnancy by 10%</li> <li>• Increase the percentage of women who maintain cessation after delivery by 10%</li> <li>• Increase the number of women enrolled in Quitline in reproductive years (15-44 years of age) by 10%</li> <li>• Increase the number of providers trained on the 5A's of tobacco cessation by 10%, implementing a provider reminder system and the KS Quitline fax referral system</li> <li>• In pilot sites: Increase the percentage of smoking women who are referred to smoking cessation counseling and programs like Quitline to 95% or higher</li> </ul>
<p><b>Primary Drivers &amp; Change Ideas</b></p>	<p><b>Women in child bearing years avoid smoking or stop and stay quit (Driver 3)</b></p> <ol style="list-style-type: none"> <li>1. Leverage use of 5As and motivational interviewing techniques to help women commit to stop and stay quit.</li> <li>2. Leverage consistent messages about tobacco and nicotine use across all community, professional and public systems.</li> <li>3. Use media/social media. Promote digital media and internet based smoking cessation interventions including apps, websites, and texts (e.g. www.women.smokefree.gov, Quit it Lite app, Cessation Nation).</li> <li>4. Enlist the support of pediatricians to inquire about smoking, counseling, and referrals postpartum.</li> </ol> <p><b>Providers recognize role in coaching and supporting women to stop and stay quit (Driver 4)</b></p> <ol style="list-style-type: none"> <li>1. Providers screen for smoking at every visit and make referrals to evidence based programs at the time of screening. Use 5As and warm referrals to Quitline and other evidence based programs at point of service.</li> <li>2. Providers follow up with women referred to evidence based programs to stop smoking. They inquire and refer again with advice that several tries may be needed.</li> <li>3. Encourage and train providers, community organizations, and health plans to use and refer women and adolescents to evidence-based smoking cessation programs like Quitline, SCRIPT®, Baby &amp; Me Tobacco Free, 5As, etc.</li> </ol> <p><b>Public Sensitivity to and awareness of women not smoking, avoiding, and ceasing all forms of tobacco and nicotine in childbearing years (Driver 5)</b></p> <ol style="list-style-type: none"> <li>1. Reinforce effective methods &amp; available supports and interventions (Quitline, other health plan programs).</li> <li>2. Reinforce that it is possible to quit, and that it may require several efforts</li> <li>3. Customize messages and content for OB/Gyn, pediatricians, and women healthcare providers so they know their role in helping women in childbearing years</li> </ol>
<p><b>State Measures</b></p>	<p><i>Outcome Measures</i></p> <ul style="list-style-type: none"> <li>• Smoking Cessation Prior to Pregnancy</li> <li>• Smoking Cessation During Pregnancy</li> <li>• Percentage of women who report smoking during pregnancy</li> <li>• Number of enrolled women Quitline participants, in childbearing years, who report cessation at 7<sup>th</sup> month after enrollment (in States where Quitline collects this data)</li> <li>• Disparity reduction in all 5 outcome measures</li> </ul> <p><i>Process Measures</i></p> <ul style="list-style-type: none"> <li>• Number of enrolled Quitline participants in childbearing years</li> </ul>
<p><b>Pilot Measures</b></p>	<p><i>Outcome Measures</i></p> <ul style="list-style-type: none"> <li>• % Pregnant women referred to Quitline who report they quit smoking at clinic visit</li> <li>• % Women with continued cessation at post-partum visit</li> </ul> <p><i>Process Measures</i></p> <ul style="list-style-type: none"> <li>• % Quitline Referrals</li> <li>• % Pregnant Women Counseled by Pilot Site to Quit</li> <li>• % Engagement of Women who Smoke</li> <li>• % Home Visitation Referrals by Clinic</li> </ul>

Kansas is proud to be featured in the Infant Mortality CollN Prevention Toolkit (Smoking Cessation Learning Network Case Study) and will utilize the resources provided as we continue advancing our efforts to reach our goal to further reduce infant mortality and eliminate disparities. Click on the link below to access the toolkit. Then, click on *Let's Get Started, Smoking*

Cessation, Case Studies, and you will see the KDHE case study (only one highlighted so far). There are videos, narrative, and tools we shared with NICHQ.

Screen Shot of the Infant Mortality CoIIN Prevention Toolkit Home Page

<http://nichq.org/preventiontoolkit/index.html>



Home Visiting: Resources related to tobacco cessation for home visitors are in development for the upcoming year. They will be placed on the Kansas home visiting website at [kshomevisiting.org](http://kshomevisiting.org). As home visitors become familiar with the Brief Tobacco Intervention approach and resources, they can better assist parents who smoke with the ability to quit. The reduction in pregnant women who smoke will assist the state with a reduction in the percentage of preterm births. Tobacco/smoking interventions have been identified as a parent education topic in the newly redesigned MCH home visiting program to be implemented July 1, 2017. The MCH Home Visiting program has undergone review and redesign. A recommended protocol, evidence-based resources, and technical assistance are available to local MCH agencies, using MCH Home Visiting as a core component of the system to identify and track women and infants who need additional supports. Trainings and additional resource information for home visitors will be provided through MIECHV to promote effective tobacco cessation information, referrals, and support practices in MIECHV sites and across MCH Home Visiting. All home visitors will utilize DAISEY (and later, IRIS) to track participant demographics, service data and referrals. Data will be monitored at the state and local levels to ensure effectiveness of service provision and identify opportunities for quality improvement.

Objective: Implement collaborative oral health initiatives, identify baseline measures, and expand oral health screening, education, and referral by 2020.

Oral Health Services for CYSHCN: The existing partnership with Oral Health Kansas will continue with dental hygienist services in the SHCN clinics. KS-SHCN Care Coordinators will continue working with families to assure they have a dental health home and are receiving preventive oral health care services. For program participants with Cleft Lip/Cleft Palate, KS-SHCN will work with Medicaid, dentist, oral surgeons, and community partners invested in oral health care in Kansas to assure children receive the care they need to support optimal health. The SHS-FAC is also interested in looking at oral health coverage gaps in the future, as part of their large group project focused on KS-SHCN Objective to "Identify needed insurance policy advocacy needs and partner with organizations to inform insurers on the needs for CYSHCN."

MCH Local Agency Strategies: There are local agencies that provide oral health screenings and apply fluoride varnish applications to children in the community. Sedgwick County Health Department provides preventive and restorative dental services to high-risk, un-insured low-income children from the age of 5-16. The Dental Clinic's strategies and screening tools

include a full functioning comprehensive dental clinic. Preventive services are provided by Wichita State University Dental Hygiene Students, supervised and instructed by a licensed Registered Dental Hygienist. Curriculum is evidenced- based and based on American Dental Association and American Dental Hygiene Association standards. The Dental Clinic also provides approximately 50% of state mandated Sedgwick County school screenings. They collaborate with community dental clinics and school nurses in an effort to provide as many screenings as possible which allow the community dental clinics to provide much needed expanded services, (cleaning, sealants and fluoride varnish).

Child Care-MCH Healthy Smiles Initiative: Child Care Licensing (CCL) will continue to collaborate with Kansas Child Care Training Opportunities (KCCTO) to offer additional level 1 and 2 trainings on oral health for children at a low cost for child care professional. CCL will collaborate to develop and offer a level 3 oral health training to child care professionals.

Objective: Build MCH capacity and support the development of a trained, qualified workforce by providing professional development events at least four times each year through 2020.

In addition to all the specific training by topic discussed across other domain sections, the MCH program in partnership with the KDHE Local Public Health (LPH) Program to provide the following professional development and support (by domain) during 2018:

#### Women & Maternal

- Work with MCH staff to focus topics for the 2018 Governor's Public Health Conference and the Regional Public Health meetings on the measures that are identified as areas of focus/need for Kansas.
- The HSHV Regional live training will be held again the fall of 2017. The HSHV program manager utilizes the Public Health Connections newsletter for live and online learning opportunities and communicates this information with the applicable MCH workforce. KS-TRAIN, managed by LPH staff, is used by the HSHV program manager to register and track participants in the live training.
- The KS-TRAIN team will be collaborating with the WIC staff on designing and building other online modules as well as assisting the MCH/Perinatal Health Consultant on the Becoming a Mom<sup>®</sup> prenatal education program modules.
- LPH staff will assist with efforts to design and implement a state-level response to Neonatal Abstinence Syndrome in Kansas.
- LPH staff will continue to participate in monthly Infant Mortality (IM) CollN calls focused on social determinants of health.

#### Perinatal & Infant

- Continue to provide workforce development opportunities focused on the measures that are identified as areas of focus/need for Kansas.
- The KS-TRAIN team will be collaborating with the WIC staff on designing and building other online modules as well as assisting the MCH/Perinatal Health Consultant on the Becoming a Mom<sup>®</sup> prenatal education program modules.
- LPH staff will assist with efforts to design and implement a response to Neonatal Abstinence Syndrome in Kansas.
- LPH staff will continue to participate in monthly CollN calls focused on social determinants of health.
- Online course development projects include rebuilding the Safe Slumber course for the Kansas childcare workforce, support development of an oral health course for Kansas dental hygienists and the rebuilding of the Kansas HIV Basic online course.

#### Child

- Continue to utilize Regional Public Health meetings and other communication venues for local public health administrators as an avenue for communicating updated changes from Kansas Medical Assistance Program (KMAP) on Kan-Be-Healthy exams/EPSTD and other important issues related to child health.
- Increase access to training and resources for local health departments related to developmental screenings.
- Continue involvement in the Kansas Alliance for Drug Endangered Children to providing training and resources to MCH staff and local health department administrators
- The KS-TRAIN Team is working with MCH staff to identify online course needs and develop a training plan for new Kansas MCH workforce.
- Continue efforts to identify, develop and implement initiatives to reduce Adverse Childhood Experiences, address social

determinants of health, and create Trauma Informed Systems of Care.

#### CSHCN

- Continue to serve as a liaison between the CYSHCN program and the local health departments.
- Participate in planning meetings around the CYSHCN strategic plan.
- Provide quality improvement training opportunities for CYSHCN staff.

#### Adolescent

- Continue to provide sessions related to adolescent health at the Governor's Public Health Conference and other training venues.
- Continue to provide information about adolescent health through the Public Health Connections electronic newsletter.
- Support partnerships for school based health initiatives (including specific efforts with USD 501 Topeka Public Schools).

#### Cross-Cutting/Life Course

- Respond to up to six requests for presentations or trainings to increase understanding of the health impacts of Adverse Childhood Experiences and support the implementation of Trauma Informed Systems of Care, in partnership with Wichita State University's Community Engagement Institute.
- Continue work to link MCH priorities to the Foundational Services.
- Continue efforts to support local health departments in conducting school inspections.
- Continue support for Kansas Health Matters (KHM).
- Continue to provide sessions related to cross cutting/life course issues at the Governor's Public Health Conference, Regional Public Health meetings and other venues
- Continue monthly population health webinars for local health department staff and other public health system partners
- LPH staff assisted with the review of MCH Aid to Local grant applications.
- Development and implementation of a performance management system at KDHE
- Support for quality improvement and accreditation efforts for local health departments and KDHE.
- Implementation and oversight of an electronic grants management system for the Aid to Local grants process.

*Health Equity and Social Determinants of Health* (SDoH): Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities." (Source: U.S. Department of Health and Human Services, Office of Minority Health. National Partnership for Action to End Health Disparities. The National Plan for Action Draft as of February 17, 2010 [Internet]. Chapter 1: Introduction)

Healthy People 2020 defines health equity as the "attainment of the highest level of health for all people"

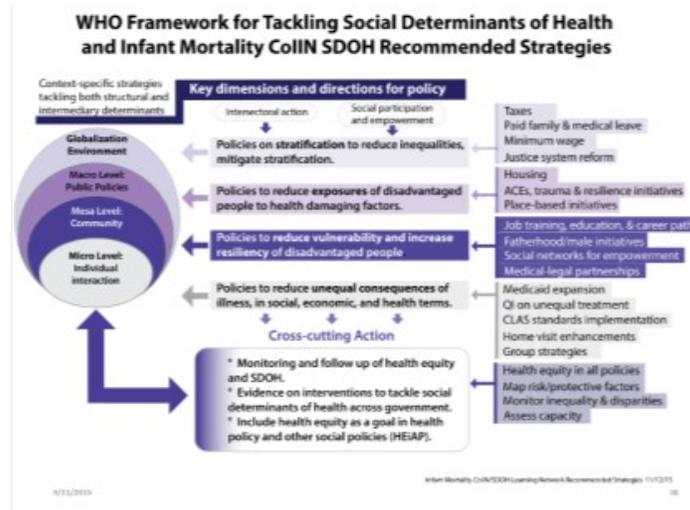
(<http://www.minorityhealth.hhs.gov/npa/templates/browse.aspx?&lvl=2&lvlid=34>). Healthy People 2020 defines a health disparity as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."

Over the last two decades, overall health in the United States has improved. However, there are striking disparities in the burden of illness and death experienced by African Americans, Hispanics, Native Americans, Alaska Natives, Asians, and Pacific Islanders, and underserved groups such as disadvantaged rural Whites. The most striking disparities include shorter life expectancy as well as higher rates of cardiovascular disease, cancer, diabetes, infant mortality, stroke, asthma, sexually transmitted diseases and mental illness. These disparities are believed to be the result of complex interactions among biological factors, the environment, and specific health behaviors. According to Healthy Kansans 2020 (set of recommendations to improve the health of all Kansans that is aligned with Healthy People 2020), lower socioeconomic and education levels, inadequate and unsafe housing, lack of access to care, quality of care, and living in close proximity to environmental hazards disproportionately affect racial, ethnic, and underserved populations and contribute to poorer health outcomes. Read more about the MCH plan to address health equity and disparities in the State Overview Section of this application/annual report.

A major area of emphasis over the next year will be on Health Equity and SDOH. Greater focus was placed on these topics as part of the 2017-2018 Kansas MCH Services Manual Revision. The MCH program is working with the KDHE Office of the Secretary to develop a plan and approach, based on the Infant Mortality CoIIN SDOH Network resources, tools, assessments, and results/experiences from 19 states that have been actively participating in the Network as part of the CoIIN initiative (2015-2016 experiences). The local MCH agencies have been provided with the following frameworks/approaches (we are using WHO and Healthy People) to address the issues collectively.

KDHE has also worked to coordinate with existing efforts taking place at the community level to address health disparities, including the Sedgwick County Healthy Start initiative and the Kickapoo Tribe in Kansas' Project LAUNCH grant. In these communities, the MCH staff team is able to identify and share best practices, and learn from community members to recognize opportunities for growth. During FY2018, we will explore expansion/adaptation of BaM into the Kickapoo Tribe in alignment with their LAUNCH efforts.

*WHO Framework: World Health Organization's framework adapted by the National Institute for Children's Health Quality for the Infant Mortality CoIIN initiative*



*Healthy People 2020 Approach to Social Determinants of Health—a “place-based” organizing framework, reflecting five (5) key areas of social determinants of health (SDOH)*



ACEs & Trauma Informed Care: See Priority 2, Objective 2 (Increase the number of providers with capacity to provide trauma-informed care by 2020).

Kansas Perinatal Community Collaboratives (KPCC)/Becoming a Mom® (BaM) Prenatal Education Program: Work is currently underway for the creation of an online training program for the BaM program. This online course will consist of 10 training modules. Program staff across sites will develop an individualized training plan with designated modules for required completion. Completion of the required components of the online training program will then certify the staff person for his/her role in program implementation. From early stages of program implementation in Kansas, the need for more comprehensive training related to the implementation of the program and group facilitation, has been apparent. With KDHE Bureau of Family Health committing dedicated staff time and funding for the project, we are now in the early stages of making this a reality. This will ease the burden of implementation on new sites, as well as with existing sites that are facing staff turnover. It will also support the standardization of curriculum delivery across sites, leading to improved program outcomes. From here, we hope to start the process of establishing the Kansas model as an evidence-based program. Course completion will provide staff with continuing education units approved by the Kansas State Board of Nursing.

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**PRIORITY 8: Information is available to support informed health decisions and choices**

**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.**

Objective: Increase the proportion of MCH grantees that provide health information education to clients to improve health decision making among women, pregnant women, children, adolescents, and children and youth with special health care needs annually.

Local MCH Agency Strategies: “What to do when your child get sick” books are easy to read and use for all literacy levels. The book and curriculum is discussed with families during clinic visits, home visits and/or after completion of the BaM prenatal education classes. Local agency nurses recognize health literacy being essential to promote healthy individuals, families, and communities. Local agency staff acknowledge that health literacy is a primary factor behind health disparities. Local MCH staff routinely assess materials for the level of health literacy and attempt to simplify information and illustrations, encourage a client's questions, and determine if a client can verbalize knowledge and understanding of the information presented. Most local agencies provide a Spanish translator at MCH and WIC services as needed to enable and strengthen communication between staff and clients. Staff realize that social, economic, environmental, and cultural factors may be underlying contributors to health and social outcomes. Educating and empowering clients by the best method possible helps to support informed health decisions and choices. Local agencies offer to help explain medical information with clients and parents if they report not understanding something. Staff make sure all written literature is an appropriate reading level for all clients.

Teen Pregnancy Targeted Case Management (TPTCM) and Pregnancy Maintenance Initiative (PMI) Programs: Case management services through the TPTCM and PMI programs will continue to include health education through one-on-one sessions and in group settings to increase client health literacy. Case managers will work with clients to identify individual healthcare needs through use of goal planning tools and will assist clients in connecting with resources available through the agency or through supportive community partners. TPTCM educational activities will include a continued focus on increasing clients' understanding of health care coverage options and improving their ability to access quality health care for themselves and their children.

Objective: Partner with Health Literacy Kansas (HLK) to provide training to improve the knowledge of parents and teens as to the importance of making informed health decisions by 2020.

SHCN Care Coordination: The KS-SHCN Care Coordinators will continue to assist clients/families in making informed health decisions by assisting them to learn about their options, make informed decisions, and assist in problem solving solutions. All information, written or oral, is presented to families with the health literacy of the family in mind. All KS-SHCN care coordinators are encouraged to participant in health literacy trainings. During care coordination training, health literacy will be discussed and all coordinators will participate in role playing activities to help them identify the families/clients literacy abilities and modify their assistance so the families/clients' needs are properly being addressed. The Care Coordinators will continue to provide training and support to clients/families to equip and empower them to be able to make health decisions independently.

Objective: By 2020, create and disseminate a toolkit for preschool through school-aged providers with a curriculum and activities designed to teach children and adolescents about healthy habits and choices.

Many local MCH agencies, including Ellsworth County Health Department, Lincoln County Health Department, and Stevens County Health Department provide targeted age-appropriate education and information to assist children in making informed decisions about health and wellness. Ford County Health Department and Nemaha County Community Health Services collaborate with local school districts to provide health and wellness information in after-school programs.

Objective: Increase youth-focused and youth-driven initiatives to support successful transition, self-determination, and advocacy by 2020.

The KS-SHCN program continues to partner with the Kansas Youth Empowerment Academy (KYEA) to provide the Faces of Change program for youth in Kansas. Faces is a program designed to build strong leadership skills for youth with disabilities. This program began in 2016, with the conclusion of the first session in the spring of 2017. The second session began shortly after that and will continue with monthly weekend sessions until November 2017. Recruitment for the third series will begin upon conclusion of the second series, but this time will include youth with and without disabilities. It is planned to be for 50 percent youth with disabilities and 50 percent those without disabilities. Throughout the second series the KYEA, KS-SHCN program and when hired, the new MCH Adolescent Health Coordinator, will work to modify the Faces curriculum to be for all youth not just those with disabilities. Follow-up evaluation will be sent to those who completed the first series to see how they have been using their leadership skills. Alumni from the first series will be guest speakers for the second and subsequent sessions.

Objective: Incorporate information regarding changes to the health care system into existing trainings and technical assistance by 2020.

The KS-SHCN program continues to build infrastructure and capacity for increased services for all CYSHCN in Kansas. KS-SHCN has been aligning program services and contractual supports with the “Standards for System of Care for Children and Youth with Special Health Care Needs.” This began with the strategic planning in 2015, however, has been enhanced with the KS-SHCN 5-Year Plan and the recently awarded D-70 Systems Integration Grant. As a requirement of the grant, a “state plan” must be developed. Rather than developing a plan specific to the grant, the team decided it would be most worthwhile to develop a plan around the overall system of care in place for CYSHCN.

This plan encompasses much more than the KS-SHCN or Title V systems, and will be used to create a plan for the 10 system standard domains. The plan was developed in five stages over the course of two years, allowing for sufficient review and assessment of each domain and related standards, utilizing a community engagement process and engaging the most appropriate partners for each domain. The process included six regional meetings (one in each public health region of the state), a statewide survey, and a full-day planning meeting with key stakeholders. Through the qualitative data received through the regional meetings, the quantitative data received through the survey, and the strategies presented at the planning meeting, a shared vision was achieved for the domains discussed. This first stage began in February and concluded in May 2016 and focused on the Medical Home and Community-Based Services and Supports domains. The second stage concluded in October 2016, focusing on Access to Care and Eligibility and Enrollment. The third stage concluded in May 2017, with a focus on the Screening, Assessment, Referral and Transition to Adulthood. The fourth stage will begin August 2017 and end in September 2017, with the focus on Family Professional Partnerships and Insurance and Financing. The fifth and final stage will occur February to May 2018, focusing on the final two domains: Health Information Technology and Quality Assurance and Improvement. The recent release of the modifications to the Standards for Systems of Care for CYSHCN (Standards 2.0) will likely impact stage four and stage five implementation. A full review is needed to determine the level of impact on this process and/or the already developed portion of the State Plan.

## Cross-Cutting/Life Course - Annual Report

NOTE: All eight of the Kansas priorities are tied to an MCH population domain as required. Five priorities are tied directly to one population domain, covering Women and Maternal, Perinatal and Infant, Child, Adolescent, and Children and Youth with Special Health Care Needs. Three priorities are tied to one domain-Cross-cutting/Life Course. The three priorities are outlined in this section (State MCH Priority 2, 6, 8).

*Local MCH Reach:* During FY2016, 58 of 80 (73%) MCH grantees provided services that aligned with the Cross-Cutting/Life Course domain.

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### PRIORITY 2: Services and supports promote healthy family functioning

#### SPM 5: Percent of children living with parents who have emotional help with parenthood

The 2011/12 National Survey of Children's Health showed that overall 91.5% of Kansas children ages 0-17 living with parents who had someone to turn to for day-to-day emotional help with parenthood/raising children. This was significantly higher than the national average of 88.1%. Child's race/ethnicity, family structure, parent's education, household income, medical home, and type of insurance all had a significant impact on reported emotional support. Non-Hispanic white children (94.8%) were more likely than Hispanic children (87.4%) and non-Hispanic children of other races (76.5%) to live with parents who had emotional support. Children in two-parent families (biological or adoptive) were more likely to live with parents who had emotional support (94.2%) than were children in single-mother households (82.7%). Children whose parents had more than high school education were more likely to live with parents who had emotional support (94.1%) than children whose parents did not complete high school (76.5%). Similarly, more children at 400 percent federal poverty level (FPL) or higher (95.3%) and 300-399 percent FPL (95.8%) reported living with parents who had emotional support compared to children in the less than 199 percent FPL (87.1%). Children who had a medical home (95.7%) were more likely than those with no medical home to live with parents who had emotional support (85.2%). More privately insured children (94.2%) reported living with parents who had emotional support compared to publicly insured children (87.3%). There were no significant disparities by child's age group, gender, special health care needs, adequacy of insurance, and urban and rural residence. The National Survey also reveals the following about children in Kansas:

- 47.7% of children ate a meal with all family members every day.
- Higher income families (400% FPL or higher) were less likely to share a meal together (39.4%).
- Hispanic families were the most likely to share a meal everyday (54.0%).
- Over half of children attended religious services at least weekly (56.0%).
- Relative to other groups, non-Hispanic black children were most likely to attend religious services at least weekly (63.1%).
- 59.7 % of children age 0-5 years are told stories or sung to by family every day.
- Hispanic children whose primary household language is Spanish are the least likely to be told stories or sung to everyday (40.4 %).

Objective: Increase opportunities to empower families and build strong MCH advocates by 2020.

*ACEs & Trauma Informed Care:* Strengthening family resilience has been a common goal among all MCH related programs at the state level in the past year. Great effort has been made by KDHE to create an awareness among local grantees of the need for focused initiatives in this area. Again this year, the annual Governor's Public Health Conference included breakout sessions supporting increased ACEs knowledge and trauma-informed approaches. Many local grantees have been partnering with other community agencies, making referrals to early childhood and parenting support programs. Focus on kindergarten readiness, centering on the social emotional health of the child, is a part of collaborative efforts at the community level, as highlighted by partnerships in the BaM collaborative models in Saline and Reno counties. As a part of the Healthy Start/*Delivering Change* initiative in Geary County, maternal and child screenings have been implemented as a part of the role of the OB Navigators and home visitors to assess strengths, risks, and needs. In 2016, partners in Geary County participated in ACEs 101 and Lemonade for Life trainings. These efforts through the federal Healthy Start initiative have been replicated through

other venues, including the place-based communities that are a part of the ECCS Impact grant, to broaden the scope of MCH programs across the state. Representatives of Kansas Title V staff have participated in all training, in an effort to gain insight into ways ACEs and resiliency tools can be provided to local Title V grantees.

Special Health Services – Family Advisory Council (SHS-FAC): The SHS-FAC has been active in providing guidance and support to all of the Special Health Service programs. Each year the SHS-FAC develops a strategic plan to identify key priorities for all programs that they would like to focus on. One of those priorities was providing assistance with a Navigational Tool Kit implementation. A subcommittee was formed to review, modify and add additional information to the Tool Kit, to streamline the resources and make it easily accessible on the KS-SHCN website for use by families and providers ([http://www.kdheks.gov/shcn/nav\\_toolkit.htm](http://www.kdheks.gov/shcn/nav_toolkit.htm)). The SHS-FAC added not only local, but state and national resources to the Toolkit. The Tool Kit project concluded in late fall of 2016. New resources are added to the Tool Kit as they are identified.

As part of the D-70 grant, the SHS-FAC helped to develop short informational webinars or videos for providers and families to assist them in caring for children with special health care needs. The families identified key topics that should be shared with all families and providers for the CYSHCN population. They decided on two topics, “Developing Positive Communication with Families” (for providers) and “Building Your Care Team” (for families), and began writing scripts to be used to produce short 5-7 minute information videos to be displayed as part of the KS-SHCN Navigational Tool Kit and as videos that can be run in providers’ offices. The videos were recorded late spring of 2017 and when finalized by the KDHE Communications Department will be displayed on the website and offered as videos to providers. The SHS-FAC has plans for additional videos in the future.

A second project revolved around Family Caregiver Health, specifically with a focus on the development of a fact sheet, “Trauma Informed Approach: A Necessary Component of Family-Centered Care.” This fact is developed from the family perspective and frames trauma informed approaches as a “system-wide approach to understanding and recognizing and responding to trauma.” The fact sheet describes what a trauma-informed approach is, key characteristics of a trauma-informed entity, and the key principles to a trauma-informed approach.



Teen Pregnancy Targeted Case Management (TPTCM) and Pregnancy Maintenance Initiative (PMI): The ten TPTCM agencies and nine PMI agencies providing services in FY 2016 incorporated parenting education as a fundamental part of their service model. Both programs provided educational materials individually through one-on-one sessions and in group settings when appropriate to facilitate peer support networks. Fathers were encouraged to participate in activities alongside the mother when appropriate to increase knowledge, skills and resources. Data for both programs are collected in DAISEY; Kansas Title V staff monitor data quality and results to inform continuous quality improvement.

Objective: Increase the number of families receiving home visiting services through coordination and referral services by 5% annually.

*Home Visiting:* The MIECHV Program continued in the targeted at-risk communities - Wyandotte County (urban Kansas City, Kansas) and five counties in rural southeast Kansas (Cherokee, Labette, Montgomery, Neosho, and Wilson) through Early Head Start, Healthy Families America, and Parents as Teachers evidence-based home visiting programs and, in Wyandotte County specifically, the Team for Infants Exposed to Substance Abuse (TIES) Program, a promising approach serving pregnant and postpartum women affected by alcohol or other drugs. From October 1, 2015, through September 30, 2016, 661 pregnant women and families with infants and young children were enrolled and provided home visiting services, an increase of over 13% compared to FY'15. Training, consultation, and other innovative evidence-based practices have been provided for staff to enhance effectiveness with identifying, engaging, serving and referring families with mental health and substance abuse concerns, maternal depression, domestic violence, and families with diverse cultures and languages. Coordinated outreach and referral (central intake) systems in both targeted areas have been enhanced and refined. Furthermore, a Kansas Home Visiting website provides resource information for other home visiting programs statewide, including a county-by-county listing of evidence-based home visiting and Part C early intervention program sites (see <http://kshomevisiting.org/>).

In February of 2017, a joint meeting of MIECHV personnel and local MCH health agencies was held. The purpose of this meeting was to bring about a better understanding of the similarities and differences of the two programs. It was an interactive, well-attended meeting and represents an important step in improving coordination and referral for home visiting services. The agenda for the day is below.



**Southeast Kansas MCH & MIECHV  
Joint Meeting  
Cherokee, Labette, Montgomery, Neosho and Wilson Counties  
February 21, 2017, 9:30-3:30**

**Agenda**

9:30-9:45.....	Welcome and Introductions
9:45-10:00.....	What We Hope to Gain Today
10:00-10:45.....	Overview of MCH and MIECHV
10:45-11:00.....	Break
11:00-Noon.....	Overview of Local Services and Collaboration
Noon - 1:00.....	Lunch on your own
1:00-2:15.....	County Team Roundtable Discussion
2:15-2:30.....	Break
2:30-3:00.....	Local Teams Report Out
3:00-3:30.....	Where Do We Go From Here?

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

**NPM 14: Smoking During Pregnancy and Household Smoking**

Cigarette smoking during pregnancy adversely affects the health of both mother and child. It increases the risk for adverse maternal conditions and poor pregnancy outcomes. Infants born to mothers who smoke weigh less than other infants, and low birth weight (<2,500 grams) is a key predictor for infant mortality. According to Kansas Vital Statistics, 11.0% (4,294) of women reported smoking during pregnancy in 2015, a slight decrease from 2014 (12.0%). From 2006 to 2015, there was a statistically significant decreasing trend observed. The smoking rate was highest for non-Hispanic Native American women, at 28.3%, followed by non-Hispanic white women, 12.6%, and non-Hispanic black women, 12.2%. Rates for Hispanic (4.2%) and non-Hispanic Asian women (1.1%) were substantially lower. Teenagers 18-19 years and women in their early twenties had the highest smoking rates (16.2% and 16.7%, respectively). Smoking rates for women in their thirties and older were sharply lower, around 7%. Among women who reported smoking during pregnancy, 72.7% reported Medicaid as principal source of payment for this delivery. This was a slight increase from 2014 (71.0%).

Exposure to environmental smoke—from cigarettes, cigars, or pipes—can be a serious health hazard for children. According to

the Centers for Disease Control and Prevention, exposure to secondhand smoke is associated with higher rates of sudden infant death syndrome (SIDS), more frequent and severe asthma, and acute respiratory infections in young children. In the 2011/12 National Survey of Children's Health, parents were asked whether anyone in the household used cigarettes, cigars, or pipe tobacco. Overall, 25.3% of Kansas children were reported to live in households where someone smokes, and 5.7% were exposed to secondhand smoke inside their homes. About 39.9% of non-Hispanic children of other races, 25.8% of non-Hispanic white children, 22.4% of non-Hispanic Black children, and 21.9% of Hispanic children lived in households with a smoker. Rates of household smoking decline as income increases. Of children with household incomes below the poverty level, 37.1% lived in a household with a smoker, as did 35.5% of children with household incomes between 100 and 199 percent of the Federal poverty level (FPL). Of children with household incomes between 200 and 399 percent of FPL, 19.5% lived with a smoker, and of children with household incomes of 400 percent or more of FPL, only 13.7% had a smoker in the household.

Objective: Increase the proportion of smoking women referred to evidence-based cessation services to 95% or higher by 2020.

Objective: Increase abstinence from cigarette smoking among pregnant women to 90% by 2020.

Kansas Title V staff have been acutely aware of data showing higher rates of smoking among young reproductive aged women and the Medicaid population. As a result, Kansas selected *smoking cessation* as one of the national learning strategies/networks to participate in as part of the Infant Mortality CollN, upon joining in July 2014. Kansas is committed to advancing the national CollN agenda and Blueprint for Change to address state priorities. The CollN process has been a driving force behind much of the work that has been done in Kansas related to smoking cessation before, during, and after pregnancy. Participation in the Smoking Cessation Learning Network has provided the platform, structure, support, and motivation to take smoking cessation efforts in the perinatal period to a new level. A state "CollN Smoking Cessation Workgroup" was formed with participating members from multiple agencies, including: the University of Kansas, March of Dimes, KDHE Bureau of Family Health and Bureau of Health Promotion, private providers, and local public health departments. This workgroup has developed and prioritized an extensive action plan, measurement strategy, and change package, which outlines Kansas' smoking cessation work plan, not only for the duration of the CollN, but for the entirety of the Title V five-year action plan. The plan is very extensive, covering several tiers of interventions that are categorized according to the Primary Drivers that have been designated by National CollN. State selected strategic priorities around smoking cessation include *building community capacity to promote education, screening, referral, and treatment for women*. Throughout 2015, 2016, and into 2017, our state's work has been focused on the following Primary Drivers: PD2: Providers and support personnel refer women to evidence-based programs like Quitline; PD4: Women in child bearing years avoid smoking or stop and stay quit; PD5: Providers recognize role in coaching and supporting women to stop and stay quit.

Creating a multi-tiered approach that includes universal screening and referral, education, counseling and medical intervention has been a priority. Work has focused on engaging women in smoking cessation services and increasing the number of referrals to evidence-based programs such as the Kansas Tobacco Quitline, improving quit rates before and during pregnancy and continued cessation in the postpartum period. At a provider level, we have worked to increase the number of providers that are trained in the 5 A's of tobacco cessation. Our efforts have also included increased promotion of the online training course on *Brief Tobacco Interventions* developed and provided by the Bureau of Health Promotion, offering 1.0 CEU credit free of charge to providers upon completion. Promotion has occurred through many venues, including state level conferences such as the Governor's Public Health Conference and webinars for local Title V grantees. Smoking cessation efforts have resulted in a private OB practice (from our *Delivering Change* Healthy Start project) and the *Kansas Perinatal Community Collaboratives* (KPCC) utilizing the March of Dimes (MOD) *Becoming a Mom*<sup>®</sup> curriculum and requiring all staff to complete the training. Course participant numbers have steadily increased throughout the past couple of years. Reports show course participants from a variety of professional backgrounds, including: nurses, dietitians, administrators, physicians, social workers, care coordinators, educators and home visitors.

Preliminary data collection/analysis of smoking data has shown only a very small increase in engagement of and enrollment in the KS Quitline services. As a result, Kansas Title V has partnered with the March of Dimes Kansas Chapter and Amerigroup (WellPoint - one of our state's Medicaid MCOs) to implement the *BABY & ME – Tobacco Free*<sup>™</sup> (BMTF)\* program in August 2015. At this time, ten of the KPCC were trained on program implementation. The BMTF program is one of the evidence-based smoking cessation programs highlighted thru the CollN Smoking Cessation Learning Network, demonstrating smoking cessation

rates of 60-70% in other states. Collaborative sites were given the opportunity to apply for Title V funding of start-up equipment required for program implementation. Nine sites applied and received funding and began implementation of the program in January 2016, following contract signing with WELCO, Inc. (owner of the BMTF program). The March of Dimes Kansas Chapter secured funding from Amerigroup for the provision of diaper incentives for these participating sites. (Note that the Healthy Start site was included in the original BMTF training and implemented the program with Healthy Start funding.) Diaper incentives are a required component of the BMTF program, creating a financial barrier to implementation of the program in many communities. The Amerigroup funding partnership was crucial in getting BMTF piloted in Kansas. Following a slow start, program enrollment numbers reached 34 by April 2016. As local program staff continued to work to engage pregnant smokers and referring community partners, concern grew about the high cost of program sustainability including a robust technical assistance fee that was to be paid by program sites to WELCO. During this time, KDHE staff worked collaboratively across bureaus to assist local programs with their efforts around recruitment and retention, through multiple webinars and conference calls with individual program sites to trouble shoot areas of increased need. By spring 2017, four BMTF program sites had withdrawn from the program, but two of those chose to continue to offer a modified incentive-based tobacco cessation model using the equipment previously purchased by KDHE. In addition, by year-end both BMTF and the modified sites had extended the incentives to cover the prenatal and postpartum periods. This was in response to the Crawford County COLLN pilot site that used this strategy early on to increase participation and dramatically improve program completion rates.

The “relaunch” of the BaM curriculum by KPCC sites, as described elsewhere in this application/report, has included a focus on 2<sup>nd</sup> and 3<sup>rd</sup> hand exposure to environmental smoke. Efforts have been made to incorporate repeat messaging across the six educational sessions around the harms of smoking in pregnancy as well as 2<sup>nd</sup> and 3<sup>rd</sup> hand exposure by the infant. Following “relaunch” of the curriculum in April 2017, messaging has been integrated into 5 of the 6 sessions. Additionally, the previously mentioned flow chart as a part of the integration toolkit, will be followed up on during June 2017 Relaunch Training, Part II, to assist staff in trouble shooting problem areas of the flow sheet and associated tools, as well as an opportunity for program sites to share challenges, strategies, and successes, in an effort to support program to program sharing and learning.

\*BABY & ME – Tobacco Free (BMTF) ([www.babyandmetobaccofree.org](http://www.babyandmetobaccofree.org)) is a smoking cessation program created to reduce the burden of tobacco use on the pregnant and post-partum population. The program’s design has proven effective in decreasing the number of women who smoke during and after pregnancy. The program uses a unique approach, combining cessation support specific to pregnant women, offering practical incentives, targeting low-income women (the largest group of smokers during pregnancy), and monitoring success. Three-year data collected from New York and Colorado indicate a 60-72% success rate. The BMTF program follows the *Clinical Best Practice Guidelines for Treating Tobacco Dependency* (HHS 2008 update) and integrates *Motivational Interviewing* skills to help pregnant women quit smoking and stay quit. Pregnant women are referred by their physician, clinic, health department or word of mouth to contact the participating agency to enroll in the program.

**Kansas BMTF Promo Card**



Quitting smoking is the single most important thing you can do for your health and the health of your baby!



**Benefits for your baby:**

- Increases the amount of oxygen your baby will get
- Increases the chances your baby's lungs will work
  - Lowers the risk that your baby will be born too early or too small
- Increases the chance that your baby will come home from the hospital with you on time

**Benefits for you:**

- Gives you more energy and helps you breathe easier
- Reduces your risk of developing smoking-related cancer and other chronic diseases
  - Saves money
- Makes your clothes, hair and home smell better
  - Makes your food taste better
- Helps you feel good about what you've done for yourself and your baby

How does the BABY & ME — Tobacco Free Program work?



**What you need to do:**

- Commit to quit smoking and stay quit during your pregnancy
- Enroll in the BABY & ME — Tobacco Free Program
- Attend 4 prenatal smoking cessation sessions
- Agree to take a monthly breath test to prove that you are tobacco-free
- Stay smoke free after your baby is born and receive a monthly voucher for free diapers, for up to 12 months!

To enroll in your local BABY & ME — Tobacco Free Program get in touch with:

(Name, Address, Phone label goes here)



- Quit Smoking
- Get Free Diapers
- Enroll Today!

Kansas BMTF Participant Diaper Voucher

**Participating Stores**  
**Walmart**  
*Save money. Live better.*  
 and stores as noted by your local  
 BABY & ME - Tobacco Free Program.

**Sponsored by the National  
 BABY & ME™ - Tobacco Free Program  
 Kansas March of Dimes  
 and Kansas Department of Health**

**march of dimes**  
**Kansas**  
 Department of Health  
 and Environment

**This entitles bearer to \$25 towards the purchase of diapers.**

Name (print) \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_ Total Value of Diapers \_\_\_\_\_

**NO CASH BACK**  
*Vouchers are redeemable at participating stores in Kansas. They are non-transferable and only for purchase of diapers. Vouchers can be used for any brand/size diapers. "BABY & ME - Tobacco Free" Program and participating stores reserve the right to verify the authenticity of the voucher and ask for personal identification, before redeeming its value. All persons participating in the Program must be registered with the "BABY & ME - Tobacco Free" Program. Vouchers may not be reproduced. Vouchers expire within 90 days of issued date. Not negotiable unless signed on reverse signature line. No cash back.*

Redeemable at participating Walmart stores in Kansas, and other stores as noted by your local BABY & ME - Tobacco Free Program. Voucher valued up to \$25.00, including sales tax.

Participant Signature \_\_\_\_\_ Issued Date \_\_\_\_\_  
 Participant Signature \_\_\_\_\_ Redeemed Date \_\_\_\_\_

**OFFICE USE ONLY**  
 Store Name \_\_\_\_\_  
 Store Number \_\_\_\_\_

THIS VOUCHER MAY NOT BE COPIED. DO NOT REPRODUCE UNDER PENALTY OF LAW. Questions regarding vouchers, please call WZL CO 716-684-1325

A snapshot of the 2016 Infant Mortality COLLN work related to smoking cessation is captured below.

**Selected Drivers**

1. Women in child bearing years avoid smoking or stop and stay quit (D3)
2. Providers recognize role in coaching and supporting women to stop and stay quit (D4)
3. Public Sensitivity to and awareness of women not smoking, avoiding, and ceasing all forms of tobacco and nicotine in childbearing years (D5)

**Successes/Ongoing Work**

- Smoking Cessation Toolkit developed and implemented in pilot sites and shared with all MCH local agencies. Standardized screening and referral approach is leading to 100% of program enrollees being screened and offered a referral to available evidence-based smoking cessation programs.
- Baby & Me Tobacco Free (BMTF), an evidence-based intervention targeted to pregnant women who smoke was implemented in 9 collaborative communities in 2015.
- Tobacco Program Partnership strengthened—regular assessment and coordination of shared areas of work leading to a comprehensive assessment and plan for tobacco/smoking cessation; training and education including:
  - o Free online “Brief Tobacco Intervention” training;
  - o Quitline webinars for all pilot sites, collaboratives, and MCH local agencies/partners; and
  - o Full-day trainings and conference skills-building sessions (5 A’s and motivational interviewing).
- WIC Research Project in partnership with the University of Kansas Medical Center to assess capacity for clinics to screen, refer, and follow up.
- Provider Survey distributed in June to assess screening and referring protocols as well as existing programs and interventions available in the communities. A summary of the results is available upon request.

**Challenges**

- Capacity and time to dedicate to the pilot sites especially related to QI, data collection, PDSA cycles.
- Continue to be smokers who do not accept referral to evidence-based smoking cessation programs even after adding incentives for women who agree to referral and have first encounter with Quit Coach.
- BMTF sites are in need of greater technical assistance related to enrollment and follow up; sites are not receiving quality interaction or response from the National BMTF Program.
- KS Quitline data and reports are limited (what is tracked and what reports we can generate on our own).
- Medicaid reimbursement for cessation counseling conducted in public health settings (under review).

**Data/Measures Highlights**

- Infant Mortality: The current state rate is 5.9 infant deaths per 1,000 live births (2015), the lowest ever recorded and a

decrease from the 2014 rate of 6.3. This surpasses the Healthy People (HP) 2020 target of 6.0. Despite this progress, disparities persist; Kansas Title V focuses on Social Determinants of Health, access, outreach, etc.

- **Preterm Birth:** The current rate is 8.8% (2015). This surpasses the HP 2020 target of 11.2%.
- **Smoking Cessation/Quitline Referrals:** In June 2016, 169 women of child-bearing age (15-44 years) enrolled in the Quitline (KanQuit), the highest number in a month since collecting CollN data in January 2015.
- **KPCC Pilot Sites:** Screening tools and referral process are in place for pregnant women who smoke. For the time period September 2015-August 2016: 100% (53) were screened for tobacco and secondhand smoke exposure; 21% were smokers—all were counseled using the 5 A's and referred to Quitline; 43% enrolled in Quitline reported quitting.

**MCH Local Agency Strategies:** Local MCH agencies continue to utilize the Kansas Tobacco Quitline as a referral resource for pregnant women to encourage them to quit smoking, as well as local tobacco cessation resources. MCH grantees provided education on the use of the Quitline and online resources to assist women to quit smoking. Training on the 5 A's method of tobacco cessation counseling was encouraged for grantee staff. MCH grantees trained in the 5 A's counseling method provided interventions to pregnant women. Local grantee Universal MCH Home Visitors linked pregnant women to smoking cessation resources, make referrals to the Quitline, and provide education and supportive services. Local MCH agencies providing BaM prenatal education utilized the Baby and Me Tobacco Free (BMTF) evidence-based practices.



**Kansas Tobacco Program Partnership:** Collaboration with the Kansas Tobacco Program has increased and improved dramatically since the IM CollN efforts were launched. In addition to aligning efforts across MCH and tobacco fund grantees, we are leveraging resources and training. The existing “Brief Tobacco Intervention” (BTI) training is now required as part of the MCH grantee orientation/training requirements for staff providing services (including clinical, screening, education, counseling, home visiting) women of reproductive age and pregnant women. Other resources available through this program include the Brief Tobacco Intervention rack card (left).

We continue to face challenges with MCH program participants accepting a referral to the Quitline (and following up with enrollment once the referral is accepted). In order to address ongoing questions and confusion around the Quitline (KanQuit) services, including programming for pregnant women, the MCH program provided a webinar (offered twice in October 2016) titled *Building an Effective Tobacco Cessation Program: KanQuit (Kansas Tobacco Quitline)* to discuss the KanQuit program—program services, enrollment, implementation processes, and reporting features. Program sites provided feedback to the KanQuit staff and as a result additional communication tools are now available. “Meeting the client where they are at” was an identified priority so moving beyond the traditional phone and fax model became a key issue. Kansas now utilizes Text2Quit, the Quit Now mobile app and makes quit coaches available through phone and

web options. The warm hand off and personal touch have been incorporated into Kansas approach. During the webinars, participants also learned how to better integrate the program into their current tobacco cessation efforts. Presenters included Diane Daldrup, MCH Program Consultant and IM CollN Smoking Cessation Lead; Matthew Schrock, KDHE Bureau of Health Promotion; Taneisha Scheuermann, PhD, University of Kansas Medical Center Preventive Medicine & Public Health.

Quitline brochures and rack cards are available for home visitors. Free nicotine replacement therapy was available effective May 31, 2017, to individuals who register for Quitline. Home visitors inform parents who are smokers of this opportunity.

**Home Visiting:** The MIECHV-funded program sites collected and reported data on smoking in the households of enrolled families. Beginning 10/1/16, in accordance with redesigned federal MIECHV Program performance measures, program sites are now tracking data on pregnant women and primary caregivers who reported using tobacco or cigarettes at the time of enrollment in the home visiting program and were referred to tobacco cessation counseling or services within 3 months of enrollment. Training opportunities and additional resource information for home visitors are being identified to encourage use of effective tobacco cessation information, referrals, and support practices.

Objective: Implement collaborative oral health initiatives, identify baseline measures, and expand oral health screening, education, and referral by 2020.

Oral Health Services for CYSHCN KS-SHCN currently partners with Oral Health Kansas and GraceMed to assure a dental hygienist is integrated as part of the Cleft Lip/Cleft Palate and Specialty Team Clinics. Through this partnership, the hygienist provides the following services at each clinic every time the child visits: a complete oral assessment, including the nationally standardized Basic Screening Survey; documentation of findings for families and clinic records; explanation of findings to families by showing signs of health and oral disease; demonstration of appropriate daily oral home care to child and families, followed with written descriptions and samples of toothbrushes appropriate for the child's condition; application of fluoride varnish when appropriate, and referrals (at family's request) to dental clinics in their respective community that can serve the child. These services provide families with the opportunity to improve and maintain their children's oral health by adopting effective daily oral hygiene and eating habits that eliminate or reduce tooth decay and periodontal disease, which are the most common chronic disease among children.

Kansas Perinatal Community Collaboratives (KPCC)/Becoming a Mom<sup>®</sup> (BaM) Program: As a part of the “relaunch” of the BaM curriculum by KPCC, as described elsewhere in this report, the handout “Tips for Good Oral Health During Pregnancy” by the National Maternal and Child Oral Health Resource Center has been added as a supplemental handout to the original curriculum. Additionally, partnership with Oral Health Kansas has led to the production of PowerPoint slides, video, and activity, all focused on the importance of good oral health in pregnancy, to be integrated into session one. Sites received in-person training June 2017, where they were also provided toolkits for completion of the guided self-exam activity and additional resources for use during the BaM sessions. Sites were encouraged to bring a partnering dental hygienist from their local community to serve as a guest presenter of the session content as available.

Child Care Licensing Healthy Smiles Initiative: Nearly 1 in 3 preschoolers are already affected by tooth decay, despite the fact that good oral health early supports the overall health of a child. Child Care Licensing partnered with Title V MCH and the Bureau of Oral Health in addition to other partners including Kansas Child Care Training Opportunities and Oral Health Kansas to launch the *Healthy Smiles* initiative, focused on reducing decay prior to school entry. A pilot/launch in Southwest Kansas in late 2015 (FY2016) resulted in 200 participating child care providers receiving a free online training about promoting good oral health through the child care setting (routines and policies).

With support from MCH, Child Care Licensing purchased 18 instructor sessions and 450 training spots for providers to complete the Level 1 course, *Oral Health in the Child Care Setting – Toothbrushing: As Easy as 1-2-3*, an online training through Kansas Child Care Training Opportunities (KCCTO). This course provides an overview of the importance of oral health in young children, the elements that cause tooth decay, and how to implement a tooth brushing routine into daily activities. As of May 2017, 405 providers have completed the level one course (of the 450 spots available). The breakdown of attendees by facility type is: 43% day care home/family child care, 51% center/preschool, and 6% other. Providers also received an Oral Health Kit containing educational materials, toothbrush and toothpaste for each child, digital timers, puppets, books, and more. A total of 105 children received education and screenings by a dental hygienist. Parents received results, referrals, and oral health literature. Results revealed 6 children had untreated decay and 60 had never been to the dentist (6 were less than 1 year of age). Tooth brushing is not required by Kansas regulation for home-based child care. Therefore, as a means to gather data on oral health practices in child care, a question regarding tooth brushing was added to the licensing inspection tool, and surveyors across the state now provide on-site consultation regarding oral health. Data obtained may guide future regulation changes and training.

Expansion in 2017: As part of the Healthy Smiles phase 2 work, Child Care Licensing purchased 18 Instructor sessions and 450 training spots for providers to complete the Level 2 course *Oral Health in the Child Care Setting – Whole Tooth and Nothing but the Tooth*. This course assists early care professionals in understanding the importance of good oral health. Specifically, they learn the importance of keeping children cavity free, the prevention of bacterial transmission, healthy snacking, and how to keep teeth clean and strong. Participants were provided numerous resources to assist them in promoting oral health in the child care setting and in the home setting for families. This oral health level 2 course opened in October 2016, and as of May 2017, 276 participants (of 450 training spots) have completed the training. The breakdown of attendees by facility type is: 41% day care home/family child care, 57% center/preschool, and 2% other. Discussion is underway with the Bureau of Oral health to repeat the on-site screenings in child care facilities similar to the phase 1 work in Southwest Kansas.

Objective: Build MCH capacity and support the development of a trained, qualified workforce by providing professional

development events at least four times each year through 2020.

More than four training opportunities were provided to the MCH workforce and partners throughout the year. The opportunities are detailed under other objectives specific to the topic and/or in the Workforce Development and Capacity section of this application and report.

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## **PRIORITY 8: Information is available to support informed health decisions and choices**

### **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.**

Health literacy is defined as the degree to which individuals have the capacity to obtain, process and understand basic information and services needed to make appropriate decisions regarding their health.<sup>1</sup> In the 2014 Kansas Behavioral Risk Factor Surveillance System (BRFSS) state-added module, three screening questions measure health literacy: 1) “How confident are you filling out medical forms by yourself?”, 2) “How often do you have problems learning about your health condition because of difficulty in understanding written information?” and 3) “How often do you have someone help you read medical materials?”. About 12.0 % of Kansas adults reported that they were not at all or a little confident in filling out medical forms by themselves; 4.7% reported that they always or often had problems learning about their health condition because of difficulty understanding written information; and 9.0% reported that they always or often had someone help them read medical materials. Rates of low literacy were significantly higher among Hispanics than non-Hispanics for all three questions. Those with lower socioeconomic status (less education, lower income, unemployment) had significantly higher rates of low health literacy than their counterparts for all three questions. Males had higher rates of low health literacy for the question “confident with forms.”

<sup>1</sup>Institute of Medicine, Health Literacy: A Prescription to End Confusion. Editors, Lynn Nielsen-Bohman, et al., Committee on Health Literacy, Board on Neuroscience and Behavioral Health. <https://www.nap.edu/catalog/10883/health-literacy-a-prescription-to-end-confusion>

Objective: Increase the proportion of MCH grantees that provide health information education to clients to improve health decision making among women, pregnant women, children, adolescents, and children and youth with special health care needs annually.

Home Visiting: In the fall 2016, a Healthcare Insurance Access Toolkit was compiled for MIECHV-funded home visiting program staff providing resource information on the ACA Health Insurance Marketplace, KanCare (Kansas Medicaid & CHIP), and local navigators as well as health literacy. The toolkit was provided to MCH home visitors and posted on the Kansas Home Visiting website for all home visiting programs statewide.

Kansas Perinatal Community Collaboratives (KPCC)/Becoming a Mom® (BaM) Program: Assuring accurate information is available to support informed health decisions and choices has been a major focus of the BaM “relaunch” initiative that has been underway this past year. As a result of focus groups and the work of the curriculum review committee, numerous supplemental handouts were added to the original curriculum in an effort to better inform participants and better prepare them as advocates for their care and the care of their baby. Additionally, as a reoccurring theme throughout each of the six sessions, participants are guided through an activity “what questions will you ask your provider”. During the activity they are encouraged and assisted in preparing questions they might ask their provider related to the information they learned during the session.

Teen Pregnancy Targeted Case Management (TPTCM) and Pregnancy Maintenance Initiative (PMI): As part of case management services provided in the TPTCM and PMI programs health information education was provided to clients through one-on-one sessions and in group settings to increase health literacy. Case managers identified individual health educational needs through the use of goal planning tools and helped ensure clients were connected to classes available through the agency or through supportive community partners. TPTCM educational activities were provided for the purpose of increasing client self-sufficiency which in part increased client knowledge of health related topics and improved their ability to obtain quality care and healthcare coverage for themselves and their children. Case managers encouraged client participation in

quarterly agency Advisory Group meetings in order to provide leadership opportunities, a platform to be a positive role model to peers and to provide feedback on program evaluation.

Objective: Increase youth-focused and youth-driven initiatives to support successful transition, self-determination, and advocacy by 2020.

Youth Leadership Development: KS-SHCN, in partnership with the Kansas Youth Empowerment Academy (KYEA), developed a youth leadership program called Faces of Change. Faces of Change focuses on leadership development through civic engagement for youth ages 17-22 with disabilities. The program occurs over seven months, with monthly sessions focusing on an area contributing to effective leadership, such as: what it means to be a true leader, authentic leadership, effective communication, and team motivation. Youth participants used the new leadership qualities that they learned throughout the program to complete an individual Community Change Project.

This program addresses risk factors for youth with disabilities and special health care needs. This program decreases the following risk factors for youth with disabilities: low self-esteem and self-efficacy, high unemployment, and bullying. During the stage of young adulthood, youth need to find abilities within and connect with others. This program has a strong emphasis on civic engagement, providing participants the opportunity to explore abilities and realize their worth to society by giving back to others. The rate of unemployment for youth with disabilities ages 16-19 is more than twice the number of youth without disabilities. Youth participants develop enhanced employability skills such as communication, active listening, team work, time management and dress attire, and more. Lastly, youth with disabilities are more likely to be bullied compared with their nondisabled peers; contributing to secondary mental health conditions and increased risk for depression and suicide. These youth are not only victims of bullying by their peers, but also experience intimidation from medical professionals, family members and school faculty. Building communication and assertiveness skills, developing problem solving skills, and creating a network of supporting peers and adults has been a positive outcomes of this program leading to positive outlets and resiliency. Through this program youth have developed enhanced communication and leadership skills. Youth with disabilities and special healthcare needs who have participated have demonstrated increased self-efficacy, self-determination, and appear to feel connected on a social and civic level to their community.

Monthly weekend sessions began in April 2016 and continue through November 2016. Immediately following the completion of the first session series recruitment for the second session series began. The second session began in April 2017 and will conclude in November 2017. The third series is slated to include youth with and without disabilities (based upon completion and evaluation findings from the first two session series). With recruitment beginning in November 2017 and the third series beginning in the Spring of 2018. Evaluations were completed throughout and at the conclusion of the program, including a youth-completed pre/post self-efficacy and leadership assessment. Additionally, the evaluation plan included long-term initiatives at one and three years after completion of the program. KS-SHCN is dedicated to offering an internship opportunity to at least one youth leader who successfully completes the program in the future.

iTransition Training: With funding support from the KS-SHCN program Families Together, Inc. held a transition training for youth to help them understand how to navigate the systems of care and learn self-advocacy skills. This was attended by 12 youth with a wide range of different disabilities. Each youth received an iTransition Booklet.

## Other Programmatic Activities

### DRIVING INNOVATION IN MATERNAL AND CHILD HEALTH

The KDHE Bureau of Family Health is developing an integrated system of MCH care coordination and outcome assessment for community level maternal and child health initiatives. Transforming systems to better serve families and children means taking good ideas and scaling up, out, and deep through innovation and a commitment to use the right tools and data to measure what matters and make informed improvements. Title V goals are infused in and supported by the entirety of the Bureau's work across programs, funding sources, resources, and shared infrastructure. **Data-driven decision making** to improve maternal and child outcomes and drive priority activities is at the core of this systems transformation. To accomplish this, KDHE has built upon and improved the data and analytics infrastructure to capture community-level work through a unique, user-friendly web-based data system, Data Application and Integration Solution for the Early Years or DAISEY. KDHE has also launched the Pregnancy Risk Assessment and Monitoring (PRAMS) in Kansas to inform better pre-natal service delivery and support. Activities are supported and made possible through the State Systems Development Initiative (SSDI) and MCH Epidemiology capacity. There is a renewed focus on **family engagement and service coordination** through innovative approaches to ensuring families receive the right support and services they need to thrive. This means a re-design of Universal Home Visiting program, using lessons learned from the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV), Delivering Change, a Healthy Start initiative that includes Universal Home Visitors, and a unique community-driven referral system, Integrated Referral and Intake System (IRIS). Finally, the system emphasizes **child development and well-being** by ensuring children receive appropriate screenings through work done by perinatal community collaboratives such as *Delivering Change*, Early Childhood Comprehensive Systems grant, and the Critical Congenital Heart Disease/Defect Screening Public Health Quality Initiative.

#### Data-Driven Approach

##### Shared Measurement Systems in MCH: DAISEY

The Bureau of Family Health worked with the University of Kansas Center for Public Partnerships & Research (KUCPPR) (<http://https://cppr.ku.edu/>) to 1) implement and support a secure, HIPAA compliant web-based shared measurement data system (DAISEY); 2) train and provide technical assistance to DAISEY users to capture MCH services at the individual level and use data to inform MCH practice and service delivery; and 3) provide analytics to improve accountability and continuous quality improvement at the state and local levels. KDHE's vision for integrated and coordinated community-level maternal and child health initiatives requires high quality, reliable data from all local MCH providers across the state. KDHE uses DAISEY to support Title V system transformation through a phased approach involving input and communication with local providers throughout the process.

*Phase 1:* Initial DAISEY implementation planning and KDHE-specific data requirement gathering began in 2015-2016 for the following statewide programs: Maternal and Child Health, Family Planning, Teen Pregnancy Targeted Case Management, Pregnancy Maintenance Initiative and Becoming a Mom. KDHE focused initial data collection design to address federal reporting requirements (e.g., FPAR) and to focus on Title V priorities, activities, and strategies. To reduce burden, KDHE intentionally and thoroughly examined each data element for state Title V priority tracking or federal requirements to support high quality data on MCH services and supports. KDHE piloted DAISEY with several providers in November 2015 and launched statewide between January and July 2016. DAISEY is available without payment to all local providers as the required centralized collection system for MCH services across the state.

Phase I began for agencies with no established electronic client level data collection system and then expanded to agencies who had stand-alone desktop systems and electronic health record (EHR) systems. Local agencies could obtain MCH-funded mobile technology (tablets, laptops) to allow real time direct entry into DAISEY as clients were being seen. To accommodate agencies already using EHR systems, those agencies were could choose to use an aggregate entry forms submitted monthly rather than entering client-level data. All local MCH agencies implemented DAISEY for either client-level or aggregate level data entry by July 1, 2016.

KDHE and KUCPPR staff provided extensive training and technical assistance users through webinars, individual phone instruction, on-site training and recorded navigational videos of the DAISEY system form by form. A DAISEY Helpdesk email is

available to provide direct technical support for system users and a website provides local agency users a central point for all DAISEY-related information (<http://daiseysolution.com/kdhe/>). User numbers as of July 1, 2017, are reflected in the table below.

Active Live User Totals		All Organization Totals	
Initiative	User Total	Grantee Total	Org Total
KDHE Title V/X	812	86	109
KDHE – Healthy Start	70	1	6
KDHE MIECHV	58	1	9

During Phase 1, KDHE simultaneously designed and implemented DAISEY for its community level federal **Healthy Start Initiative**, Delivering Change, in Geary County, KS. This program focuses on reducing infant mortality and improving health equity with a Collective Impact approach. Delivering Change uses DAISEY differently by collaboratively and securely sharing service provision information about all clients served by all health and social service providers to better coordinate care and track community level outcomes. It is similar to how an EHR would operate, but instead captures services across non-clinical partners and providers serving those same families. This innovative model of collaboration and use of DAISEY supports high quality coordinated MCH and early childhood services and outcomes.

*Phase 2:* In 2016-2017, DAISEY’s data and analytics infrastructure were enhanced to further support KDHE’s vision for integrated and coordinated community-level maternal and child health initiatives. Focus shifted from implementation to using data to drive decisions and quality MCH services. Customized, visual reports in DAISEY allowed all users and KDHE staff review data quality, meet compliance reporting needs, and give information to the state and local agencies to use for quality assurance, program improvement and describing clients served, services provided, and referrals made. Reports use filters to display a user’s organizational data only while KDHE staff can roll up or drill down for all agencies and programs across the state. DAISEY reports help local agencies and KDHE easily demonstrate the need for maternal and child health services and to share the impact of their programs at the community, regional, and statewide level. Extensive report training, guides, and webinars were provided to help users understand, access, navigate, filter, troubleshoot data quality, and download underlying data.



### Maternal & Child Health Service Report Primary Healthcare Coverage



#### Primary Healthcare Coverage

Date of Activity  
1/1/2016 8/30/2017

Select Grantee  
(All)

Select Organization  
(All)

	Prenatal/Pregnant Woman	Post-Partum Woman	Woman (18-44 years)	Infant (< 1 year)	Child (1-11 years)	Adolescent (12-22 years)
None/Self Pay	1,019	476	349	319	1,036	1,241
Private Insurance	742	1,255	292	439	1,541	1,055
Tricare	45	87	5	13	22	6
KanCare/Medicaid	1,793	1,995	406	1,845	4,677	1,352
CHIP (Formerly HealthWave)	3	7	1	11	183	107
Other Public Insurance	41	61	11	9	20	9
Unknown/Not Reported	57	170	55	25	56	5
Null	0	1	0	0	1	1

#### Primary Healthcare Coverage: Children with Special Healthcare Needs

	Infant (< 1 year)	Child (1-11 years)	Adolescent (12-22 years)
None/Self Pay	7	7	6
Private Insurance	10	21	8
KanCare/Medicaid	46	113	55
CHIP (Formerly HealthWave)	0	1	3
Tricare	1	0	0

During Phase 2, the Kansas **Maternal, Infant, Early Childhood Home Visiting (MIECHV)** also transitioned to DAISEY as its

shared measurement system to drive high quality data collection and reporting for federal HRSA benchmarks and assess impact. With that transition, KDHE has built a portfolio of Title V programs using DAISEY to provide a comprehensive overview of progress towards priorities and services across multiple funding sources.

*Phase 3:* Shared measurement work in 2017-2018 will continue to build on prior accomplishment by further supporting KDHE's vision for integrated and coordinated community-level maternal and child health initiatives. Priorities under Title V will help focus all MCH programs and services to use comprehensive data at the state and local level for impact analysis and quality improvement. Phase 3 will leverage DAISEY to its fullest potential and help state and local partners shift focus from data collection and reporting for compliance purposes to using data for program improvement, funding and program justification, and "telling the story" of the programs/local agencies. Efforts will also be directed at helping MCH partner with other services through the collaborative use of data to drive continuous quality improvement and assurance efforts locally. Shared measurement in MCH will also allow a more comprehensive impact analysis of whether outcomes for children and families are improving in alignment with Title V priorities.

To provide a central access point for all DAISEY-related information, a website was developed for use by local agency users: <http://daiseysolution.com/kdhe/>. Information available on the website includes user request templates, data security forms and policies, an implementation guide, user manual, instructional videos, printable versions of forms, report guides, the Data Dictionary and a calendar of scheduled trainings.

#### MCH Community Check Box

The shared measurement system, DAISEY, addresses our need to collect data from the local level as to the participants being served (visits provided and services, education, and referrals provided during those visits). The state-level MCH action plan reflects the assessments, priorities, and guiding principles of state and local MCH efforts. A challenge of this plan is how to best capture, characterize, and communicate what Title V MCH is doing across the state and how to use this information for learning, improved collaboration, and quality improvement.

In order to address this gap, the Title V program is partnering with the KU Work Group for Community Health and Development (<http://communityhealth.ku.edu>) to develop and implement a monitoring and evaluation system (Community Check Box – CCB) of efforts outlined in the State Action Plan. The purpose of the System is to support monitoring and evaluation of comprehensive, multi-level initiatives using participatory approaches and integrated technical supports. This system makes it easier to: a) Capture activities related to implementation (e.g., what was done, when, with whom); b) Code activities by type (e.g., development activities, services provided, community/system changes); c) Characterize activities by attribute (e.g., priority addressed, strategy used); and d) Communicate and reflect (i.e., using online graphs and integrated reflection questions). The core team was trained on use of the Check Box in May 2017, and entry is underway.

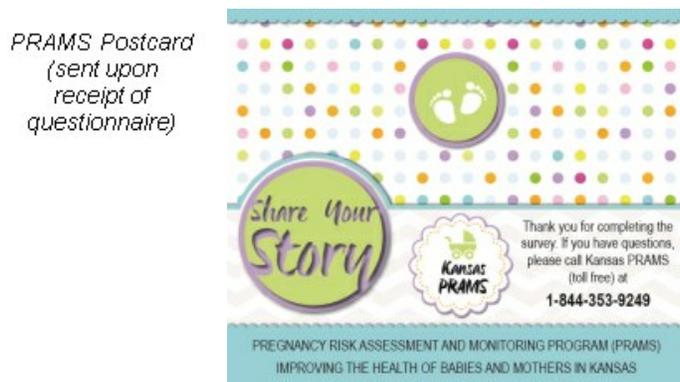
As part of our work with the KU Work Group, we have been intentional and continuously thought about the importance of monitoring and evaluation. In an effort to expand the impact of the Check Box, we are working on MCH Evaluation Questions, many of which align with the Check Box categories for inputs and processes. For example:

- What amount (and pattern) of development activities are engaged in by MCH staff and partners?
- What is the distribution of development activities by type?
- To what extent is the Title V MCH Program:
  - promoting and providing family-centered, community-based, coordinated care for children and youth with special health care needs and their families?
  - implementing activities as intended and planned?
  - having an impact all population domains?
  - engaging consumers at all levels to assure activities and services meet the needs individuals and families
  - contributing to assuring mothers and children (in particular those with low income or with limited availability of health services) access to quality MCH services?
- Are there improvements in behaviors related to MCH?
- Is the Title V MCH Program utilizing a Collective Impact approach?

### Pregnancy Risk Assessment & Monitoring (PRAMS) Activity & Support

Infrastructure to support development and sustainability of PRAMS is a priority. In August 2016, KDHE launched a Steering Committee of public and private sectors with geographic and cultural diversity (includes KS MCH Council members from the Women/Maternal and Perinatal/Infant work groups). A Charter established governance guidelines and insure future diversity and sustainability. Quarterly meetings occurred with the MCH Council with additional input sought as needed through a SharePoint site for easy document sharing (survey tools, reports, etc.) among Steering Committee members and targeted stakeholder groups.

IRB for PRAMS data collection was secured January 3, 2017, after which Kansas' first survey was developed in partnership with Steering Committee and the Council (approved by CDC February 2017). Per CDC recommendations, 1,475-1,700 surveys are distributed to support the required 60% survey return rate. To assist, a marketing and promotion campaign focuses on new families' desire to share their birth experience through a "Tell Your Baby's Story" theme.



Mailing began in April 2017, and Kansas' first PRAMS report is scheduled for review in 2019. Kansas launched a website ([www.kdheks.gov/prams/index.htm](http://www.kdheks.gov/prams/index.htm)). Year 2 survey development is underway and the 2019 report will inform the Kansas Title V priorities and factor into the state needs assessment. Title V staff and partners participated in the CDC site visit in July 2017.

### Infant Mortality (IM) CollN

Infant Mortality CollN efforts specifically collaborated with Vital Statistics to develop a "real" time vital records reporting system/infrastructure in order to provide provisional vital statistics data to the CollN Team. In alignment with Title V, priorities include quality improvement efforts on smoking cessation and reducing early and preterm birth through appropriate utilization of progesterone and elimination of early elective delivery. Although the CollN ends in July, Kansas' efforts include infusing CollN activities, strategies and tools throughout its MCH programs and includes data on these efforts at the local level in the DAISEY shared measurement system to track progress and measure impact in reducing infant mortality.

### **Family Engagement and Service Coordination**

#### MCH Universal Home Visiting Model: Redesign & Standardization

In 2016, KDHE redesigned and improved the MCH home visiting program by exploring the work of the Healthy Start initiative, *Delivering Change*, and its Universal Home Visitor program. Initial design focused on the best structure, format, and requirements for a Universal program. This model differs from others because it seeks to provide assessment and screening to all pregnant and postpartum women and infants, regardless of income or other eligibility requirements. If families require further services, they receive referral to other, more-intensive care. MCH staff trained home visitors and supervisors in 6 regional locations in October 2016. Full day trainings consisted of defining MCH Home Visiting; its goals and purpose; target populations, and the new MCH Home Visiting Services transformation. At trainings, participants recommended home visiting service changes related to program supervision; orientation and training; visit protocol (initiation, location, frequency, duration, documentation); assessments/tools (intake, family assessment, screening, checklists); program curriculum; outreach and recruitment; coordination of services (referral and follow-up); and new program name and branding, MCH Home Visiting. Home visitors and their supervisors were given the opportunity to provide input on the transformation of their MCH home visiting services and a draft form was presented at the Governor's Public Health Conference, allowing feedback before



## **Child Development & Wellbeing**

### Early Childhood Comprehensive Systems

Kansas' Early Childhood Comprehensive Systems (ECCS) Impact grant project builds on existing state and local efforts to improve outcomes for children and families. The project scales up by implementing policies that will support communities in routinely and systematically screening for children's development and maternal depression. Through this project, children birth to age 5 receive ongoing screening across diverse service providers (e.g., pediatricians, day care providers, family support programs) using standardized tools such as the Ages and Stages Questionnaires®. New mothers are screened for depression using standardized tools such as the Edinburgh Postnatal Depression Scale. Participating communities have access to shared data systems, including ASQ Enterprise and DAISEY to improve provider communication and participant outcomes. The project scales deep by using Collective Impact and relationship-strengthening strategies at the state and county levels. The project scales out by increasing the number of children and mothers screened and moving towards on-target development by age three.

### Critical Congenital Heart Disease/Defect Screening (CCHD) Public Health Quality Initiative

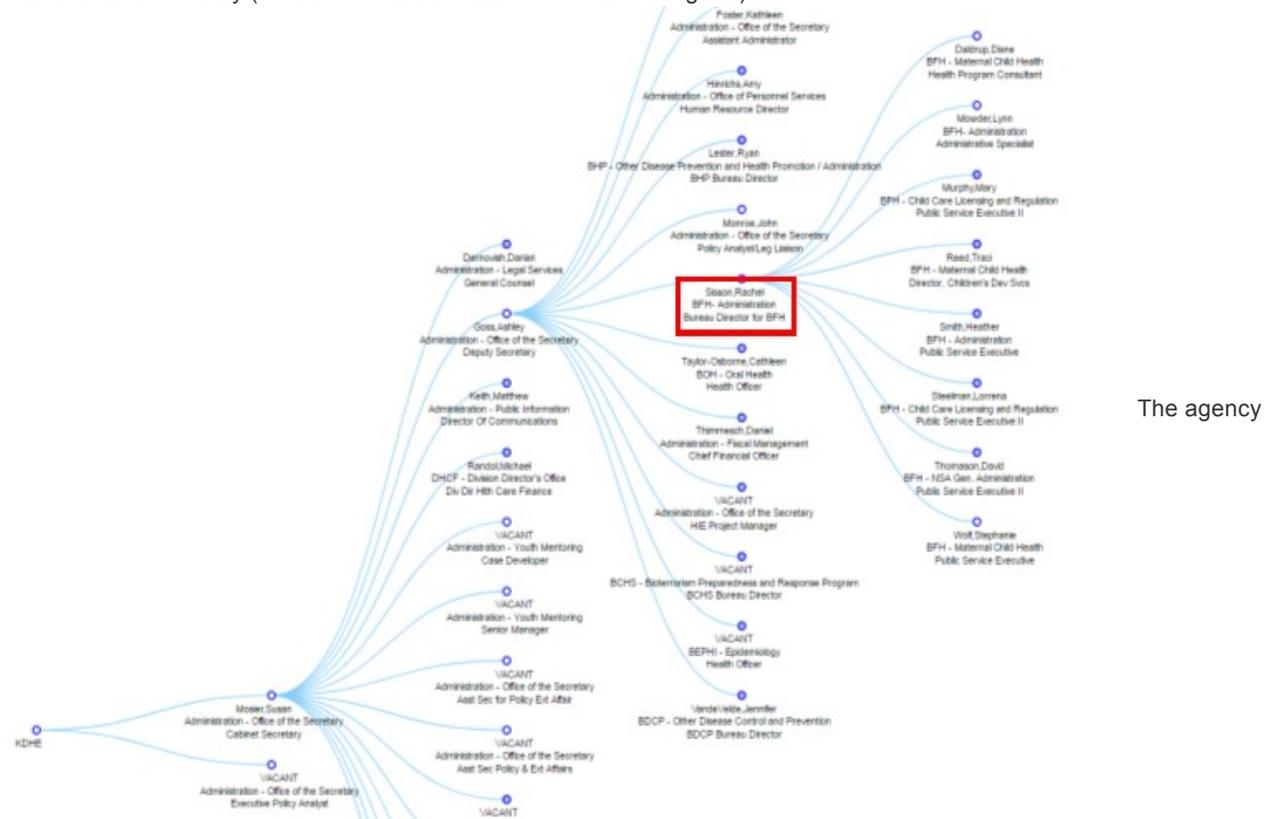
The Newborn Screening Follow-Up (NBSFU) program completed the second year of a comprehensive QI public health initiative related to CCHD Screening. This initiative involves training birthing facilities on the proper screening and referral protocols and developing a reporting mechanism to support monitoring and follow up activities. Work with sites began February 2014, at which time 78% of newborns in Kansas were being screened for CCHD prior to discharge (representing 30% of birthing facilities). As of July 2016, 100% of Kansas newborns are screened for CCHD. "At Children's Mercy Hospital over the last year, we have seen a dramatic decrease in the number of newborns presenting critically ill due to their Critical Congenital Heart Defect (CCHD). The impact of pulse oximetry on early diagnosis of CCHD is clearly saving lives". – Stephen Kaine, MD

**NEW PENDING OPPORTUNITY: Maternal and Child Environmental Health Collaborative Improvement and Innovation Network (MCEH CollN):** The Title V program in partnership with the Environmental Public Health Tracking Program (EPHTP) and Lead Hazard Prevention Program (LHPP) submitted a letter of commitment/support to JSI (January 2017) to participate in the MCEH CollN. In addition to overseeing the MCH Block Grant, the Bureau houses the LHPP and partners with EPHTP through the provision of blood-lead surveillance activities. KDHE is actively participating in the Infant Mortality CollN, and the MCEH CollN presents an important opportunity to expand our work in quality improvement. Kansas is very fortunate to have a strong and engaged MCH community. Thus, our participation on the MCEH CollN would be an extension of our collaborative efforts.

## II.F.2 MCH Workforce Development and Capacity

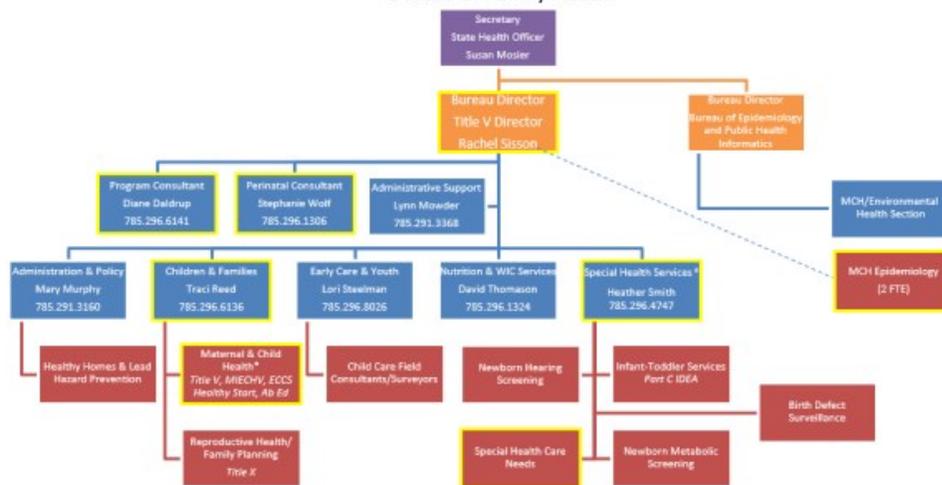
### Title V & Organizational Structure

The State's public health agency, Kansas Department of Health and Environment (KDHE), is responsible for the administration of programs carried out with allotments under Title V [Section 509(b)]. The agency has three divisions: Public Health, Health Care Finance (Medicaid/State Health Insurance), and Environment. The Division of Public Health has six bureaus: Family Health; Disease Control & Prevention; Community Health Systems; Health Promotion; Oral Health; and Epidemiology & Public Health Informatics. The Title V Maternal & Child Health (MCH) Services Block Grant program is administered by the Bureau of Family Health (BFH) in the Division of Public Health. The mission of the Bureau is to “provide leadership to enhance the health of Kansas women and children through partnerships with families and communities.” BFH has five sections: Children & Families; Special Health Services; Nutrition & WIC Services; Early Care & Youth Programs (Child Care Licensing) and Administration & Policy (includes the Lead Hazard Prevention Program).



organizational charts (KDHE and Bureau of Family Health) are included below.

**Kansas Department of Health & Environment  
Division of Public Health  
Bureau of Family Health**



\*Includes Aid to Local Programs/Grant Projects: Title V MCH, Pregnancy Maintenance Initiative (PMI), Teen Pregnancy Targeted Case Management (TPTCM), Home Visiting (universal and MIECHV), Early Childhood Comprehensive Systems Impact (ECCS); Abstinence Education; Healthy Start; staffing for Woman's Right to Know (WRTK), and KS MCH Council

#Includes staffing for Kansas Resource Guide, Systems Integration and Help Me Grow, Newborn Screening and Hearing Screening Councils

### Title V Maternal & Child Health (MCH) Workforce

The KDHE Bureau of Family Health (BFH) programs partially funded by the federal-state Title V Block Grant include MCH, SHCN, and Child Care. Within the Division of Public Health, other Bureaus that receive support include the Bureau of Epidemiology and Public Health Informatics (Vital records data sharing, analysis, reporting) and the Bureau of Community Health Systems (local public health workforce development, training, capacity building, systems development). Local agencies including health departments and Federally Qualified Health Centers are independent entities that apply for MCH funds annually as part of the agency's competitive Aid to Local application process.

Effective July 2017, the Bureau of Family Health (BFH) has 83.2 full-time equivalent (FTEs) positions. The Title V Director and an Assistant total 2 FTEs. Section staffing follows. Special Health Services staffs the core Title V CYSHCN team and has 19.6 FTEs including a Director (MPH) and program staff including Special Health Care Needs (SHCN). Children & Families staffs the core Title V MCH team and has 13 FTEs including a Director (LMSW) and RN, BSN. MCH Block Grant funds provide salaries for approximately 22% of the staffing in the Bureau, supporting administration, CYSHCN, and MCH. MCH funding also supports part-time staff in the Bureau of Community Health Systems' Local Public Health Program for workforce development, capacity building, and training and the Office of Vital Statistics for data access and analysis. MCH and SSDI funding supports two full time epidemiologists within the Bureau of Epidemiology and Public Health Informatics. The epidemiologists interface with epidemiological work conducted in other Bureaus inside the agency and with other organizations and efforts in the state. Both epidemiologists coordinate all data analyses for the Title V needs assessment with an outside contractor. Both assist programs with assessments and evaluations, conduct research, and address epidemiologic needs of the BFH. One position is specifically assigned to work with Medicaid (data sharing, review/analysis, application and impact on programmatic efforts and state and local initiatives).

### Title V Capacity to Provide Services for MCH Populations

The MCH and CYSHCN teams are key to building partnerships at the state level and providing support to the local level to improve state-local coordination and alignment with program vision. In addition to more than 70 local programs' affiliated staff and partners, the Bureau of Family Health has experienced and visionary staff, especially when it comes to the Title V state team. The current Title V staff (with expertise by domain) are listed below. Biosketches for key management staff are also

provided.

TITLE V STAFF	TITLE V DOMAIN					
	Women/ Maternal	Perinatal/ Infant	Child	Adolescent	Children with Special Health Care Needs	Cross- cutting/ Life Course
<b>Rachel Sisson</b> Title V MCH Director Bureau Director	x	x	x	x	x	x
<b>Heather Smith</b> Title V SHCN Director Special Health Services Director	x	x	x	x	x	x
<b>Stephanie Wolf</b> Perinatal Consultant	x	x	x	x	x	x
<b>Traci Reed</b> Children & Families Director	x	x	x	x		x
<b>Kayzy Bigler</b> SHCN Manager		x	x	x	x	x
<b>Carrie Akin</b> MCH Program Mgr.	x	x	x	x		x
<b>Tamara Thomas</b> MCH Program Mgr.	x	x	x	x		x
<b>Deborah Richardson</b> Home Visiting Mgr.	x	x	x			x
<b>Phyllis Marmon</b> Home Visiting Consultant	x	x				x
<b>Diane Daldrup</b> MCH Consultant	x	x				x
<b>Vacant</b> MCH Consultant			x	x		x
<b>Lori Steelman</b> Child Care Director		x	x	x		x

**NOTE:** Jamie Kim and (Vacant), MCH Epidemiologists, support all domains. Vital Statistics staff provide support for all domains and projects as requested. The Local Public Health Program provides staff and resources for training health departments and other public health activities.

### Leadership/Management Biosketches

*Rachel Sisson* was appointed as the Bureau of Family Health Director and Title V Director in 2012. She has nearly 20 years of experience related to workforce development and managing statewide programs including Division of Public Health programs such as health occupations credentialing and human care regulation. She holds a Master's degree in Early Childhood Education and Bachelor's degree in Family Studies and Human Services from Kansas State University. Rachel received the AMCHP 2016 Excellence in State MCH Leadership Award for significant contributions to the health of women, children, and families in Kansas.

*Heather Smith* serves as the Special Health Services and Kansas Special Health Care Needs Director. From 2015 to 2017, she served as the Region VII Director on the Association of Maternal and Child Health Program (AMCHP) Board of Directors. From 2009 to 2013, she served as a Project Coordinator for the Kansas Children and Youth with Special Health Care Needs program. Heather has a Master's degree in Public Health and a Bachelor's in Child and Family Development, both from Missouri State University. She participated in the Kansas Public Health Leadership Institute in 2012.

*Jamie Kim* has served as the MCH epidemiologist since 2003 and serves as the State Systems Development Initiative (SSDI) project director. Priority job assignments focus on pregnant women and infants (infant mortality, Perinatal Periods of Risk approach (PPOR), maternal mortality and morbidity), CYSHCN (birth defects surveillance, newborn screening, and health disparities in children due to disability status), and WIC. She earned a Master of Public Health (in association with the University of Kansas) and Bachelor of Science in Chemistry from Wichita State University.

## Kansas Maternal & Child Health Council (KMCHC)

The primary partner group that regularly advises the state Title V program (expanding capacity even further) is the Kansas Maternal & Child Health Council membership. The KMCHC ([www.kansasmch.org](http://www.kansasmch.org)) serves in an advisory capacity to the Title V Program, monitors progress, and addresses specific needs for MCH populations. The Kansas Chapter of the American Academy of Pediatrics (KAAP\*) serves as the lead agency and fiscal agent for the Council. A formal partnership exists between KAAP and KDHE to assure access to high quality MCH services in Kansas, resulting in improved outcomes. The Council is comprised of a multidisciplinary team of professionals, including family members, with expertise in MCH. The council members are identified and, in consultation with KDHE, selected to serve on the Council by the KAAP. The Title V needs assessment and state action plan is the guiding document as it relates to the ongoing work of the Council. KDHE and KAAP convene the Council at least once each quarter. A decision was made in September 2015 to merge the Blue Ribbon Panel on Infant Mortality with the KMCHC, resulting in greater coordination and impact. The Panel was established in 2009 to develop a set of recommendations to reduce infant mortality in Kansas. Work and membership is now integrated into the KMCHC, with most of the members previously on the Panel serving on the Perinatal/Infant Health workgroup. The KMCHC Chair is Dennis Cooley, MD, FAAP. Membership is 40-45 members at any given time. A KMCHC member roster is available here:

<http://www.kansasmch.org/members.asp>.

\*KAAP is a professional organization comprised of pediatricians with a professional affiliation to obstetricians, gynecologists, family practice physicians and other professionals dedicated to promoting improved maternal and child health and delivery of care in Kansas.

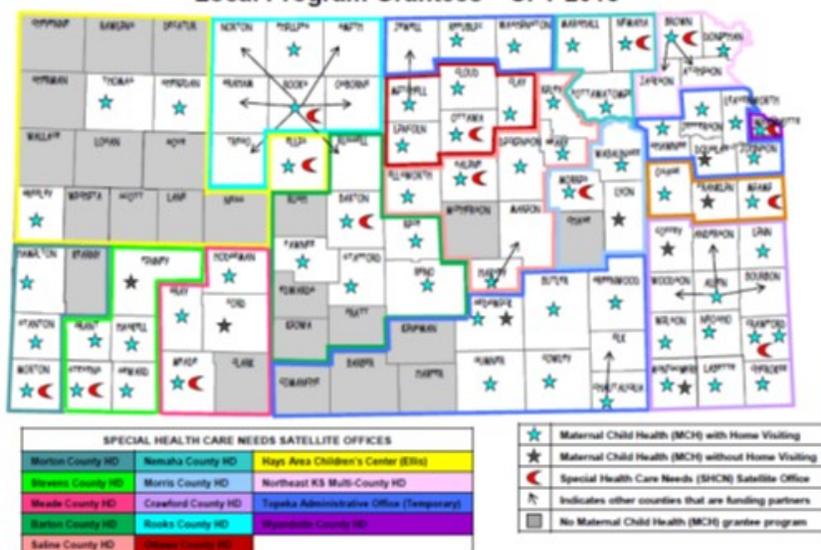
### **Service Delivery System, Structure, & Partnerships**

The majority of programs funded by the Block Grant are delivered by health departments and safety net clinics (independent entities). These agencies are positioned to provide many core public health services in addition to MCH, so the delivery system has the advantages of convenience and comprehensive care. The services delivered by local agencies are designed to address ongoing needs and those identified as part of the most recent needs assessment. When funds are allocated to external programs, the Bureau maintains contracts for the use of the funds to outline the nature of the work in support of the MCH priorities.

Services are to be in compliance with Title V legislation and in accordance with the Kansas MCH Manual available here: [http://www.kdheks.gov/c-f/downloads/SFY18\\_Kansas\\_MCH\\_Service\\_Manual.pdf](http://www.kdheks.gov/c-f/downloads/SFY18_Kansas_MCH_Service_Manual.pdf). The manual provides background on the Title V Maternal and Child Health Block Grant legislation/authority, Kansas MCH program principles, and service guidance. In addition, it outlines expectations for program supervision and staffing. In order to support local programs with carrying out program activities that align with and advance the state action plan, additional resources have been developed and provided. These include a staff training/orientation checklist and several other appendix resources related to practice and national performance measures.

The contractual process with local agencies begins with the development of Grant Application Guidance/Reporting Materials annually in December. These materials are available by mid-January to local agencies to apply for Title V funding as part of the aid to local funding process. The review process which informs funding recommendations involves external reviewers applying guidance and a scoring matrix, funding formula based on poverty and population by county/target area, and willingness/ability to comply with grant requirements. Detailed client and service data is required to be collected, aggregate progress reports and affidavits of expenditures are required quarterly, and site visits are conducted to verify compliance with funding requirements and progress toward priorities, goals, objectives, and measures. More information about the [MCH Aid to Local Program](http://www.kdheks.gov/doc_lib/MaternalAndChildHealthServices.html) including guidance, is available online here: [http://www.kdheks.gov/doc\\_lib/MaternalAndChildHealthServices.html](http://www.kdheks.gov/doc_lib/MaternalAndChildHealthServices.html). Aid to Local contract documents and the list of local 2018 MCH grantees statewide are attached as supporting documents. A map of 2018 MCH grantees/local agencies is provided below and in supporting documents. The maps also indicate SHCN regions and satellite office lead counties.

## Maternal & Child Health Local Program Grantees – SFY 2018



### Local MCH Workforce Development

The MCH Navigator and online MCH Assessment are utilized and fully integrated into the professional development planning and performance reviews for all staff. All MCH program staff (existing) and supervisors must complete MCH training via the online [MCH Navigator](#). Two courses must be completed within three months of grant award or hire, whichever applies. ([MCH 101](#) and [MCH Orientation](#))

Local MCH program staff who screen for smoking and/or work directly with participants who smoke are required to complete *Addressing Tobacco Use in Kansas: Brief Tobacco Intervention Online Training* ([kstobaccointervention.org](http://kstobaccointervention.org)), an interactive, online course for health care providers demonstrating a “brief tobacco intervention” providers can use with patients who use tobacco products.

Annual/ongoing training requirements for all MCH Program Staff include Technical Assistance Calls/Webinars throughout the year and the Governor’s Public Health Conference. A “conference-alternative” option is available to program staff who are unable to attend the required annual Governor’s Public Health Conference. At least two courses must be completed via the [MCH Navigator](#). Courses selected must be identified on the “personalized learning plan” as a result of completing the online [MCH Navigator Self-Assessment](#).

### 2016 Public Health Regional Meetings

State Title V staff facilitated FY 2016 3rd quarter meetings in all six public health regions with local health department administrators and staff. Updates were provided related to BFH programs and services (Children & Families, Special Health Services, Nutrition & WIC Services, and Child Care Licensing). The primary focus was on Children & Families programs including MCH & Family Planning. Participants learned about program priorities, the launch of DAISEY, Aid to Local reporting and application for SFY17, technical assistance and training opportunities. Participants were also provided information about MCH priorities, plans, and performance measures for the period 2016-2020.

Date	Location	Attendees
1/14/2016	SE Region - Chanute, KS	31
2/3/2016	SC Region - Hutchinson, KS	41
2/10/2016	SW Region - Garden City, KS	29
2/11/2016	NW Region - Oakley, KS	19
3/2/2016	NC Region - Beloit, KS	25
3/8/2016	NE Region - Topeka, KS	28

Governor's Public Health Conference

Title V staff provided extensive support for the Annual Kansas Governor's Public Health Conference which included pre-conference sessions focused on the Title V Priorities and NPMs as well as aid to local program requirements, data collection, reporting, technical assistance and training. The MCH session also included training on the revised Bright Futures guidelines and their relevance to public health service delivery, the importance of family engagement and how to engage families at multiple levels within an agency and the community collaborative model and its applicability to maternal and child health programs. A wide selection of breakout sessions tailored to meet the changing needs of the populations served through public health programs and initiatives was offered.

Date	Session	Attendees
04/26/16	2016 Pre-Conference Session	104
04/25/17	2017 Pre-Conference Session	111
04/26/17	MCH Home Visiting Session	120

MCH Technical Assistance Webinars for Local Agencies/Grantees – (SFY 16 and 17)

KDHE MCH staff provide technical assistance and training webinars throughout the year to local MCH agencies. In SFY 2016 and SFY 2017 a wide variety of topics was presented, including how to complete a MCH application and progress report in Catalyst; how to complete a budget; how to develop program goals, objectives and outcome measures; Title V State Action Plan; introduction to DAISEY; DAISEY implementation; DAISEY data dictionary; completing DAISEY forms (direct and aggregate entry); DAISEY Reports (Data Quality and Program Reports); and open mic sessions during which agencies could raise any topic related to the program.



Date	Title/Topic	Attendees
3/16/2017	SFY17 MCH TA Webinar - Title V State Action Plan	77
2/7/2017	DAISEY Data Quality Reports	66
2/2/2017	DAISEY Data Quality Reports	70
1/31/2017	TPTCM FY 2018 Application	14
1/30/2017	FY 2018 PMI Application	15
1/25/2017	SFY18 MCH Grant Application	32
1/19/2017	SFY17 MCH TA Webinar - MCH Policy/Procedure Manual & Goals, Objectives and Outcome Measures	62
1/17/2017	SFY18 MCH Grant Application	32
11/17/2016	SFY17 MCH TA Webinar - Client Satisfaction Survey Exchange	57
9/29/2016	SFY17 MCH Progress Report	26
9/22/2016	PMI FY 2017 Quarterly Progress Report	8
9/22/2016	TPTCM FY 2017 Quarterly Progress Report	12
9/21/2016	SFY17 MCH Progress Report	25
7/28/2016	Review of MCH Tableau reports in DAISEY	33
7/28/2016	Review of TPTCM Tableau reports in DAISEY	7
7/25/2016	Review of PMI Tableau reports in DAISEY	5
7/25/2016	Review of MCH Tableau reports in DAISEY	30
6/7/2016	MCH Aggregate Forms	20
6/6/2016	TPTCM Aggregate Forms	3
4/25/2016	BaM Monthly Integration Webinar	13
2/24/2016	Becoming a Mom Integration Training, Part...	11
2/18/2016	MCH TA Webinar Open-Mic	14
2/16/2016	KIPHS Users Webinar regarding DAISEY	45
2/12/2016	PMI FY 2017 Application	13
2/4/2016	TPTCM FY17 Application	14
1/21/2016	MCH January TA Webinar	37
1/13/2016	MCH January TA Webinar	54
1/11/2016	DAISEY - EHR Webinar	34
12/17/2015	MCH December TA Webinar	27
12/17/2015	DAISEY - KIPHS Webinar	23
12/14/2015	DAISEY - KIPHS Webinar	15
12/14/2015	DAISEY Implementation	37
12/10/2015	MCH December TA Webinar	45
11/12/2015	DAISEY Data Dictionary--TPTCM	15
11/9/2015	DAISEY Data Dictionary--MCH	77
11/3/2015	DAISEY Data Dictionary--PMI	17
11/3/2015	DAISEY Data Dictionary--MCH	71
10/27/2015	DAISEY Launch Q&A for BaM Sites	9
10/14/2015	DAISEY Discussion with vendors	7
9/16/2015	Introduction to DAISEY	15
9/10/2015	TPTCM Progress Report in Catalyst	12
9/2/2015	PMI Progress Report in Catalyst	13
8/27/2015	MCH Progress Reports in Catalyst	38
8/26/2015	MCH Progress Reports in Catalyst	68
8/5/2015	Introduction to DAISEY	61
8/4/2015	Introduction to DAISEY	87
7/30/2015	MCH Webinar	35
7/29/2015	MCH Webinar	59

MCH Local Agency Monitoring Visits (on site)

Technical assistance and training is also provided by KDHE MCH staff during onsite monitoring visits conducted with local MCH agencies on a three-year cycle. The monitoring tool used for the onsite visits includes sections for administration/management, data, program effectiveness, target populations/interventions, outreach, and partnership/collaboration. At the end of the site visit, KDHE staff discuss with agency staff their strengths, challenges and any technical assistance needs they may have. During a review of quarterly progress reports, if KDHE MCH staff identify a local MCH agency needing assistance or if an agency requests additional assistance, a special/off-cycle site visit may also be conducted.

Site Visit Date	Local Agency/Grantee
11/16/2016	Sumner County Health Department
11/15/2016	Stafford County Health Department
10/13/2016	Grant County Health Department
8/25/2016	Barton County Health Department
8/24/2016	Thomas County Health Department
8/23/2016	Ford County Health Department
7/27/2016	Mercy Hospital-Fort Scott
7/20/2016	Sedgwick County Health Department
6/30/2016	Greeley County Health Department
6/29/2016	Finney County Health Department
3/31/2016	SEK-Multi County Health Department
3/28/2016	Dickinson County Health Department
2/25/2016	Geary County Health Department
12/15/2015	Geary County Health Department

*Local Public Health (LPH) staff funded by Title V facilitated/offered the following during 2016*

The Local Public Health Program develops and disseminates the e-newsletter Public Health Connections. Training information, articles, funding opportunities and resources are provided for those who work with Kansas populations. The Bureau of Health Promotion, the Midwest Dairy Council and the KS-TRAIN are frequent contributors with information about health for the public health workforce. [http://www.kdheks.gov/olrh/PH\\_Connections/Connect05-17.pdf](http://www.kdheks.gov/olrh/PH_Connections/Connect05-17.pdf). The Public Health Connections electronic newsletter was published and disseminated across the state to public health partners and MCH local agencies/grantees monthly. The content is relevant to all MCH population domains and the State MCH Action Plan.

KS-TRAIN learning management system staff support registration and tracking of live training as well as offering of online course opportunities relevant to MCH with topics including: breastfeeding, Baby Behaviors (feeding cues), school bullying policies, Hepatitis B during pregnancy, family planning, adolescent health, perinatal health, and more.

**State Title V Workforce Development & Training Needs**

In addition to required agency training programs like Public Health Quality Improvement, the Bureau and Title V state staff participate in annual training. Past events that applied to all staff in the Bureau include The Change Cycle, Leadership Challenge, and Bridges Out of Poverty.

During FY 2016, the major all-staff event for Title V and Bureau staff centered on work culture and leadership and included resources such as the developmental relationships framework. The University of Kansas (KU) presented a customized program for the team in September 2015 that included a session on “rules of engagement” which challenged us to think about what behaviors we want to model in our work and in our work environment. Staff who were present provided comments and suggested rules. More than a hundred potential thoughts were condensed into proposed rules of engagement, and staff selected those they felt the Bureau should adopt in response to a survey sent out after the event.



The top four rules selected by those that responded to the survey are listed below. These are now the official Bureau of Family Health Rules of Engagement.

1. Be accountable and reliable.
2. Focus on the positive.
3. Set an example.
4. Strive for better.



The image on the right reflects these rules and behaviors we collectively feel are important to model in our work with each other, partners, individuals/families, and the public. Directors have posters hanging in their offices as a reminder and point of discussion as necessary.



The FY 2017 event built upon the 2016 work and was again facilitated by the KU Center for Public Partnerships and Research. The staff event was intended to assist the Bureau and Title V staff with: 1) operationalizing the BFH rules of engagement as a tool to build leadership capacity and work culture; 2) engaging all staff as leaders; and, 3) the role of BFH staff as leaders across Kansas. The facilitators completed the following:

- Review key concepts of leadership and positive work culture
- Introduce the BFH rules of engagement
- Introduce *strengths* using the Clifton Strengths Finder 2.0
- Use team-building exercises to engage participants in critical thinking
- Guide participants in identifying actionable strategies to implement elements of positive work culture and leadership behaviors.



Staff training needs include cultural competency, health equity, Medicaid policies, Quality Improvement (cycles/data collection), program evaluation, drafting aim and outcome statements, monitoring sub-recipients, care coordination, and telehealth. In addition, there is special emphasis on training the local workforce on these same topics, as well as the importance of data-driven decisions and use of data to advance public health, shared measurement systems (client record data and referral information), Adverse Childhood Experiences (ACEs), One Key Question®, Trauma-Informed Systems of Care, Neonatal Abstinence Syndrome, Maternal Mortality, and School Based Health Centers/Services.

### II.F.3. Family Consumer Partnership

*Kansas invests in family **engagement** and family **partnership** to affirm that the family voice is a critical component to moving services in the right direction.*

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The Kansas Title V Program provides opportunities for engagement at varying levels of involvement and intensity to fit the needs of consumers and families. Families and consumers provide firsthand knowledge and insight to areas that state program staff may not have considered, as well as suggestions on how to make positive changes for the MCH populations, especially CSHCN.

#### **Families Participate in Kansas MCH Efforts as Council Members, Professionals, and Experts**

##### SPECIAL HEALTH SERVICES FAMILY ADVISORY COUNCIL (SHS-FAC)

Family consumer partnerships continue to be the strength of the KS-SHCN program. Program staff understand that any initiative or project must be vetted through families in order to know that it is a valid project with value. The program exists to improve the lives of individuals with special health care needs and the program has adopted the philosophy “nothing about us without us”, so buy-in from those who will be directly affected by changes needs to occur frequently. For this reason, the SHS-FAC is financially supported, including providing the family members a consultant fee and travel reimbursement. The Council is made up of a variety of families who have children with a wide range of special health care needs and vary in age from newborn to adulthood. This council not only advises the SHS programs but assist in developing programs, materials and promotional activities to spread the word about program services. SHS-FAC members receive valuable training on Title V and MCH core competencies. Program staff are constantly working towards recruiting FAC members of more diverse ethnic backgrounds.

KS-SHCN staff serve as the agency lead, with support from the Executive Committee comprised of three FAC members who assist in the development of agendas, bring key issues to the table, and provide oversight of FAC operations. The Executive Committee was created to provide an expanded leadership opportunity and allow interested FAC members to be more engaged, in addition to assuring the meetings remained focused on member interests. The FAC has responsibility for assuring SHS programs are accountable in moving forward with family/consumer partnership as the central focus.

FAC members are encouraged to engage in community initiatives to support their interests. This can include members participating in local peer support groups, community projects and charitable organizations, research and advocacy efforts associated with their child’s condition, and as engaged family members of other state agencies or systems, such as part of the Managed Care Organization (MCO) Consumer Groups. While financial support is not offered for these other activities, encouragement, resources, information, and assistance is available from agency staff liaisons and programs. FAC members engaged in these other efforts will share information on these activities with other members, allowing for dialogue and resource sharing during and in-between meetings.

The FAC hold a strategic planning session once per year to outline tasks and objectives they want to focus on for the upcoming year. More information about the focus for this coming year is described in the CSHCN domain plan.

This past year, the FAC members requested an opportunity for continued engagement for members who have exceeded the number of years eligible to serve on the Council. Thus, the FAC Alumni and Mentorship Program (AMP) was developed for members who have to leave the Council due to term limits or personal reasons, but would still like to be involved with the FAC at some level. Continued engagement opportunities are offered to these seasoned and motivated family professionals, allowing them to continue their contributions and see the impact of their foundational work. The mentor program is to assist new members in learning about the FAC and their role as a member. Former or current members who have served 2 or more years as an FAC member can participate in a mentor capacity. Additionally, we hope to nurture their investment and expand the cross cutting community of Title V family and consumer partners.

KANSAS MATERNAL AND CHILD HEALTH COUNCIL (KMCHC)

Family representation on the state MCH Council began in 2014. The council serves to advise KDHE on cross-cutting issues across the lifespan of Kansas women, children and families. During 2016, an additional family member was added to the council to bring a new perspective to council initiatives. Since that time, improvements have continued as related to *family and consumer representation, partnership, and visibility*.

- A family/consumer KMCHC application was developed and piloted.
- The reimbursement policy was updated to reflect greater support for family and consumer representatives (increased stipend, reimbursement for all out of pocket expenses related to travel, and a child care stipend with prior approval).
- Council membership has been expanded to include more family/consumer representatives (at least 2 for each of the four domain sub/work groups).
- A new member welcome call from the Title V team, a copy of the bylaws, and a personal KMCHC orientation workbook.
- Family leaders are provided opportunities for a “debriefing,” following each meeting to assure active engagement and sufficient support.

FAMILY DELEGATE PROGRAM

The KS AMCHP Family Delegate appointment process was initiated by the CYSHCN Director in 2013 to increase opportunities for family leadership within Title V and ensure comprehensive supports and resources are available for delegates. A competitive application process involves a mentorship plan resulting in a mutually agreed-upon project to advance the MCH/Title V 5-year plan. Delegates are allowed to continue for two consecutive years, if interested. Donna Yadrich was appointed the first delegate through this process (2013-2014) and has continued on as the Delegate. The Family Delegate also reviews applications for MCH funding from local agencies and fully participates in the annual block grant review process.

INFANT MORTALITY COLLABORATIVE IMPROVEMENT & INNOVATION NETWORK (IM CoIN)

The Kansas Family Delegate serves as a State Team Member for the IM CoIN initiative. As a result, the state has developed change ideas for both networks: smoking cessation and pre and early term birth. The image below provides a screen shot of the Kansas IM CoIN priority areas/strategies, drivers, and change ideas specifically related to family and consumer engagement. An example of a change idea in the CoIN plans is below.

Family & Consumer Engagement Change Ideas – Apply to All Networks				
Driver	Benefits	Leads	Measures	Comments
PD3 <i>Health providers practice authentic consumer engagement</i>	<p>Providers will be invited (at every point of contact) to deepen consumer engagement skills as they participate in MCH planning and evaluate outcomes.</p> <p>Providers and staff affiliated with CYSCHN program will share their experiences with consumer engagement to their MCH peers.</p> <p>Providers/staff recognize that consumers can also serve them as providers of engagement.</p>	<p>D. Yadrich (Family Delegate)</p> <p>CYSCHN leadership</p> <p>MCH leadership</p>	<p>Percent of providers/staff that can describe authentic engagement</p> <p>Percent of providers/staff reporting deepening practices of engagement</p> <p>Percent of providers relaying specific examples of consumer engagement in their office/institution/agency</p>	<p>Staff and providers need to be educated and encouraged to continually embed consumer partnership in practice.</p> <p>We need to quantify health outcomes of increased consumer engagement.</p>

PERINATAL COLLABORATIVES (Utilizing the March of Dimes *Becoming a Mom*<sup>®</sup> curriculum)

Family and consumer partnership is an area of interest for the Kansas perinatal collaboration/birth outcomes model. Intentions are to build in an *integration* component centered on this concept. Input from consumers is utilized in making decisions around program implementation, program updates/revisions/improvements, and priority areas for focus in future years.

**Increasing Awareness and Commitment: Bureau of Family Health and Core MCH Team**

Although leadership is provided by the Title V program, the Bureau of Family Health prioritizes family engagement. This is demonstrated through commitment of time and resources. There are designated positions with responsibilities across programs, including the SHCN Program Manager and MCH Perinatal Consultant. Families are engaged at all stages (design,

planning, implementation, evaluation) in an ongoing, continuous way as described above.

The Title V MCH and CSHCN core teams meet monthly with other Bureau of Family Health MCH partners including WIC, MIECHV/Home Visiting, and Child Care to review progress with activities related to the state MCH plan and discuss success, challenges, and opportunities for further collaboration. A special emphasis has been around family and consumer engagement. The team as a whole has been challenged to reflect on how they as staff and their respective grants/programs are engaging family members and consumers in a meaningful way. In order to support staff in their role and expectations to promote this idea and vision to local communities, the SHCN Program Manager/Family Leader expert presented to the MCH Coordination team in December 2016. During her presentation, *Evaluating Existing Engagement Efforts & Opportunities for Improvement*, she challenged staff to commit to engaging families. They were asked to set a deadline and she conducts periodic follow-up with the team to track progress made.

### **National Representation & Recognition for the Kansas Family Engagement Approach**

The Title V program has increased awareness about the importance of family and consumer engagement at the state and local/community levels as well as nationally. Three specific ways Kansas shared at the national level are detailed below:

- January 2016 – AMCHP Family Leader Cohort presentation (Title V CSHCN Director, Staff and Family Delegate)
- March 2016 – AMCHP Cohort Leadership presentation (Title V MCH Director)
- April 2016 – Family Leadership Poster at AMCHP 2016 (Title V CSHCN Director, Staff and Family Delegate)
- March 2017 – at AMCHP 2017 (Title V Staff and 3 Family Leaders)

#### **II.F.4. Health Reform**

The state's capacity to address health reform from the context of the National Workforce Development Center's (WDC) definition\* of "health transformation" is higher due to program changes which shift the focus to the integration of public health and primary care, collaborative service delivery models, and from disease management to prevention and population health management. There is also a shift specifically from direct clinical services to care coordination and family empowerment/self-sufficiency as it relates to special health care needs. Additionally, the focus has historically revolved around a multidisciplinary approach to the provision of services under the medical home approach.

Kansas did not expand Medicaid so few formal Title V activities have taken place at the state level around expansion. MCH staff works closely with Medicaid staff and Managed Care Organizations to align efforts and collaborate to increase access and improve services for Medicaid beneficiaries. Partnership with eligibility workers supports referral and support for the application process with a "no wrong door" approach to referral for eligibility/applications support at the local level.

*\*The National WDC's definition of health transformation is reflected throughout Center activities and provides an opportunity for all states/territories, regardless of their environment, to embrace the changes and opportunities to promote maternal and child health.*

## II.F.5. Emerging Issues

### Opioid Epidemic & Neonatal Abstinence Syndrome

The opioid prescription epidemic has impacted all age, race, sex, economic and social populations in the US. It has even affected the most vulnerable population--pregnant women and infants. Neonatal Abstinence Syndrome (NAS) is a postnatal drug withdrawal syndrome that results from in utero exposure to addictive prescription or illicit drugs. The incidence of NAS is increasing at a rapid rate nationwide. On average, the cost of delivering a baby diagnosed with NAS is much higher and the hospital length of stay is significantly longer, compared to a newborn without NAS.

Based on the Kansas hospital discharge data, between 2010 and 2014, 433 infants were diagnosed with NAS in Kansas. Infants diagnosed with NAS were predominantly Caucasian, non-Hispanic ethnicity, insured by Medicaid and resided in urban counties. NAS patients were more likely to have complications than other hospital births including transient tachypnea of the newborn, meconium aspiration syndrome, respiratory distress syndrome, other neonatal respiratory diagnoses, jaundice, feeding difficulty, seizures and sepsis. Between 2000 and 2014, the overall incidence of NAS in Kansas significantly increased from 0.3 per 1,000 hospital births to 2.9 per 1,000 hospital births. Although this rate is lower than multi-state estimates, Kansas' increase in NAS incidence is higher.

KDHE is planning a state-level response to Neonatal Abstinence Syndrome (NAS). The Secretary and State Health Officer has delegated the responsibility for planning and execution to Title V. The immediate task at hand has been to plan a full-day meeting to take place August 28, 2017.

#### Meeting Goals:

1. Present NAS within the context of the opioid epidemic to bring agencies and stakeholders/partners to a shared level of understanding.
2. Introduce Vermont Oxford Network's (VON) NAS Universal Training Program as a tool to support Kansas with statewide training and essential resources needed to implement the work and assess progress over time.
3. Discuss a path for Kansas going forward.

#### Meeting Outcomes:

- Shared understanding about the issue of NAS and why it's important for KS to respond
- Support to establish the Kansas Perinatal Quality Collaborative
- Commitment to a VON NAS Universal Training Program Subscription for KS

Long-term Outcome: Comprehensive approach to NAS 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)

### Maternal Mortality & Pregnancy-Associated Deaths

Maternal mortality surveillance is necessary to identify and address factors contributing to poor pregnancy outcomes for women, and a structured pregnancy-related death review process is an important tool in the State's efforts to improve the health of Kansas women before, during and after pregnancy. During the 2017 Legislative Session, a bill was introduced (HB 2244) that establishes the Maternal Mortality Review (MMR) Committee to be housed within KDHE to review maternal deaths and develop prevention strategies. The bill didn't progress; however, in response to the bill (which was drafted jointly by the American Congress of Obstetricians and Gynecologists [ACOG] Kansas Section and March of Dimes) the Title V Director convened an internal and external team to discuss implementing MMR and establishing a MMR Committee. In addition, the Title V Director and key staff had a planning call with Review to Action staff from CDC and AMCHP. Kansas ACOG provided a letter of support to work alongside KDHE on implementation.

The KDHE Bureaus of Family Health (Title V program) and Epidemiology and Public Health Informatics are reviewing and utilizing essential MMR resources made available to states through the Review to Action website ([www.reviewtoaction.org](http://www.reviewtoaction.org)), a collaboration between the CDC, AMCHP, and CDC Foundation. Several resources are guiding conversations. The Title V Director and MCH Epidemiologist facilitated a discussion with the Kansas Section of ACOG on May 19, 2017, to further plan for

implementation. The meeting/discussion was productive and included Dr. Melissa Hague, Kansas ACOG Chair. Initial steps completed to date include: review of national and Kansas data; review of existing statutes and identified gaps (to be addressed through future proposed amendments to legislation); committee structure, staffing, and membership; review of existing resources (peer states and Review to Action/CDC and AMCHP); proposed Review Committee members; resources to support costs; and timeline for next steps. We also plan to utilize the AIM (Alliance for Innovation on Maternal Health) Program resources as we advance and expand maternal health efforts. <http://safehealthcareforeverywoman.org/aim-program/>

## II.F.6. Public Input

### FFY2018 Title V Block Grant Application/FFY2016 Annual Report Feedback

The Kansas Title V Team is committed to collecting input throughout the year and works in partnership with local agencies and the state MCH Council to assess and identify needs. Always looking for input, the staff work in additional opportunities to collect input and feedback through regular technical assistance calls/webinars as well as during local site visits, community meetings, and conferences/events. The input directly impacts programmatic decisions and state action plan activities continuously and throughout the year.

In addition, a public input survey is developed and posted annually (via survey monkey) to collect information on the DRAFT Application and Annual Report from consumers and partners across the state that are informed of and concerned about the needs of MCH populations. Details related to this year's public input process for the application/report and period follow.

Public Comment Period: June 16 – July 3, 2017

Methods: A post card was developed and distributed to partners and MCH Council members via email and in-person meetings.

**Kansas Maternal & Child Health Partner**

**We need your feedback!**

As part of the annual Title V Maternal & Child Health (MCH) Services Block Grant program, Kansas is required to provide a federal report and application available to the public for the purpose of gathering input. The purpose of this survey is to collect information, opinions, and perspectives from consumers and partners across the state who are informed of and concerned about the needs of the MCH population, established services and resources, and existing factors that affect the implementation of policy and programs. Find more information about the program and view the application: <http://www.kdheks.gov/bfh/>.

Your input is very important to us and will be kept strictly confidential.

<https://www.surveymonkey.com/r/5GPZQ62>

The survey will close for public input on July 3, 2017 to assure input can be included in our annual Block Grant Application. Thank you for your comments!

**KANSAS**  
MATERNAL &  
CHILD HEALTH

The following email was sent by the Title V Director to partners statewide (see partner list below).

*Dear Kansas Maternal & Child Health Partner:*

*As the Kansas Title V Maternal & Child Health (MCH) Director, it is my pleasure to release the (draft) Kansas MCH Services Block Grant 2018 Application and 2016 Annual Report. The MCH Block Grant is administered by the Kansas Department of Health and Environment, Division of Public Health, Bureau of Family Health. The document is available for public review and comment on the [Bureau of Family Health website](#).*

*Please take time to review this year's block grant application and provide comments and/or additional detail you might have to strengthen the application and ensure plans and reports represent our collective efforts statewide. This year's application includes the newest State Action Plan for the period 2016-2020 (priorities, measures, strategies) which was developed in*

response to the most recent statewide, comprehensive needs assessment Kansas is required to conduct every five years. Each of you provided input through the process in some way and we thank you! We are asking you again for your time and input. After reviewing the draft document, we ask that you complete a short [online survey](#). Please respond to the survey by **July 3** in order to ensure that your comments are reviewed and considered for the application. Resources to increase your knowledge about the MCH block grant program and Kansas' priority issues for 2016-2020 can be found on the Bureau of Family Health's [MCH Block Grant website](#).

Your input is valuable and needed to assure the MCH Program is guided by the needs of Kansas families and priority populations: women of reproductive age, pregnant women, infants, children, adolescents, and individuals with special health care needs. Whether you are a parent, health professional, government official, advocate, or member of the general public, MCH activities touch your life. Success lies in the strength of partnerships and collaborations to maximize reach and promote efficiency.

Thank you for your dedication and commitment to working together for a healthier Kansas.

Key Partner List (not comprehensive)

- American Congress of Obstetricians and Gynecologist (ACOG) Kansas Section
- Birth Centers
- Cerebral Palsy Research Foundation
- Child Care Providers and Facility Owners
- Children's Alliance
- Families Together
- Family Advisory Council
- Family Planning grantees
- High 5 for Mom and Baby
- Kansas Action for Children
- Kansas Association for the Medically Underserved
- Kansas Breastfeeding Coalition
- Kansas Chapter of American Academy of Pediatrics
- Kansas Chapter of Family Physicians
- Kansas Children's Service League
- Kansas Department of Aging and Disability Services
- Kansas Department for Children and Families
- Kansas Foundation for Medical Care
- Kansas Health Foundation
- Kansas Hospital Association and members
- Kansas Maternal & Child Health Council members
- Kansas Perinatal Quality Collaborative members
- Kansas Public Health Leadership Institute and Core Public Health Programs
- Kansas School Nurse Organization and members
- Kansas State Department of Education
- Kansas State University
- Kansas University Medical Center/Kansas University
- KDHE Department of Public Health Directors/staff
- Kansas Infant Death and SIDS (KIDS) Network
- Local Health Department Administrators
- Managed care organizations
- March of Dimes
- MCH grantees and partners
- Mother & Child Health Coalition of Greater Kansas City
- Newborn Hearing Advisory
- Newborn Screening Advisory
- Nutrition Physical Activity Collaborative
- School nurses
- Special Health Care Needs Specialty Clinics/Providers
- State Children's Institutions
- Sunflower Foundation
- Teen Pregnancy Targeted Case Management and Pregnancy Maintenance Initiative grantees
- United Methodist Health Ministry Fund and grantees/partners
- WIC Advisory Committee
- WIC grantees/representatives

Summary Results:

A total of 44 responses were received. Although we had a very low response, 65.6% responded that this was their first time providing feedback on a draft MCH application/annual report. Based on the information contained in the draft application/annual report, the majority of the respondents strongly agreed or agreed that they had a better understanding of the state MCH Priorities and plans for population health domains.

- Women/Maternal Health (97.6%)
- Perinatal/Infant Health (97.6%)
- Child Health (97.6%)
- Adolescent Health (95.2%)
- Children and Youth with Special Health Care Needs (95.2%)
- Cross-Cutting/Life Course (95.0%)

The majority responded that the 2018 Application and 2016 Annual Report:

- clearly indicates activities, progress, accomplishments, and future activities for each of the state priorities (97.6%);
- demonstrates strong capacity to address priority MCH issues and indicates progress and forward-movement for MCH in Kansas (95.2%); and
- accurately reflects the capacity/work/activities across Kansas as they relate to the state priorities (92.9%).

After reviewing “Five Year State Action Plan” and “Budget Narratives and Forms”, the majority responded that:

- the state action plan and strategies were adequately addressed (89.2%);
- the MCH Workforce Development and Capacity, Family/Consumer Partnership, Health Reform, and Emerging Issues were adequately addressed (97.0%); and
- the resource allocation/expenditures were adequately addressed (90.6%).

A Public Input Executive Summary document is developed each year based on the application input. The document is published on the Bureau of Family Health MCH Block Grant website once finalized.

## II.F.7. Technical Assistance

**Collecting Measurable Evidence around the CYSHCN Population:** As the Kansas Special Health Care Needs (KS-SHCN) program has transformed and transitioned to a program focused on community-based services and supports, the model for service delivery is naturally changing. The expansion from six to fourteen regional offices over the past three years and the shift from clinical and direct services support to care coordination services creates a need for more relevant, timely data around the children and youth with special health care needs (CYSHCN) population. Historically, data for CYSHCN came from the National Survey for Children with Special Health Care Needs (NS-CSHCN), with a recent shift to considering CYSHCN a subset population of the National Survey on Children's Health (NSCH). With this shift, states may experience fewer data points specific to the CYSHCN population and needs; however, what we receive in return is more data around family experiences and overall child health. Therefore, a need has been identified to consider a state-specific data set to best capture the impact and long-term outcomes of shifting to a care coordination model. Extensive evaluation planning is complete for the KS-SHCN Care Coordination model. However, it is unclear how to fully measure the impact of the non-KS-SHCN families served through Aid to Local and community partnerships. Technical assistance could help to better understand, in real-time, the needs of the CYSHCN population in Kansas.

**Neonatal Abstinence Syndrome (planning and implementation of a state-level response including establishing a perinatal quality collaborative):** The Kansas Title V Director submitted a Technical Assistance (TA) request to MCHB to support travel and fees for two national experts/speakers based on goals for a state meeting in 2017. The TA request was approved in June 2017. This TA (content and funding/support) is essential to bringing Cabinet agencies, stakeholders/local agencies/MCH and public health grantees, all sector partners, and patients/women/families together to discuss the issue of NAS. Title V MCH efforts around NAS will impact the state's Priority 1 for Women & Maternal Health (comprehensive services before, during, and after pregnancy). Screening during the well visit (NPM #1) relates to the initiative as well. More TA will be needed in the coming year(s).

**Baby-Friendly® Hospitals:** Kansas MCH and the United Methodist Health Ministry Fund (UMHMF) have teamed up to provide financial and technical assistance to support up to six hospitals in the state to move toward Baby-Friendly designation (implementing the 10 steps to support breastfeeding). The goal is to receive technical assistance through the Carolina Global Breastfeeding Institute (CGBI). The Kansas Title V Director submitted a Technical Assistance (TA) request to MCHB to support TA and coaching through December 2017; it was approved in July.

**Planning & Collaboration with Title X including One Key Question®:** The KDHE Children & Families Section includes the Title V MCH and Title X Family Planning programs. The programs spent several days together with a facilitator prior to 2016 to set priorities, goals, objectives, and identify linkages between MCH and Title X/Family Planning. The staff also identified needed resources and potential impact on local agencies and clients/families served. Technical assistance would support continuing this work and further develop the state-level plan to leverage Title X funds and/or increase coordination and collaboration between the Kansas Title V and Title X programs. Once the state has developed a vision/plan for integrating services and programs where appropriate, messaging and activities must take place with the local level grantees/programs. The outcomes would be improved reproductive, maternal, and infant health and a continuum of care and integrated community-based services.

**Title V MCH/Medicaid Intra-agency Coordination & Collaboration:** Consultation with a national expert is needed to strengthen the mandated relationship, especially where data sharing is concerned, and identify collaborative projects aimed at reducing disparities, advancing work/efforts related to shared priorities and needs, improving outcomes, and reducing health care costs. As the largest single payer for maternity care, Medicaid and CHIP play a key role in promoting access to care and ensuring quality of care during the perinatal period. The state's participation in the Collaborative Improvement and Innovation Network (CoIIN) expansion to reduce infant mortality through improved availability and reporting of timely provisional data to inform efforts and track outcomes that drive quality improvement and collaborative learning requires the state's abilities to access/use the linked vital records with Medicaid/CHIP administrative/claims data. One of the CoIIN measures, initiation of progesterone in women on Medicaid with prior preterm birth, is specified for use of linked vital records birth data and Medicaid/CHIP claims data.

**Other Technical Assistance Areas for Consideration:** maternal mortality review and committee launch, collecting measurable evidence related to program impact, program evaluation, school health, strategies and approaches for bullying prevention and building strong character/social-emotional development for children and youth.

### III. Budget Narrative

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
<b>Federal Allocation</b>	\$4,670,131	\$3,537,640	\$4,682,822	\$3,401,635
<b>Unobligated Balance</b>	\$0	\$0	\$0	\$0
<b>State Funds</b>	\$3,722,188	\$3,625,272	\$3,524,276	\$3,795,067
<b>Local Funds</b>	\$4,740,394	\$4,264,315	\$4,401,548	\$4,016,345
<b>Other Funds</b>	\$0	\$0	\$0	\$0
<b>Program Funds</b>	\$0	\$0	\$0	\$0
<b>SubTotal</b>	\$13,132,713	\$11,427,227	\$12,608,646	\$11,213,047
<b>Other Federal Funds</b>	\$80,287,199		\$76,927,990	\$68,796,517
<b>Total</b>	\$93,419,912	\$11,427,227	\$89,536,636	\$80,009,564

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2016		2017	
	Budgeted	Expended	Budgeted	Expended
<b>Federal Allocation</b>	\$4,686,020	\$4,758,053	\$4,689,065	
<b>Unobligated Balance</b>	\$0	\$0	\$0	
<b>State Funds</b>	\$3,567,032	\$3,775,412	\$3,557,713	
<b>Local Funds</b>	\$4,401,548	\$3,906,503	\$3,981,689	
<b>Other Funds</b>	\$0	\$0	\$0	
<b>Program Funds</b>	\$0	\$0	\$0	
<b>SubTotal</b>	\$12,654,600	\$12,439,968	\$12,228,467	
<b>Other Federal Funds</b>	\$69,994,218	\$69,501,932	\$58,007,639	
<b>Total</b>	\$82,648,818	\$81,941,900	\$70,236,106	

	2018	
	Budgeted	Expended
<b>Federal Allocation</b>	\$4,651,427	
<b>Unobligated Balance</b>	\$0	
<b>State Funds</b>	\$3,531,773	
<b>Local Funds</b>	\$3,906,504	
<b>Other Funds</b>	\$0	
<b>Program Funds</b>	\$0	
<b>SubTotal</b>	\$12,089,704	
<b>Other Federal Funds</b>	\$71,105,934	
<b>Total</b>	\$83,195,638	

### III.A. Expenditures

The State maintains budget documentation for all Block Grant funding allocations and expenditures for tracking and reporting. Expenses are tracked through the state's accounting system, SMART. All federal and non-federal (state and local) expenditures are tracked and reported separately. Expenditure detail for State Fiscal Year (SFY) 2016 is reflected on Forms 3a and 3b.

**2016 Expenditures:** The FY 2016 block grant partnership expenditures were updated to reflect actual expenditures based on the state accounting system at the time the application was compiled (reflected on Forms 2, 3a and 3b). The following expenditures were reported: \$4,758,053 federal (total authorized); \$3,775,412 state; and \$3,906,503 local for total MCH expenditures to date of \$12,439,968.

The total FY 2016, federal spending to support MCH and CSHCN initiatives within the state health department included:

- \$120,287 Bureau of Epidemiology and Public Health Informatics, including the Office of Vital Statistics;
- \$29,017 Local Public Health program;
- \$152,181 Child Care Licensing;
- \$197,103 salary and operating expenditures for the director, assistant, and fiscal support;
- \$663,213 Children & Families/MCH Section expenditures for staff and operating costs related to overseeing the MCH grantees/local agencies and aid to local program activities, conducting site monitoring visits, supporting local and state initiatives, and more;
- \$2,240,158 MCH Aid to Local payments to local agencies for services totals.
- \$1,062,546 Special Health Care Needs (SHCN) staff, operating costs, contracts and supplies;
- \$88,479 Direct Services\*
  - \*Expenses for Direct Services are tracked separately through the Kansas SHCN program (effective SFY 2014) and break down as follows by type of service: Durable Medical Equipment (DME) \$964; Hospital \$14,486; Pharmacy \$37,522; Physician/Office Charges \$12,360; Lab \$66; Specialty Clinic Fees \$21,280; Audiology \$1,800.
- \$1,839 PRAMS telephone support (from pilot project – BRFSS staff)
- \$290,934 administrative costs

Form 2 Expenditures Details: Form 2 reveals the Title V expenditures for FY 2016 are in compliance with the 30% - 30% requirements for priority populations: preventive and primary care for children \$1,485,579 (31%) and children with special health care needs \$1,542,915 (32%), similar to previous reporting periods. Other requirements related to expenditures such as administrative costs at \$290,934 (6%) (less than 10%) and maintenance of effort are maintained.

Form 2 also provides expenditures for other federal funds administered through the Bureau of Family Health, overseen by the Title V Director. The total expenditures for FY 2016 are \$69,668,372 and include the following: Women, Infants, and Children (WIC) \$58,610,012; Breastfeeding Peer Counselor Program \$371,462; Early Childhood Comprehensive Systems \$136,820; Systems Integration \$116,979; Newborn Hearing Screening \$202,271; Maternal, Infant and Early Childhood Home Visiting (MIECHV) \$2,041,789; Part C Infant-Toddler Services \$4,006,765; Abstinence Education \$511,257; Family Planning \$2,454,693; Toxic Substances (Lead Hazard) \$261,813; and Healthy Start \$954,510.

Form 3a Expenditures by Types of Individuals Served: All Block Grant partnership expenditures (federal, state, and local), not including administrative costs of \$290,934, total \$12,149,034 (\$4,467,119 Federal; \$7,681,915 Non-Federal). Expenditures by "Types of Individuals Served" (MCH population groups) includes: Pregnant Women and Infants <1 Year \$4,708,854 (federal and nonfederal); Children & Adolescents 1-22 Years \$3,774,083; and CSHCN \$3,666,097.

Form 3b Expenditures by Types of Services: All Block Grant partnership expenditures (federal, state, and local), total \$12,439,968 (including administrative costs). Expenditures by "Types of Services" (MCH pyramid) include: Direct Services \$379,756 (\$88,479 federal/\$291,276 non-federal) (3%); Enabling Services \$6,498,196 (\$2,158,965 federal/\$4,339,231 non-federal) (52%); and Public Health Services and Systems \$5,562,016 (\$2,510,609 federal/\$3,051,408 non-federal) (45%). More direct services spending is reflected in the state portion in an effort to serve all individuals based on eligibility and state

mandate. The Kansas Title V MCH and CSHCN programs strictly adhere to the mandate of Title V as the payer of last resort, and the direct services paid only reflects services that were not covered or reimbursed through another provider (payer).

All expenditures are in line with previous reporting periods with no significant variations to be discussed. The state is well within its required maintenance of effort of \$2,352,511 with expenditures of \$3,775,412 in FY 2016 at the time of reporting. Kansas meets its match requirement through the use of State funds that support Maternal and Child Health programming and affiliated programming.

### III.B. Budget

Kansas Maternal & Child Health (MCH) and Special Health Care Needs (SHCN) Directors in partnership with the state Council and programs provide input into the allocation and budgeting process for the Title V MCH Block Grant, state budget, and process of prioritizing programs for MCH resources based on the State MCH Needs Assessment and 5-Year State Action Plan.

**2018 Budget:** The total State budget submitted for Fiscal Year 2018 and detailed on Form 2 is \$83,195,638. This amount represents the budgeted MCH federal allocation, state contribution/funds, local contribution/funds, and other federal funds administered under the direction of the Title V Director in the Bureau of Family Health. The amounts break down as follows: budgeted MCH federal allocation \$4,651,427 (based on the allocated amounts in the State budget and a final authorized federal MCH award amounts for FFY15 and FFY16); state MCH funds \$3,531,773; local MCH funds \$3,906,504; and estimated other federal funds \$71,105,934. Other federal funds includes the following: Women, Infants, and Children (WIC) \$59,534,594; Breastfeeding Peer Counselor Program \$486,249; Early Childhood Comprehensive Systems \$151,020; Systems Integration \$244,156; Newborn Hearing Screening \$218,660; Maternal, Infant and Early Childhood Home Visiting (MIECHV) Formula \$1,091,064 and Development \$1,516,019; Part C Infant-Toddler Services \$4,032,960; Abstinence Education \$511,500; Family Planning \$2,352,000; Toxic Substances (Lead Hazard) \$287,462; and Healthy Start \$680,250. Note: Some "other" federal funds budgeted amounts reflect the state's budget at the time of the application submission. The actual amount the agency receives will not be known until the official Notice of Award is received from the funding agency. NOTE: State Systems Development Initiative (SSDI) funding is administered through the Bureau of Epidemiology and Public Health Informatics (BEPHI), not Bureau of Family Health/Title V Director; however, 100% of the SSDI funding supports MCH Epidemiology capacity and activities.

Form 2 MCH Budget Details. Overall, Kansas' MCH federal-state-local partnership budget totals \$12,089,704 (federal MCH funds \$4,651,427; state MCH funds \$3,531,773; local MCH funds \$3,906,504). The federal allocation is budgeted to support Title V MCH and SHCN initiatives, workforce development, and infrastructure/systems within the state health department as follows: \$94,747 Bureau of Epidemiology and Public Health Informatics, including the Office of Vital Statistics; \$52,619 Local Public Health Program. Within the Bureau of Family Health, \$159,375 to support Child Care Licensing activities and partnerships related to health and safety regulations as well as MCH-Child Care initiatives; \$592,225 for MCH staffing, MCH aid to local programming, monitoring, and other operations; \$193,781 for director, assistant, and fiscal support; \$971,580 for SHCN staffing, programming, outreach, and care coordination; \$97,158 for direct services (not reimbursed by other providers) (an estimate based on 2015 and 2016 expenditures); \$119,164 for safe sleep initiatives (training, capacity, infrastructure building, and community baby shower expansion); \$20,000 for breastfeeding support and capacity; \$50,000 for hospital-based breastfeeding initiatives; \$50,500 to support the Kansas Maternal & Child Health Council and state action plan monitoring activities; \$100,000 to support data collection/shared measurement systems; \$101,399 to support regional public health/needs assessment processes, focus groups, and alignment activities; \$1,880,787 for local MCH agencies providing community-based, family centered services including home visiting (local public health departments, community health centers, hospitals, health foundations); and \$265,250 for administration costs.

The Kansas budget for FY 2017 meets the maintenance of effort requirement of \$2,352,511. The Title V match requirement is achieved through projected State matching funds budgeted at \$3,531,773 which include \$94,926 for MCH aid to local operations; \$204,848 for universal home visiting services delivered by MCH grantees/local agencies; \$82,972 for Kansas Infant Death and SIDS (KIDS) Network of Kansas (safe sleep initiatives); \$457,302 for newborn screening follow up; \$48,776 for SHCN administration, case management, care coordination, and services; \$2,169,614 for MCH aid to local programming; \$105,537 for seating clinics; \$199,274 for PKU services; and \$173,402 for SHCN direct services. Local match is projected to total \$3,906,504 (estimated based on actual SFY16 match and SFY17 match as of June 2017 reported by local grantees/agencies).

The Title V budget and funding allocations are in compliance with the 30% - 30% requirements: preventive and primary care for children \$1,434,816 (30.8%) and children with special health care needs \$1,476,175 (31.7%), similar to previous reporting periods (see Form 2). Other requirements related to budget categories such as administrative costs \$265,250 (5.8%, less than 10% as required) and maintenance of effort are maintained. The current indirect cost rate for KDHE is 18.0% effective July 2017, down from the previous rate of 21.3%.

Form 3a Budget by Types of Individuals Served. Considering the total budget of \$12,089,704 (\$11,824,454 excluding budgeted administration costs of \$265,250), Form 3a details the (federal/nonfederal) budgeted amounts by types of individuals served including \$1,475,186 federal and \$3,381,617 nonfederal for pregnant women and infants under 1 year of age; \$1,434,816 federal and \$2,944,265 nonfederal for children and adolescents 1-22 years; \$1,476,175 federal and \$1,112,395 nonfederal for children with special health care needs (CSHCN).

Form 3b Budget by Types of Services. Considering the total budget of \$12,089,704, Form 3b details the (federal/nonfederal) budgeted amounts by types of services including \$97,158 federal and \$173,402 nonfederal for direct services (2%); \$1,916,624 federal and \$4,111,860 nonfederal for enabling services (50%); and \$2,637,645 federal and \$3,153,015 nonfederal for public health services and systems (48%).

There are no significant variations in the budgeted amounts reported by the state on Forms 2 and 3, as compared to previous years' reporting.

#### **IV. Title V-Medicaid IAA/MOU**

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - [Title V-Medicaid Agreement\\_wAlignment Docs.pdf](#)

## V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - [Action Plan\\_Profiles\\_Data Table.pdf](#)

Supporting Document #02 - [KS State Plan for Systems of Care for CYSHCN\\_DRAFT.pdf](#)

Supporting Document #03 - [MCH ATL Supplement Doc.pdf](#)

Supporting Document #04 - [SHS BG Supplement Doc - ATL.pdf](#)

Supporting Document #05 - [Special projects Binder.pdf](#)

## VI. Appendix

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**Form 2**  
**MCH Budget/Expenditure Details**

State: Kansas

	FY18 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 4,651,427	
A. Preventive and Primary Care for Children	\$ 1,434,816	(30.8%)
B. Children with Special Health Care Needs	\$ 1,476,175	(31.7%)
C. Title V Administrative Costs	\$ 265,250	(5.8%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	\$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 3,531,773	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 3,906,504	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 7,438,277	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 2,352,511		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	\$ 12,089,704	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	\$ 71,105,934	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 83,195,638	

OTHER FEDERAL FUNDS	FY18 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	\$ 511,500
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	\$ 2,607,083
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	\$ 151,020
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	\$ 680,250
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Implementation Grants for Systems of Services for CYSHCN	\$ 244,156
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 218,660
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 2,352,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	\$ 59,534,594
US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)	\$ 486,249
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	\$ 4,032,960
US Environmental Protection Agency > Office of Pollution Prevention and Toxics (OPPT) > Toxic Substance	\$ 287,462

	FY16 Annual Report Budgeted		FY16 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 4,686,020		\$ 4,758,053	
A. Preventive and Primary Care for Children	\$ 1,560,389	(33.3%)	\$ 1,485,579	(31.2%)
B. Children with Special Health Care Needs	\$ 1,511,975	(32.3%)	\$ 1,542,915	(32.4%)
C. Title V Administrative Costs	\$ 200,000	(4.3%)	\$ 290,934	(6.2%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	\$ 0		\$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 3,567,032		\$ 3,775,412	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 4,401,548		\$ 3,906,503	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0		\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 0		\$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 7,968,580		\$ 7,681,915	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 2,352,511				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	\$ 12,654,600		\$ 12,439,968	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	\$ 69,994,218		\$ 69,501,932	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 82,648,818		\$ 81,941,900	

OTHER FEDERAL FUNDS	FY16 Annual Report Budgeted	FY16 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	\$ 398,223	\$ 511,257
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	\$ 10,456,142	\$ 2,041,789
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	\$ 140,000	\$ 136,820
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 2,522,000	\$ 2,454,693
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	\$ 50,831,875	\$ 58,610,012
US Department of Education > Office of Special Education Programs > Early Identification and Intervention Infants/Toddlers	\$ 4,217,833	\$ 4,006,765
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 95,734	\$ 95,374
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 250,000	\$ 202,271
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	\$ 625,000	\$ 954,510
US Department of Agriculture (USDA) > Food and Nutrition Services > Breastfeeding PeerEd	\$ 457,411	\$ 371,462
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Systems Integration		\$ 116,979

**Form Notes for Form 2:**

None

**Field Level Notes for Form 2:**

1.	<b>Field Name:</b>	<b>Federal Allocation, C. Title V Administrative Costs</b>
	<b>Fiscal Year:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>Application Budgeted</b>
	<b>Field Note:</b>	The administrative costs are expected to be less for the coming year. Administrative costs were higher than expected in 2016 per the report expended.
2.	<b>Field Name:</b>	<b>Federal Allocation, C. Title V Administrative Costs:</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	See application budgeted note; agency administrative costs were higher than expected in 2016 and are expected to go down in the coming year.
3.	<b>Field Name:</b>	<b>4. LOCAL MCH FUNDS</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	Based on actuals

**Data Alerts: None**

**Form 3a**  
**Budget and Expenditure Details by Types of Individuals Served**  
**State: Kansas**

**I. TYPES OF INDIVIDUALS SERVED**

IA. Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Pregnant Women	\$ 737,593	\$ 719,313
2. Infants < 1 year	\$ 737,593	\$ 719,312
3. Children 1-22 years	\$ 1,434,816	\$ 1,485,579
4. CSHCN	\$ 1,476,175	\$ 1,542,915
5. All Others	\$ 0	\$ 0
Federal Total of Individuals Served	\$ 4,386,177	\$ 4,467,119

IB. Non Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Pregnant Women	\$ 1,690,809	\$ 1,635,115
2. Infants < 1 year	\$ 1,690,808	\$ 1,635,114
3. Children 1-22 years	\$ 2,944,265	\$ 2,288,504
4. CSHCN	\$ 1,112,395	\$ 2,123,182
5. All Others	\$ 0	\$ 0
Non Federal Total of Individuals Served	\$ 7,438,277	\$ 7,681,915
Federal State MCH Block Grant Partnership Total	\$ 11,824,454	\$ 12,149,034

**Form Notes for Form 3a:**

None

**Field Level Notes for Form 3a:**

None

**Form 3b**  
**Budget and Expenditure Details by Types of Services**  
**State: Kansas**

**II. TYPES OF SERVICES**

IIA. Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Direct Services	\$ 97,158	\$ 88,479
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 0	\$ 0
B. Preventive and Primary Care Services for Children	\$ 0	\$ 0
C. Services for CSHCN	\$ 97,158	\$ 88,479
2. Enabling Services	\$ 1,916,624	\$ 2,158,965
3. Public Health Services and Systems	\$ 2,637,645	\$ 2,510,609
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 37,522
Physician/Office Services		\$ 12,360
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 14,486
Dental Care (Does Not Include Orthodontic Services)		\$ 0
Durable Medical Equipment and Supplies		\$ 965
Laboratory Services		\$ 66
Other		
Clinic Fees		\$ 21,280
Audiology		\$ 1,800
Direct Services Line 4 Expended Total		\$ 88,479
<b>Federal Total</b>	<b>\$ 4,651,427</b>	<b>\$ 4,758,053</b>

IIB. Non-Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Direct Services	\$ 173,402	\$ 291,276
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 0	\$ 0
B. Preventive and Primary Care Services for Children	\$ 0	\$ 0
C. Services for CSHCN	\$ 173,402	\$ 291,276
2. Enabling Services	\$ 4,111,860	\$ 4,339,231
3. Public Health Services and Systems	\$ 3,153,015	\$ 3,051,408
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 0
Physician/Office Services		\$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 0
Dental Care (Does Not Include Orthodontic Services)		\$ 0
Durable Medical Equipment and Supplies		\$ 291,276
Laboratory Services		\$ 0
Direct Services Line 4 Expended Total		\$ 291,276
<b>Non-Federal Total</b>	\$ 7,438,277	\$ 7,681,915

**Form Notes for Form 3b:**

None

**Field Level Notes for Form 3b:**

None

**Form 4**  
**Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated**  
**State: Kansas**

Total Births by Occurrence: 40,132

**1. Core RUSP Conditions**

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Core RUSP Conditions	40,132 (100.0%)	318	83	83 (100.0%)

Program Name(s)				
Propionic acidemia	Methylmalonic acidemia (methylmalonyl-CoA mutase)	Methylmalonic acidemia (cobalamin disorders)	Isovaleric acidemia	3-Methylcrotonyl-CoA carboxylase deficiency
3-Hydroxy-3-methylglutaric aciduria	Holocarboxylase synthase deficiency	β-Ketothiolase deficiency	Glutaric acidemia type I	Carnitine uptake defect/carnitine transport defect
Medium-chain acyl-CoA dehydrogenase deficiency	Very long-chain acyl-CoA dehydrogenase deficiency	Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	Trifunctional protein deficiency	Argininosuccinic aciduria
Citrullinemia, type I	Maple syrup urine disease	Homocystinuria	Classic phenylketonuria	Tyrosinemia, type I
Primary congenital hypothyroidism	Congenital adrenal hyperplasia	S,S disease (Sickle cell anemia)	S, β-thalassemia	S,C disease
Biotinidase deficiency	Critical congenital heart disease	Cystic fibrosis	Hearing loss	Classic galactosemia

## 2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Newborn Hearing	39,831 (99.2%)	771	55	55 (100.0%)

## 3. Screening Programs for Older Children & Women

None

## 4. Long-Term Follow-Up

Newborn Metabolic Screening (NBS): NBS Follow-up generally ends at the onset of treatment, however referrals into the Special Health Care Needs (SHCN) program can provide opportunity for ongoing long-term follow-up. Additionally, a new staff position, shared by NBS and SHCN, will be utilized to develop a long-term NBS follow-up program in the coming years.

Newborn Hearing Screening (NBHS): The SoundBeginnings program follows hearing screens on infants from the initial screens in the hospital to appointments with hearing specialists and to other agencies that provide services for children with hearing loss. Infants identified with hearing loss are referred to early intervention so they can receive the appropriate services to support normal speech and language development. As with NBS, NBHS will refer children with identified hearing loss to SHCN, providing opportunity for ongoing follow-up and support for specialty services.

**Form Notes for Form 4:**

None

**Field Level Notes for Form 4:**

None

**Data Alerts: None**

**Form 5a  
Unduplicated Count of Individuals Served under Title V**

**State: Kansas**

**Reporting Year 2016**

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	5,237	34.4	7.9	21.3	30.5	5.9
2. Infants < 1 Year of Age	9,574	38.3	13.3	12.2	23.1	13.1
3. Children 1 to 22 Years of Age	55,892	28.8	13.3	20.8	24.0	13.1
4. Children with Special Health Care Needs	2,060	47.3	4.5	40.7	5.5	2.0
5. Others	4,735	34.5	4.3	30.2	28.7	2.3
<b>Total</b>	<b>77,498</b>					

**Form Notes for Form 5a:**

Calendar Year 2015

**Field Level Notes for Form 5a:**

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1.	<b>Field Name:</b>	<b>Children with Special Health Care Needs</b>
	<b>Fiscal Year:</b>	<b>2016</b>

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**Field Note:**

This estimate includes data based upon the internal tracking logs for children and families who apply to the KS-SHCN program and receive direct services, those who receive assistance for diagnostic services, and those who receive a direct service through the KS-SHCN clinics (as reported as unduplicated through quarterly and annual data reports from the contracted vendor). These estimates may not completely reflect a true unduplicated count as the data received from contractors is aggregate and does not include identifiers to determine if they are also served through a direct assistance program.

**Form 5b**  
**Total Recipient Count of Individuals Served by Title V**

**State: Kansas**

**Reporting Year 2016**

Types Of Individuals Served	Total Served
1. Pregnant Women	40,463
2. Infants < 1 Year of Age	40,132
3. Children 1 to 22 Years of Age	851,797
4. Children with Special Health Care Needs	137,336
5. Others	420,494
<b>Total</b>	1,490,222

**Form Notes for Form 5b:**

Calendar Year 2015.

**Field Level Notes for Form 5b:**

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1.	<b>Field Name:</b>	<b>Pregnant Women</b>
	<b>Fiscal Year:</b>	<b>2016</b>
<hr/>		
<b>Field Note:</b>		
<p>The FY2018 Application/FY2016 Annual Reports data on Form 5B are not directly comparable to previous years of data because of the changes in clarifying instructions, dated May 22, 2017. The data were pulled based on the example: "Fund local health departments to engage provider groups and promote screening for perinatal depression, smoking, or substance use (count all births in funded counties)".</p>		
<p>Eighty-one grantees/counties were funded to address the local needs of pregnant and postpartum women and provide/promote MCH services, such as well woman care/annual visit, prenatal/post-partum nursing assessment, immunization, dental, high-risk case management, counseling, education (e.g., alcohol/substance abuse, breastfeeding, car seat safety/installation, family violence, health care coverage/Medicaid eligibility, infant care, oral health, safe sleep, smoking cessation/second-hand exposure), perinatal depression screening, etc. All births in funded counties are included.</p>		
<hr/>		
2.	<b>Field Name:</b>	<b>Infants Less Than One Year</b>
	<b>Fiscal Year:</b>	<b>2016</b>
<hr/>		
<b>Field Note:</b>		
<p>The FY2018 Application/FY2016 Annual Reports data in Form 5B are not directly comparable to previous years of data because of the changes in clarifying instructions, dated May 22, 2017. The data were pulled based on the example: "Administer, develop guidelines/standards/policies, or otherwise assure the newborn screening program (count all infants or births)".</p>		
<p>The Kansas population-based universal newborn metabolic and hearing programs encompass all components of a comprehensive state system: screening, follow-up/referral tracking, diagnosis, management, education, and evaluation. Furthermore, eighty-one grantees/counties were funded to address the local needs of infants &lt; 1 year of age and provide/promote MCH services, such as well infant visit, sick infant visit, immunization, etc. All births in Kansas are included.</p>		
<hr/>		
3.	<b>Field Name:</b>	<b>Children 1 to 22 Year of Age</b>
	<b>Fiscal Year:</b>	<b>2016</b>
<hr/>		
<b>Field Note:</b>		
<p>The FY2018 Application/FY2016 Annual Reports data on Form 5B are not directly comparable to previous years of data because of the changes in clarifying instructions, dated May 22, 2017. The data were pulled based on the example: "Fund local health departments to promote and advance the medical home model among all pediatric providers (count number of children in funded counties)".</p>		
<p>Eighty-one grantees/counties were funded to address the local needs of children 1-21 years and provide/promote MCH services, such as well child/adolescent visit, sick child/adolescent visit, dental, immunization, counseling, education, pregnancy test, breast exam, Pap smear, gonorrhea test, chlamydia test, syphilis test, HIV test, developmental screening, lead screening, hearing screening, vision screening, etc. All children 1-21 years in funded counties are included.</p>		

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4. **Field Name:** **Children With Special Health Care Needs**

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**Fiscal Year:** **2016**

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**Field Note:**

The FY2018 Application/FY2016 Annual Reports data on Form 5B are not directly comparable to previous years of data because of the changes in clarifying instructions, dated May 22, 2017.

The 2015 KS CSHCN estimates (synthetic estimates) were constructed from the NSCH 2011/12 estimate and the Census Bureau 2015 estimate. Planning and preparation for the KS State Plan for Systems of Care for CYSHCN began in late 2015, with a five-phase public engagement effort that will continue through 2018. The purpose of the tours is to engage agencies, organizations and stakeholders serving CYSHCN in developing a state plan that applies the National Standards for Systems of Care for CYSHCN within KS to strengthen collaboration, support systems integration and improve service delivery for CYSHCN in Kansas. All CYSHCN (synthetic estimates) in Kansas are included.

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5. **Field Name:** **Others**

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**Fiscal Year:** **2016**

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**Field Note:**

The FY2018 Application/FY2016 Annual Reports data on Form 5B are not directly comparable to previous years of data because of the changes in clarifying instructions, dated May 22, 2017.

Eighty-one grantees/counties were funded to address the local needs of women 22-44 years and provide/promote MCH services, such as well women care/annual visit, dental, counseling, education, pregnancy test, breast exam, Pap smear, gonorrhea test, chlamydia test, syphilis test, HIV test, etc. All women 22-44 years in funded counties are included.

**Form 6**  
**Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX**

**State: Kansas**

**Reporting Year 2016**

**I. Unduplicated Count by Race**

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	40,463	33,301	2,920	207	1,237	73	975	1,750
Title V Served	5,237	4,527	309	32	73	17	173	106
Eligible for Title XIX	11,903	9,233	1,720	262	156	26	0	506
2. Total Infants in State	40,221	33,134	2,871	204	1,231	73	971	1,737
Title V Served	9,574	8,277	576	57	126	30	317	191
Eligible for Title XIX	16,902	8,442	1,498	183	110	22	0	6,647

**II. Unduplicated Count by Ethnicity**

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	33,981	6,430	52	40,463
Title V Served	3,735	1,495	7	5,237
Eligible for Title XIX	9,669	2,016	218	11,903
2. Total Infants in State	33,779	6,392	50	40,221
Title V Served	6,822	2,744	8	9,574
Eligible for Title XIX	7,762	3,020	6,120	16,902

**Form Notes for Form 6:**

Calendar Year 2015

**Field Level Notes for Form 6:**

None

**Form 7**  
**State MCH Toll-Free Telephone Line and Other Appropriate Methods Data**

**State: Kansas**

<b>A. State MCH Toll-Free Telephone Lines</b>	<b>2018 Application Year</b>	<b>2016 Reporting Year</b>
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 332-6262	(800) 332-6262
2. State MCH Toll-Free "Hotline" Name	Kansas Resource Guide (KRG)	Kansas Resource Guide (KRG)
3. Name of Contact Person for State MCH "Hotline"	Genoveva Fernandez	Genoveva Fernandez
4. Contact Person's Telephone Number	(800) 332-6262	(800) 332-6262
5. Number of Calls Received on the State MCH "Hotline"		973

<b>B. Other Appropriate Methods</b>	<b>2018 Application Year</b>	<b>2016 Reporting Year</b>
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	<a href="http://www.kdheks.gov/c-f/mch.htm">http://www.kdheks.gov/c-f/mch.htm</a> ; <a href="http://www.kansasmch.org">http://www.kansasmch.org</a>	<a href="http://www.kdheks.gov/c-f/mch.htm">http://www.kdheks.gov/c-f/mch.htm</a> ; <a href="http://www.kansasmch.org">http://www.kansasmch.org</a>
4. Number of Hits to the State Title V Program Website		2,504
5. State Title V Social Media Websites	<a href="http://www.facebook.com/kansasmch">http://www.facebook.com/kansasmch</a>	<a href="http://www.facebook.com/kansasmch">http://www.facebook.com/kansasmch</a>
6. Number of Hits to the State Title V Program Social Media Websites		170

**Form Notes for Form 7:**

None

**Form 8**  
**State MCH and CSHCN Directors Contact Information**

**State: Kansas**

**1. Title V Maternal and Child Health (MCH) Director**

Name	Rachel Sisson
Title	Bureau of Family Health Director/Title V MCH Director
Address 1	1000 SW Jackson Street
Address 2	
City/State/Zip	Topeka / KS / 66612
Telephone	(785) 296-1310
Extension	
Email	rachel.sisson@ks.gov

**2. Title V Children with Special Health Care Needs (CSHCN) Director**

Name	Heather Smith
Title	Special Health Services Director/Title V CSHCN Director
Address 1	1000 SW Jackson Street
Address 2	
City/State/Zip	Topeka / KS / 66612
Telephone	(785) 296-4747
Extension	
Email	heather.smith@ks.gov

### 3. State Family or Youth Leader (Optional)

Name	Donna Yadrich
Title	Family Leader/Owner, AudreySpirit LLC
Address 1	13605 Polfer Road
Address 2	
City/State/Zip	Kansas City / KS / 66109
Telephone	(913) 980-6282
Extension	
Email	donna@audreyspirit.com

**Form Notes for Form 8:**

None

**Form 9**  
**List of MCH Priority Needs**

**State: Kansas**

**Application Year 2018**

No.	Priority Need
1.	Women have access to and receive coordinated, comprehensive services before, during and after pregnancy.
2.	Services and supports promote healthy family functioning.
3.	Developmentally appropriate care and services are provided across the lifespan.
4.	Families are empowered to make educated choices about infant health and well-being.
5.	Communities and providers support physical, social and emotional health.
6.	Professionals have the knowledge and skills to address the needs of maternal and child health populations.
7.	Services are comprehensive and coordinated across systems and providers.
8.	Information is available to support informed health decisions and choices.

**Form 9 State Priorities-Needs Assessment Year - Application Year 2016**

<b>No.</b>	<b>Priority Need</b>	<b>Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)</b>	<b>Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure</b>
1.	Women have access to and receive coordinated, comprehensive care and services before, during and after pregnancy.	Continued	
2.	Services and supports promote healthy family functioning.	New	
3.	Developmentally appropriate care and services are provided across the lifespan.	New	
4.	Families are empowered to make educated choices about nutrition and physical activity.	Replaced	
5.	Communities and providers support physical, social, and emotional health.	New	
6.	Professionals have the knowledge and skills to address the needs of maternal and child health populations.	New	
7.	Services are comprehensive and coordinated across systems and providers.	Continued	
8.	Information is available to support informed health decisions and choices.	New	

**Form Notes for Form 9:**

None

**Field Level Notes for Form 9:**

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**Field Name:**

Priority Need 1

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**Field Note:**

Priorities are more comprehensive for this new period. Previous priorities are not lost, rather they are being addressed even though they don't stand alone in the state's list of 8 current priorities. For example, two previous priorities for Women/Maternal related to mental/behavioral health and preterm birth. These issues are objectives and strategies under the new priority.

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**Field Name:**

Priority Need 2

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**Field Note:**

This is a new cross-cutting priority.

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**Field Name:**

Priority Need 3

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**Field Note:**

This is a new priority addressing children and adolescent health needs such as developmental screening, child care safety/healthy and safe environments, injury prevention, and more.

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**Field Name:**

Priority Need 4

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**Field Note:**

This priority doesn't specifically call out breastfeeding as the previous priority but includes targeted work related to increased breastfeeding rates: initiation, exclusivity and duration. In addition, it includes work related to childhood obesity and addresses the previous priority for children and adolescents "All children and youth achieve and maintain healthy weight".

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**Field Name:**

Priority Need 5

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**Field Note:**

This priority is new wording but objectives and strategies address the previous priority "Reduce child and adolescent risk behaviors relating to alcohol, tobacco and other drugs".

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**Field Name:**

Priority Need 6

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**Field Note:**

New priority focusing on the capacity, skills, and competencies of professionals--are the prepared and "ready" to address unique issues MCH populations are facing in their community?

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**Field Name:**

Priority Need 7

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**Field Note:**

This priority is comprehensive in nature, with objectives and strategies focusing on more targeted issues/focus areas. This priority address previous CYSHCN priorities "All CYSHCN receive coordinated, comprehensive care within a medical home"; "Improve the capacity of YSHCN to achieve maximum potential in all aspects of adult life, including appropriate health care, meaningful work, and self-determined independence"; and "Financing for CYSHCN services minimizes financial hardship for their families".

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**Field Name:**

Priority Need 8

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**Field Note:**

This is a new priority focusing on health literacy, navigating the health system, individuals being proactive when it comes to health care, services, coverage, transition, and more.

**Form 10a  
National Outcome Measures (NOMs)**

**State: Kansas**

**Form Notes for Form 10a NPMs, NOMs, SPMs, SOMs, and ESMs.**

None

**NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester**

**Data Source: National Vital Statistics System (NVSS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	83.6 %	0.2 %	32,685	39,081
2014	82.5 %	0.2 %	32,285	39,137
2013	79.6 %	0.2 %	30,846	38,743
2012	78.9 %	0.2 %	31,663	40,128
2011	77.4 %	0.2 %	29,663	38,337
2010	75.3 %	0.2 %	29,814	39,611
2009	74.8 %	0.2 %	29,610	39,605

**Legends:**

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 1 - Notes:**

None

**Data Alerts: None**

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	111.2	5.6 %	405	36,418
2013	92.8	5.1 %	335	36,084
2012	111.4	5.5 %	416	37,351
2011	97.1	5.1 %	361	37,177
2010	103.3	5.2 %	394	38,142
2009	103.6	5.1 %	411	39,673
2008	94.7	4.9 %	378	39,917

**Legends:**

- Indicator has a numerator  $\leq 10$  and is not reportable
- Indicator has a numerator  $< 20$  and should be interpreted with caution

**NOM 2 - Notes:**

None

**Data Alerts: None**

**NOM 3 - Maternal mortality rate per 100,000 live births**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2015	17.8	3.0 %	35	197,199
2010_2014	19.6	3.1 %	39	198,694
2009_2013	20.4	3.2 %	41	200,867
2008_2012	17.7	2.9 %	36	203,861
2007_2011	15.6	2.8 %	32	205,524
2006_2010	15.0	2.7 %	31	206,850
2005_2009	14.1	2.6 %	29	206,089

**Legends:**

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

**NOM 3 - Notes:**

None

**Data Alerts: None**

**NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	6.8 %	0.1 %	2,672	39,142
2014	7.0 %	0.1 %	2,759	39,207
2013	7.0 %	0.1 %	2,721	38,824
2012	7.1 %	0.1 %	2,879	40,324
2011	7.2 %	0.1 %	2,854	39,620
2010	7.1 %	0.1 %	2,881	40,628
2009	7.3 %	0.1 %	3,011	41,381

**Legends:**

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 4.1 - Notes:**

None

**Data Alerts: None**

**NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	1.2 %	0.1 %	476	39,142
2014	1.3 %	0.1 %	493	39,207
2013	1.3 %	0.1 %	484	38,824
2012	1.3 %	0.1 %	531	40,324
2011	1.3 %	0.1 %	509	39,620
2010	1.2 %	0.1 %	487	40,628
2009	1.4 %	0.1 %	567	41,381

**Legends:**

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 4.2 - Notes:**

None

**Data Alerts: None**

**NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	5.6 %	0.1 %	2,196	39,142
2014	5.8 %	0.1 %	2,266	39,207
2013	5.8 %	0.1 %	2,237	38,824
2012	5.8 %	0.1 %	2,348	40,324
2011	5.9 %	0.1 %	2,345	39,620
2010	5.9 %	0.1 %	2,394	40,628
2009	5.9 %	0.1 %	2,444	41,381

**Legends:**

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 4.3 - Notes:**

None

**Data Alerts: None**

**NOM 5.1 - Percent of preterm births (<37 weeks)**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	8.8 %	0.1 %	3,426	39,134
2014	8.7 %	0.1 %	3,423	39,209
2013	8.9 %	0.1 %	3,447	38,824
2012	9.0 %	0.1 %	3,635	40,322
2011	9.1 %	0.1 %	3,596	39,601
2010	8.8 %	0.1 %	3,563	40,589
2009	9.2 %	0.1 %	3,808	41,325

**Legends:**

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 5.1 - Notes:**

None

**Data Alerts: None**

**NOM 5.2 - Percent of early preterm births (<34 weeks)**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	2.4 %	0.1 %	945	39,134
2014	2.5 %	0.1 %	989	39,209
2013	2.7 %	0.1 %	1,035	38,824
2012	2.7 %	0.1 %	1,078	40,322
2011	2.6 %	0.1 %	1,043	39,601
2010	2.5 %	0.1 %	1,014	40,589
2009	2.6 %	0.1 %	1,082	41,325

**Legends:**

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 5.2 - Notes:**

None

**Data Alerts: None**

**NOM 5.3 - Percent of late preterm births (34-36 weeks)**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	6.3 %	0.1 %	2,481	39,134
2014	6.2 %	0.1 %	2,434	39,209
2013	6.2 %	0.1 %	2,412	38,824
2012	6.3 %	0.1 %	2,557	40,322
2011	6.5 %	0.1 %	2,553	39,601
2010	6.3 %	0.1 %	2,549	40,589
2009	6.6 %	0.1 %	2,726	41,325

**Legends:**

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 5.3 - Notes:**

None

**Data Alerts: None**

**NOM 6 - Percent of early term births (37, 38 weeks)**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	24.1 %	0.2 %	9,432	39,134
2014	24.3 %	0.2 %	9,525	39,209
2013	23.0 %	0.2 %	8,936	38,824
2012	24.6 %	0.2 %	9,905	40,322
2011	25.4 %	0.2 %	10,043	39,601
2010	25.7 %	0.2 %	10,447	40,589
2009	26.8 %	0.2 %	11,067	41,325

**Legends:**

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 6 - Notes:**

None

**Data Alerts: None**

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

Data Source: CMS Hospital Compare

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	2.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	3.0 %			
2014/Q2-2015/Q1	4.0 %			
2014/Q1-2014/Q4	5.0 %			
2013/Q4-2014/Q3	5.0 %			
2013/Q3-2014/Q2	6.0 %			
2013/Q2-2014/Q1	8.0 %			

**Legends:**  
■ Indicator results were based on a shorter time period than required for reporting

**NOM 7 - Notes:**

None

**Data Alerts: None**

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	6.1	0.4 %	240	39,325
2013	6.6	0.4 %	258	38,954
2012	6.9	0.4 %	281	40,479
2011	6.1	0.4 %	243	39,762
2010	6.2	0.4 %	252	40,759
2009	6.7	0.4 %	277	41,529

**Legends:**

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

**NOM 8 - Notes:**

None

**Data Alerts: None**

**NOM 9.1 - Infant mortality rate per 1,000 live births**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	6.2	0.4 %	243	39,223
2013	6.5	0.4 %	252	38,839
2012	6.3	0.4 %	254	40,341
2011	6.2	0.4 %	247	39,642
2010	6.2	0.4 %	252	40,649
2009	7.1	0.4 %	294	41,396

**Legends:**

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

**NOM 9.1 - Notes:**

None

**Data Alerts: None**

**NOM 9.2 - Neonatal mortality rate per 1,000 live births**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	4.5	0.3 %	175	39,223
2013	4.4	0.3 %	169	38,839
2012	4.3	0.3 %	174	40,341
2011	4.0	0.3 %	159	39,642
2010	4.2	0.3 %	172	40,649
2009	4.3	0.3 %	178	41,396

**Legends:**

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

**NOM 9.2 - Notes:**

None

**Data Alerts: None**

**NOM 9.3 - Post neonatal mortality rate per 1,000 live births**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	1.7	0.2 %	68	39,223
2013	2.1	0.2 %	83	38,839
2012	2.0	0.2 %	80	40,341
2011	2.2	0.2 %	88	39,642
2010	2.0	0.2 %	80	40,649
2009	2.8	0.3 %	116	41,396

**Legends:**

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

**NOM 9.3 - Notes:**

None

**Data Alerts: None**

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	211.6	23.3 %	83	39,223
2013	213.7	23.5 %	83	38,839
2012	205.8	22.6 %	83	40,341
2011	204.3	22.7 %	81	39,642
2010	196.8	22.0 %	80	40,649
2009	236.7	23.9 %	98	41,396

**Legends:**

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

**NOM 9.4 - Notes:**

None

**Data Alerts: None**

**NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	89.2	15.1 %	35	39,223
2013	133.9	18.6 %	52	38,839
2012	111.6	16.6 %	45	40,341
2011	106.0	16.4 %	42	39,642
2010	100.9	15.8 %	41	40,649
2009	118.4	16.9 %	49	41,396

**Legends:**

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

**NOM 9.5 - Notes:**

None

**Data Alerts: None**

**NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy**

**FAD Not Available for this measure.**

**NOM 10 - Notes:**

None

**Data Alerts: None**

**NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations**

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	5.5	0.4 %	199	36,431
2013	5.9	0.4 %	214	36,165
2012	4.7	0.4 %	174	37,355
2011	4.2	0.3 %	157	37,177
2010	3.4	0.3 %	129	38,142
2009	2.3	0.2 %	93	39,677
2008	1.8	0.2 %	71	39,917

**Legends:**

-  Indicator has a numerator ≤10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

**NOM 11 - Notes:**

None

**Data Alerts: None**

**NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)**

**FAD Not Available for this measure.**

**NOM 12 - Notes:**

None

**Data Alerts: None**

**NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)**

**FAD Not Available for this measure.**

**NOM 13 - Notes:**

None

**Data Alerts: None**

**NOM 14 - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months**

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	18.1 %	1.3 %	120,620	666,589

**Legends:**

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% and should be interpreted with caution

**NOM 14 - Notes:**

None

**Data Alerts: None**

**NOM 15 - Child Mortality rate, ages 1 through 9 per 100,000**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	20.8	2.4 %	75	361,112
2014	15.7	2.1 %	57	363,940
2013	24.1	2.6 %	88	365,495
2012	19.6	2.3 %	72	366,922
2011	22.2	2.5 %	81	365,569
2010	27.0	2.7 %	99	367,153
2009	21.8	2.5 %	79	362,262

**Legends:**

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

**NOM 15 - Notes:**

None

**Data Alerts: None**

**NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	30.7	2.8 %	123	400,526
2014	35.7	3.0 %	143	400,763
2013	31.9	2.8 %	128	401,152
2012	32.9	2.9 %	132	400,793
2011	32.2	2.8 %	130	404,061
2010	38.2	3.1 %	154	402,705
2009	39.0	3.1 %	157	402,855

**Legends:**

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

**NOM 16.1 - Notes:**

None

**Data Alerts: None**

**NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013_2015	14.0	1.5 %	84	602,119
2012_2014	15.1	1.6 %	91	601,943
2011_2013	14.4	1.5 %	87	605,975
2010_2012	18.2	1.7 %	111	609,260
2009_2011	20.2	1.8 %	124	613,565
2008_2010	23.4	2.0 %	144	615,409
2007_2009	24.1	2.0 %	149	619,073

**Legends:**

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

**NOM 16.2 - Notes:**

None

**Data Alerts: None**

**NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013_2015	11.0	1.4 %	66	602,119
2012_2014	12.6	1.5 %	76	601,943
2011_2013	13.0	1.5 %	79	605,975
2010_2012	13.6	1.5 %	83	609,260
2009_2011	10.3	1.3 %	63	613,565
2008_2010	9.6	1.3 %	59	615,409
2007_2009	8.7	1.2 %	54	619,073

**Legends:**

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

**NOM 16.3 - Notes:**

None

**Data Alerts: None**

**NOM 17.1 - Percent of children with special health care needs**

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	19.4 %	1.3 %	139,623	720,400
2007	20.7 %	1.3 %	144,683	699,044
2003	20.4 %	1.1 %	141,515	692,847

**Legends:**

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% and should be interpreted with caution

**NOM 17.1 - Notes:**

None

**Data Alerts: None**

**NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system**

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	22.8 %	2.1 %	25,499	111,748

**Legends:**

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% and should be interpreted with caution

**NOM 17.2 - Notes:**

None

**Data Alerts: None**

**NOM 17.3 - Percent of children diagnosed with an autism spectrum disorder**

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	1.0 %	0.3 %	5,857	604,484
2007	1.0 %	0.3 %	5,819	582,082

**Legends:**

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

**NOM 17.3 - Notes:**

None

**Data Alerts: None**

**NOM 17.4 - Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)**

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	8.8 %	1.1 %	53,268	603,604
2007	7.2 %	0.8 %	41,542	580,463

**Legends:**

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

**NOM 17.4 - Notes:**

None

**Data Alerts: None**

**NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling**

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	72.6 % ⚡	5.5 % ⚡	37,787 ⚡	52,077 ⚡
2007	72.2 %	5.1 %	38,051	52,674
2003	62.9 % ⚡	5.5 % ⚡	32,093 ⚡	51,056 ⚡

**Legends:**

- 🚫 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

**NOM 18 - Notes:**

None

**Data Alerts: None**

**NOM 19 - Percent of children in excellent or very good health**

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	86.8 %	1.2 %	624,437	719,046
2007	85.3 %	1.2 %	596,113	698,929
2003	86.3 %	1.0 %	597,734	692,666

**Legends:**

- 🚩 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

**NOM 19 - Notes:**

None

**Data Alerts: None**

**NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)**

**Data Source: National Survey of Children's Health (NSCH)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	30.2 %	2.3 %	95,210	315,762
2007	31.1 %	2.1 %	90,333	290,635
2003	30.0 %	1.9 %	93,959	312,892

**Legends:**

-  Indicator has an unweighted denominator <30 and is not reportable
-  Indicator has a confidence interval width >20% and should be interpreted with caution

**Data Source: WIC**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	29.7 %	0.3 %	7,579	25,532
2012	29.7 %	0.3 %	8,888	29,939
2010	30.9 %	0.3 %	9,408	30,458
2008	31.0 %	0.3 %	8,170	26,342

**Legends:**

-  Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable
-  Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	28.9 %	1.4 %	40,990	141,855
2011	24.1 %	1.1 %	32,928	136,688
2009	25.1 %	1.5 %	33,233	132,280
2007	25.3 %	1.6 %	32,253	127,528
2005	24.9 %	1.3 %	35,358	141,896

**Legends:**

- 🚩 Indicator has an unweighted denominator <100 and is not reportable
- ⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

**NOM 20 - Notes:**

None

**Data Alerts: None**

**NOM 21 - Percent of children without health insurance**

Data Source: American Community Survey (ACS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	5.2 %	0.6 %	37,068	718,517
2014	6.2 %	0.6 %	44,705	723,985
2013	6.7 %	0.6 %	48,325	718,520
2012	6.9 %	0.5 %	49,694	719,066
2011	6.1 %	0.5 %	44,263	721,601
2010	7.7 %	0.6 %	55,698	725,339
2009	8.2 %	0.6 %	57,156	700,793

**Legends:**

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

**NOM 21 - Notes:**

None

**Data Alerts: None**

**NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3\*:3:1:4)**

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	75.2 %	3.2 %	43,886	58,367
2014	76.5 %	3.6 %	44,149	57,728
2013	68.7 %	3.6 %	39,644	57,726
2012	65.0 %	3.4 %	37,798	58,137
2011	73.5 %	3.6 %	43,953	59,803
2010	54.9 %	3.8 %	32,378	58,955
2009	46.0 %	4.4 %	28,749	62,455

**Legends:**

- 🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
- ⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.1 - Notes:**

None

**Data Alerts: None**

**NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza**

Data Source: National Immunization Survey (NIS) - Flu

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2016	55.6 %	2.1 %	373,913	672,869
2014_2015	55.5 %	2.4 %	380,682	685,790
2013_2014	57.5 %	2.0 %	391,033	680,154
2012_2013	45.9 %	1.9 %	310,168	676,228
2011_2012	47.8 %	2.4 %	313,530	656,064
2010_2011	47.0 %	3.2 %	308,085	655,501
2009_2010	39.0 %	1.6 %	271,928	697,252

**Legends:**

- 🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
- ⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.2 - Notes:**

None

**Data Alerts: None**

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

Data Source: National Immunization Survey (NIS) - Teen (Female)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	50.9 %	4.5 %	49,006	96,321
2014	38.3 %	4.9 %	36,873	96,340
2013	39.9 %	5.0 %	38,897	97,402
2012	42.7 % ⚡	5.4 % ⚡	41,349 ⚡	96,737 ⚡
2011	37.2 %	4.5 %	36,187	97,259
2010	40.2 %	4.3 %	38,353	95,491
2009	44.1 % ⚡	5.4 % ⚡	41,245 ⚡	93,442 ⚡

**Legends:**

- 🚩 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
- ⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Teen (Male)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	36.0 %	4.2 %	36,616	101,851
2014	32.8 %	4.4 %	33,498	102,029
2013	25.1 %	4.4 %	25,770	102,720
2012	13.5 %	3.5 %	13,813	101,998
2011	NR 🚩	NR 🚩	NR 🚩	NR 🚩

**Legends:**

- 🚩 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
- ⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.3 - Notes:**

None

**Data Alerts: None**

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

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	87.3 %	2.2 %	173,003	198,172
2014	79.8 %	2.9 %	158,243	198,370
2013	84.6 %	2.5 %	169,347	200,122
2012	92.2 %	1.7 %	183,268	198,735
2011	79.1 %	2.8 %	158,210	199,999
2010	76.8 %	2.4 %	151,261	196,881
2009	63.6 %	3.5 %	122,436	192,607

**Legends:**

- 🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
- ⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.4 - Notes:**

None

**Data Alerts: None**

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

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	63.7 %	3.0 %	126,260	198,172
2014	65.1 %	3.3 %	129,129	198,370
2013	55.9 %	3.5 %	111,787	200,122
2012	55.9 %	3.7 %	111,176	198,735
2011	47.7 %	3.4 %	95,410	199,999
2010	50.2 %	2.9 %	98,866	196,881
2009	38.3 %	3.5 %	73,838	192,607

**Legends:**

- 🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
- ⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.5 - Notes:**

None

**Data Alerts: None**

**Form 10a**  
**National Performance Measures (NPMs)**  
**State: Kansas**

**NPM 1 - Percent of women with a past year preventive medical visit**

Federally Available Data	
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)	
	2016
Annual Objective	73.7
Annual Indicator	65.1
Numerator	317,072
Denominator	486,998
Data Source	BRFSS
Data Source Year	2015

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	75.7	77.7	79.8	81.9	84.0	86.3

**Field Level Notes for Form 10a NPMs:**

None

**NPM 4 - A) Percent of infants who are ever breastfed**

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	87.2
Annual Indicator	83.8
Numerator	32,783
Denominator	39,126
Data Source	NIS
Data Source Year	2013

State Provided Data	
	2016
Annual Objective	87.2
Annual Indicator	87.4
Numerator	34,078
Denominator	38,998
Data Source	Kansas Vital Statistics
Data Source Year	2015
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	88.6	90.0	91.5	92.9	94.3	95.7

**Field Level Notes for Form 10a NPMs:**

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1.      **Field Name:**                      **2016**

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**Column Name:**                    **State Provided Data**

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**Field Note:**

Data for 2016 will be available in fall 2016. 2015 data were used.

**NPM 4 - B) Percent of infants breastfed exclusively through 6 months**

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	27.7
Annual Indicator	23.4
Numerator	9,025
Denominator	38,643
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	29.4	31.2	33.2	35.2	37.5	39.8

**Field Level Notes for Form 10a NPMs:**

None

**NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool**

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	40.7
Annual Indicator	37.0
Numerator	70,393
Denominator	190,075
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	44.8	49.3	54.2	59.6	65.5	72.0

**Field Level Notes for Form 10a NPMs:**

None

**NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19 (Child Health)**

Federally Available Data	
Data Source: HCUP - State Inpatient Databases (SID) - CHILD	
	2016
Annual Objective	80.9
Annual Indicator	80.8
Numerator	325
Denominator	402,420
Data Source	SID-CHILD
Data Source Year	2014

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	75.1	69.8	64.8	60.2	55.9	52.0

**Field Level Notes for Form 10a NPMs:**

None

**NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	9.9
Annual Indicator	11.0
Numerator	25,495
Denominator	231,663
Data Source	NSCH
Data Source Year	2011_2012

Federally Available Data	
Data Source: Youth Risk Behavior Surveillance System (YRBSS)	
	2016
Annual Objective	9.9
Annual Indicator	27.9
Numerator	39,871
Denominator	142,707
Data Source	YRBSS
Data Source Year	2013

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	9.4	8.9	8.5	8.1	7.7	7.3

**Field Level Notes for Form 10a NPMs:**

None

**NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	85.5
Annual Indicator	83.4
Numerator	191,615
Denominator	229,749
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	86.6	87.6	88.7	89.8	91.0	92.1

**Field Level Notes for Form 10a NPMs:**

None

**NPM 11 - Percent of children with and without special health care needs having a medical home**

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2016
Annual Objective	62.1
Annual Indicator	53.8
Numerator	74,319
Denominator	138,094
Data Source	NSCH-CSHCN
Data Source Year	2011_2012

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	63.6	65.2	66.8	68.5	70.2	72.0

**Field Level Notes for Form 10a NPMs:**

None

**NPM 14 - A) Percent of women who smoke during pregnancy**

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2016
Annual Objective	11.4
Annual Indicator	11.0
Numerator	4,298
Denominator	39,083
Data Source	NVSS
Data Source Year	2015

State Provided Data	
	2016
Annual Objective	11.4
Annual Indicator	11
Numerator	4,294
Denominator	39,052
Data Source	Kansas Vital Statistics
Data Source Year	2015
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	10.7	10.0	9.3	8.7	8.1	7.6

**Field Level Notes for Form 10a NPMs:**

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1.      **Field Name:**                      **2016**

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**Column Name:**                    **State Provided Data**

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**Field Note:**

Data for 2016 will be available in fall 2016. 2015 data were used.

**NPM 14 - B) Percent of children who live in households where someone smokes**

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	23.5
Annual Indicator	25.3
Numerator	180,387
Denominator	713,663
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	21.8	20.2	18.8	17.4	16.2	15.0

**Field Level Notes for Form 10a NPMs:**

None

**Form 10a  
State Performance Measures (SPMs)**

**State: Kansas**

**SPM 1 - Percent of preterm births (<37 weeks gestation)**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	8.8
Numerator	3,426
Denominator	39,105
Data Source	Kansas Vital Statistics
Data Source Year	2015
Provisional or Final ?	Provisional

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	8.3	8.1	7.9	7.8	7.6	7.4

**Field Level Notes for Form 10a SPMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**  
Data for 2016 will be available in fall 2016. 2015 data were used.

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

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	91.5
Numerator	657,320
Denominator	718,755
Data Source	NSCH
Data Source Year	2011_2012
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	92.4	93.3	94.3	95.2	96.2	97.1

**Field Level Notes for Form 10a SPMs:**

None

**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**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	28.2
Numerator	133,276
Denominator	473,426
Data Source	NSCH
Data Source Year	2011_2012
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	29.6	31.1	32.6	34.3	36.0	37.8

**Field Level Notes for Form 10a SPMs:**

None

**SPM 4 - Number of Safe Sleep (SIDS/SUID) trainings provided to professionals**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	2,588
Numerator	
Denominator	
Data Source	KIDS
Data Source Year	FY2015
Provisional or Final ?	Provisional

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	5,000.0	5,500.0	6,000.0	6,500.0	7,000.0	7,500.0

**Field Level Notes for Form 10a SPMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	FY2015 data provided.

**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**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	47
Numerator	987,775
Denominator	2,101,649
Data Source	Kaiser Family Foundation
Data Source Year	2008
Provisional or Final ?	Provisional

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	44.7	42.4	40.3	38.3	36.4	34.5

**Field Level Notes for Form 10a SPMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

The 2016 BRFSS (CDC Module) health literacy data will be available in summer 2017.

**Form 10a  
Evidence-Based or –Informed Strategy Measures (ESMs)**

State: Kansas

**ESM 1.1 - Percent of women program participants (18-44 years) that received education on the importance of a well-woman visit in the past year**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	9.6
Numerator	562
Denominator	5,824
Data Source	DAISEY
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	20.0	30.0	40.0	50.0	60.0	70.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 4.1 - Percent of WIC infants breastfed exclusively through six months in designated Communities Supporting Breastfeeding**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	19.5
Numerator	1,022
Denominator	5,254
Data Source	KWIC
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	22.5	25.0	27.5	30.0	32.5	35.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 6.1 - Percent of program providers using a parent-completed developmental screening tool during an infant or child visit (ages 10 through 71 months)**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	88.4
Numerator	38
Denominator	43
Data Source	DAISEY
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	90.0	91.0	92.0	93.0	94.0	95.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 7.1 - Number of free car seat safety inspections completed by certified child passenger safety technicians**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	969
Numerator	
Denominator	
Data Source	Kansas Traffic Safety Resource Office
Data Source Year	2015
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	1,050.0	1,100.0	1,200.0	1,250.0	1,300.0	1,350.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 9.1 - Number of schools implementing evidence-based or informed anti-bullying practices and/or programs**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	12
Numerator	
Denominator	
Data Source	Second Step Schools
Data Source Year	2015-2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	12.0	12.0	24.0	24.0	24.0	24.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

School Year 2015-2016: Kansas Department of Health and Environment, Bureau of Health Promotion, Second Step Schools

**ESM 10.1 - Percent of adolescent program participants (12-21 years) that received education on the importance of a well-visit in the past year**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	17.3
Numerator	744
Denominator	4,297
Data Source	DAISEY
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	30.0	40.0	50.0	60.0	70.0	80.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 11.1 - Percent of families who experience an improved independent ability to navigate the systems of care**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Kansas Special Health Services
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	5.0	10.0	15.0	20.0	25.0	30.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

It is currently being piloted. The data will be available in January of 2018.

**ESM 14.1 - Percent of pregnant women program participants who smoke referred to the Tobacco Quitline and enrolled/accepted services**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	13.3
Numerator	13
Denominator	98
Data Source	DAISEY
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	15.0	17.5	20.0	22.5	25.0	27.5

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**  
Only client level data, no aggregate data, are included.

**Form 10b**  
**State Performance Measure (SPM) Detail Sheets**

**State: Kansas**

**SPM 1 - Percent of preterm births (<37 weeks gestation)**  
**Population Domain(s) – Women/Maternal Health**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To reduce the proportion of all preterm, early term, and early elective deliveries.								
<b>Definition:</b>	<table border="1" style="width: 100%;"> <tr> <td style="background-color: #4F81BD; color: white;"><b>Numerator:</b></td> <td>Number of live births before 37 weeks of complete gestation</td> </tr> <tr> <td style="background-color: #4F81BD; color: white;"><b>Denominator:</b></td> <td>Number of live births</td> </tr> <tr> <td style="background-color: #4F81BD; color: white;"><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td style="background-color: #4F81BD; color: white;"><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Number of live births before 37 weeks of complete gestation	<b>Denominator:</b>	Number of live births	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of live births before 37 weeks of complete gestation								
<b>Denominator:</b>	Number of live births								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Healthy People 2020 Objective:</b>	Identical to Maternal, Infant, and Child Health (MICH) Objective 9.1: Reduce total preterm births (PTB). (Baseline: 12.7% in 2007, Target 11.4%)								
<b>Data Sources and Data Issues:</b>	Kansas birth certificate, Bureau of Epidemiology and Public Health and Informatics, Kansas Department of Health and Environment								
<b>Significance:</b>	<p>Babies born preterm, before 37 completed weeks of gestation, are at increased risk of immediate life-threatening health problems, as well as long-term complications and developmental delays. Among preterm infants, complications that can occur during the newborn period include respiratory distress, jaundice, anemia, and infection, while long-term complications can include learning and behavioral problems, cerebral palsy, lung problems, and vision and hearing loss. As a result of these risks, preterm birth is a leading cause of infant death and childhood disability. Although the risk of complications is greatest among those babies who are born the earliest, even those babies born "late preterm" (34 to 36 weeks' gestation) and "early term" (37, 38 weeks' gestation) are more likely than full-term babies to experience morbidity and mortality.</p> <p>Infants born to non-Hispanic Black women have the highest rates of preterm birth, particularly early preterm birth. In 2012, 16.5 percent of non-Hispanic Black infants were born preterm and 5.9 percent were born early preterm--these rates are 1.6 and 2.0 times the rates for infants born to non-Hispanic Whites women (10.3 and 2.9 percent, respectively). Infants born to Puerto Rican, Cuban, and American Indian/Alaska Native mothers also had elevated rates of preterm and early preterm birth.</p> <p>Non-medically indicated early term births (37,38 weeks) present avoidable risks of neonatal morbidity and costly NICU admission (Clark et al, 2009; Tita et al, 2009). Early elective delivery prior to 39 weeks is an endorsed perinatal quality measure by the Joint Commission, National Quality Forum, ACOG/NCQA, Leapfrog Group, and CMS/CHIPRA.</p>								

**SPM 2 - Percent of children living with parents who have emotional help with parenthood**  
**Population Domain(s) – Cross-Cutting/Life Course**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the proportion of children living with parents receiving emotional support (help with parenthood)								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of children age 0-17 years have parents who have someone to go to for emotional help with parenting when they need it</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of children age 0-17 years</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Number of children age 0-17 years have parents who have someone to go to for emotional help with parenting when they need it	<b>Denominator:</b>	Number of children age 0-17 years	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of children age 0-17 years have parents who have someone to go to for emotional help with parenting when they need it								
<b>Denominator:</b>	Number of children age 0-17 years								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Healthy People 2020 Objective:</b>	Related to Early and Middle Childhood (EMC) Objective 1 (Developmental): Increase the proportion of children who are ready for school in all five domains of healthy development: physical development, social-emotional development, approaches to learning, language, and cognitive development								
<b>Data Sources and Data Issues:</b>	National Survey of Children’s Health								
<b>Significance:</b>	The demands of parenting can cause considerable stress for families. Children and adolescents were less likely to engage in externalizing (acting out behavior) and display depression symptoms (sadness, feelings of worthlessness or withdrawn behavior), or have to be retained in a previous grade, when their mothers reported having emotional support with childrearing. These children and adolescents were also likely to display social competence and school engagement than were their counterparts whose mothers did not report having emotional support.								

**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**  
**Population Domain(s) – Child Health**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the number of children and adolescents who are physically active.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of children ages 6 through 11 and adolescents ages 12 through 17 (NSCH), and adolescents in grades 9 through 12 (YRBSS) who report being physically active at least 60 minutes per day in the past week</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of children ages 6 through 11 and adolescents ages 12 through 17 (NSCH) and number of adolescents in grades 9 through 12 (YRBSS)</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Number of children ages 6 through 11 and adolescents ages 12 through 17 (NSCH), and adolescents in grades 9 through 12 (YRBSS) who report being physically active at least 60 minutes per day in the past week	<b>Denominator:</b>	Number of children ages 6 through 11 and adolescents ages 12 through 17 (NSCH) and number of adolescents in grades 9 through 12 (YRBSS)	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of children ages 6 through 11 and adolescents ages 12 through 17 (NSCH), and adolescents in grades 9 through 12 (YRBSS) who report being physically active at least 60 minutes per day in the past week								
<b>Denominator:</b>	Number of children ages 6 through 11 and adolescents ages 12 through 17 (NSCH) and number of adolescents in grades 9 through 12 (YRBSS)								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Healthy People 2020 Objective:</b>	<p>Related to Physical Activity (PA) Objective 4.1: Increase the proportion of the Nation’s public and private elementary schools that require daily physical education for all students. (Baseline: 3.8%, Target: 4.2%)</p> <p>Related to Physical Activity (PA) Objective 3: Increase the proportion of adolescents who meet current Federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity. (Baseline: 18.4%, Target: 20.2% for adolescents to meet current physical activity guidelines for aerobic physical activity)</p>								
<b>Data Sources and Data Issues:</b>	National Survey of Children’s Health (NSCH) and Youth Risk Behavior Surveillance System (YRBSS). The revised NSCH will capture physical activity of at least 60 minutes per day with baseline NSCH data reflecting at least 20 minutes per day.								
<b>Significance:</b>	Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Physical activity in children and adolescents reduces the risk of early life risk factors for cardiovascular disease, hypertension, Type II diabetes, and osteoporosis. In addition to aerobic and muscle-strengthening activities, bone-strengthening activities are especially important for children and young adolescents because the majority of peak bone mass is obtained by the end of adolescence.								

**SPM 4 - Number of Safe Sleep (SIDS/SUID) trainings provided to professionals**  
**Population Domain(s) – Perinatal/Infant Health**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the number of professionals who have received Safe Sleep trainings.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of professionals who have received Safe Sleep training</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Not applicable</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>20,000</td> </tr> </table>	<b>Numerator:</b>	Number of professionals who have received Safe Sleep training	<b>Denominator:</b>	Not applicable	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	20,000
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<b>Denominator:</b>	Not applicable								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	20,000								
<b>Healthy People 2020 Objective:</b>	Related to Maternal, Infant, and Child Health (MICH) Objective 1.3 Reduce the rate of all infant deaths (within 1 year); MICH Objective 1.8 Reduce the rate of infant deaths from sudden infant death syndrome (SIDS); MICH Objective 1.9 Reduce the rate of infant deaths from sudden unexpected infant deaths (includes SIDS, Unknown Cause, Accidental Suffocation, and Strangulation in Bed); MICH Objective 20: Increase the proportion of infants placed to sleep on their backs								
<b>Data Sources and Data Issues:</b>	Kansas Infant Death and SIDS (KIDS) Network								
<b>Significance:</b>	Sleep-related infant deaths, called Sudden Unexpected Infant deaths (SUIDS), are the leading cause of infant death after the first month of life. Risk of SUIDS increases when babies are placed on their side or stomach to sleep. Placing babies on their back, on a firm surface, and without loose bedding are the recommended practices to follow according to AAP.								

**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**  
**Population Domain(s) – Cross-Cutting/Life Course**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To decrease the proportion of adults that report difficulty in understanding the information doctors, nurses and other health professionals tell them.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of adults aged 18 or older who report that it is somewhat difficult or very difficult to understand the information that doctors, nurses and other health professionals tell them</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of adults aged 18 or older</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Number of adults aged 18 or older who report that it is somewhat difficult or very difficult to understand the information that doctors, nurses and other health professionals tell them	<b>Denominator:</b>	Number of adults aged 18 or older	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of adults aged 18 or older who report that it is somewhat difficult or very difficult to understand the information that doctors, nurses and other health professionals tell them								
<b>Denominator:</b>	Number of adults aged 18 or older								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Healthy People 2020 Objective:</b>	Related to Health Communication and Health Information Technology (HC/HIT) Objective 1.1: Increase the proportion of persons who report their health care provider always gave them easy-to-understand instructions about what to do to take care of their illness or health condition. Objective 1.2: Increase the proportion of persons who report their health care provider always asked them to describe how they will follow the instructions. Objective 1.3: Increase the proportion of persons who report their health care providers' office always offered help in filling out a form.								
<b>Data Sources and Data Issues:</b>	Behavioral Risk Factor Surveillance System (BRFSS)								
<b>Significance:</b>	<p>Communication barriers often go undetected in health care settings and can have serious effects on the health and safety of patients. Limited literacy skills are one of the strongest predictors of poor health outcomes for patients. Health literacy can affect health status, health outcomes, health care use and health care costs. The entire health care systems relies on the assumption that patients can understand complex written and spoken information. If patients cannot understand health information, they cannot take necessary actions for their health or make appropriate health decisions.</p> <p>Reference: Graham S, Brookey J. Do Patients Understand? Perm J. 2008 Summer; 12(3): 67–69.</p>								

**Form 10b**  
**State Outcome Measure (SOM) Detail Sheets**  
**State: Kansas**

No State Outcome Measures were created by the State.

**Form 10c  
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets**

**State: Kansas**

**ESM 1.1 - Percent of women program participants (18-44 years) that received education on the importance of a well-woman visit in the past year**

**NPM 1 – Percent of women with a past year preventive medical visit**

<b>Measure Status:</b>	Active	
<b>Goal:</b>	To ensure supportive programming for well woman visits/preventive health care.	
<b>Definition:</b>	<b>Numerator:</b>	Number of MCH women (including pregnant and postpartum, 18-44 years) program participants who have received education on on the importance of a well woman/ preventative visit in the reporting year
	<b>Denominator:</b>	Number of MCH women (including pregnant and postpartum, ages 18-44) program participants
	<b>Unit Type:</b>	Percentage
	<b>Unit Number:</b>	100
<b>Data Sources and Data Issues:</b>	Data Application and Integration Solution for the Early Years (DAISEY): Web-based comprehensive data collection and reporting system/shared measurement system used by all MCH grantees to capture client and visit/service data	
<b>Significance:</b>	A well woman visit is a way to make sure an individual is staying healthy. These include a full checkup, separate from a visit for sickness or injury. The focus is on preventive care which includes, but is not limited to, shots, screenings, education, and counseling.	

**ESM 4.1 - Percent of WIC infants breastfed exclusively through six months in designated Communities Supporting Breastfeeding**

**NPM 4 – A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the number of WIC infants breastfed exclusively through six months of age, in communities defined as either a city or county, that have been designated as a “Community Supporting Breastfeeding” by the Kansas Breastfeeding Coalition, Inc.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of WIC infants breastfed exclusively through six months in communities that have reached the designation of a “Community Supporting Breastfeeding”</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of WIC infants in communities that have reached the designation of a Community Supporting Breastfeeding</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Number of WIC infants breastfed exclusively through six months in communities that have reached the designation of a “Community Supporting Breastfeeding”	<b>Denominator:</b>	Number of WIC infants in communities that have reached the designation of a Community Supporting Breastfeeding	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
	<b>Numerator:</b>	Number of WIC infants breastfed exclusively through six months in communities that have reached the designation of a “Community Supporting Breastfeeding”							
	<b>Denominator:</b>	Number of WIC infants in communities that have reached the designation of a Community Supporting Breastfeeding							
	<b>Unit Type:</b>	Percentage							
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	Kansas WIC Data System (KWIC)								
<b>Significance:</b>	Human milk is the preferred feeding for all infants, including premature and sick newborns. Exclusive breastfeeding is ideal nutrition and sufficient to support optimal growth and development for approximately the first 6 months after birth. The advantages of breastfeeding are indisputable and include nutritional, immunological and psychological benefits to both mother and infant, as well as economic benefits. If mothers get the support they need in the first 4 weeks of a new baby’s life, they are more likely to keep breastfeeding. Mothers may need help finding people who are trained to assist with breastfeeding after they leave the hospital. Without help, some mothers may stop breastfeeding. Communities often provide a number of resources and programs to help breastfeeding mothers. The Surgeon General recommends programs which provide mother-to-mother support and peer counseling, use a variety of media venues to reach young women and their families, and the expansion of the use of programs in the workplace that allow lactating mothers to have direct access to their babies.								

**ESM 6.1 - Percent of program providers using a parent-completed developmental screening tool during an infant or child visit (ages 10 through 71 months)**

**NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To ensure supportive programming for developmental screenings.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of MCH program providers serving children (ages 10 through 71 months) that are utilizing a parent-completed developmental screening tool as part of an infant or child well visit</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of MCH program providers in the state</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Number of MCH program providers serving children (ages 10 through 71 months) that are utilizing a parent-completed developmental screening tool as part of an infant or child well visit	<b>Denominator:</b>	Number of MCH program providers in the state	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of MCH program providers serving children (ages 10 through 71 months) that are utilizing a parent-completed developmental screening tool as part of an infant or child well visit								
<b>Denominator:</b>	Number of MCH program providers in the state								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	Data Application and Integration Solution for the Early Years (DAISEY): Web-based comprehensive data collection and reporting system/shared measurement system used by all MCH grantees to capture client and visit/service data								
<b>Significance:</b>	The Title V Maternal and Child Health Services Block Grant to States Program guidance defines the significance of this goal as follows: Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics recommends screening tests begin at the nine month visit.								

**ESM 7.1 - Number of free car seat safety inspections completed by certified child passenger safety technicians**  
**NPM 7 – Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the number of free car seat safety inspections completed by certified child passenger safety technicians								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of free car seat safety inspections completed by certified child passenger safety technicians</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Not applicable</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>5,000</td> </tr> </table>	<b>Numerator:</b>	Number of free car seat safety inspections completed by certified child passenger safety technicians	<b>Denominator:</b>	Not applicable	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	5,000
<b>Numerator:</b>	Number of free car seat safety inspections completed by certified child passenger safety technicians								
<b>Denominator:</b>	Not applicable								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	5,000								
<b>Data Sources and Data Issues:</b>	Kansas Traffic Safety Resource Office								
<b>Significance:</b>	<p>Injury is the leading cause of child mortality. For those who suffer non-fatal severe injuries, many will become children with special health care needs. Effective interventions to reduce injury exist but are not fully implemented in systems of care that serve children and their families. Reducing the burden of nonfatal injury can greatly improve the life course trajectory of infants, children, and adolescents resulting in improved quality of life and cost savings.</p> <p>Motor vehicle injuries are a leading cause of death among children in the United States. A correctly used car seat or seatbelt can keep a child from being ejected during a car crash. Many times, child restraint systems are used incorrectly. An estimated 46% of car and booster seats (59% of car seats and 20% of booster seats) are misused in a way that can reduce their effectiveness. The Community Preventive Service Task Force recommends car seat laws and car seat distribution plus education programs to increase restraint use and decrease injuries and death to child passengers.</p>								

**ESM 9.1 - Number of schools implementing evidence-based or informed anti-bullying practices and/or programs**  
**NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the number of schools implementing anti-bullying policies, practices, or programs so students receive information about bullying or social-emotional/character development to reduce the negative impact on overall health and well-being.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of schools implementing evidence-based or informed anti-bullying practices and/or programs</td> </tr> <tr> <td><b>Denominator:</b></td> <td>N/A</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>1,500</td> </tr> </table>	<b>Numerator:</b>	Number of schools implementing evidence-based or informed anti-bullying practices and/or programs	<b>Denominator:</b>	N/A	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	1,500
<b>Numerator:</b>	Number of schools implementing evidence-based or informed anti-bullying practices and/or programs								
<b>Denominator:</b>	N/A								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	1,500								
<b>Data Sources and Data Issues:</b>	Kansas Department of Health and Environment, Bureau of Health Promotion, Second Step Schools								
<b>Significance:</b>	Bullying is one type of youth violence that threatens young people’s well-being. Bullying can result in physical injuries, social and emotional difficulties, and academic problems. Training school staff and students to prevent and address bullying can help sustain bullying prevention efforts across time. There are some multiple evidence-based programs or curricula available for schools to implement to help reduce bullying.								

**ESM 10.1 - Percent of adolescent program participants (12-21 years) that received education on the importance of a well-visit in the past year**

**NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To ensure supportive programming for well adolescent visits/preventive health care.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of adolescent program participants (12-21 years) who have received education on the importance of a well adolescent/preventative visit in the reporting year</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of adolescent program participants (12-21 years)</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Number of adolescent program participants (12-21 years) who have received education on the importance of a well adolescent/preventative visit in the reporting year	<b>Denominator:</b>	Number of adolescent program participants (12-21 years)	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
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<b>Denominator:</b>	Number of adolescent program participants (12-21 years)								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	Data Application and Integration Solution for the Early Years (DAISEY): Web-based comprehensive data collection and reporting system/shared measurement system used by all MCH grantees to capture client and visit/service data								
<b>Significance:</b>	Adolescence is an important period of development physically, psychologically, and socially. As adolescents move from childhood to adulthood, they are responsible for their health including annual preventive well visits which help to maintain a healthy lifestyle, avoid damaging behaviors, manage chronic conditions, and prevent disease.								

**ESM 11.1 - Percent of families who experience an improved independent ability to navigate the systems of care**  
**NPM 11 – Percent of children with and without special health care needs having a medical home**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the proportion of families who experience an improved independent ability to navigate the systems of care within a year.								
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #4F81BD; color: white;"><b>Numerator:</b></td> <td>Number of families who show an improved ability to navigate the systems of care as demonstrated by their care level status. A care level is determined by the identified needs based on the KS-SHCN Care Coordination Assessment.</td> </tr> <tr> <td style="background-color: #4F81BD; color: white;"><b>Denominator:</b></td> <td>Number of families who receive support for care coordination and have completed a follow-up KS-SHCN Care Coordination Assessment in the past year. This information is based on data from the KS-SHCN Care Coordination Assessment.</td> </tr> <tr> <td style="background-color: #4F81BD; color: white;"><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td style="background-color: #4F81BD; color: white;"><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Number of families who show an improved ability to navigate the systems of care as demonstrated by their care level status. A care level is determined by the identified needs based on the KS-SHCN Care Coordination Assessment.	<b>Denominator:</b>	Number of families who receive support for care coordination and have completed a follow-up KS-SHCN Care Coordination Assessment in the past year. This information is based on data from the KS-SHCN Care Coordination Assessment.	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
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<b>Denominator:</b>	Number of families who receive support for care coordination and have completed a follow-up KS-SHCN Care Coordination Assessment in the past year. This information is based on data from the KS-SHCN Care Coordination Assessment.								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	<p>KS-SHCN Care Coordination Measurement Tool</p> <p>The lead care coordinator has a conversation with the family to identify their needs and assigned a level 1,2,3 to them to indicate the amount of assistance they will need from the care coordinator assigned to their case. Improved ability means that they will not show as many needs based upon the re-evaluation in 1 year. They are classified level 3 with five or more needs, level two with 2-4 needs and level one with no 0-1 need.</p>								
<b>Significance:</b>	<p>Care coordination involves the “deliberate organization of patient care activities between two or more participants (including the patient) involved in the patient’s care to facilitate the appropriate delivery of health services.” Care coordination is a key function of the medical home.</p> <p>The Family Advisory Council for Kansas defines care coordination as a patient and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the capabilities of families. It addresses interrelated medical, behavioral, educational, social, developmental, and financial needs to achieve optimal health. Key activities of care coordination involve the creation of care plans, care tracking, and timely, structured information for all members of the care team, including the patient and their family.</p> <p>The care coordination curriculum developed by Boston Children’s Hospital is an evidence-informed program designed to help individuals, including patients and families, articulate the principles and activities necessary to serve as a care coordinator. The curriculum was designed to be adapted for multiple settings, including a state’s Title V program.</p>								

**ESM 14.1 - Percent of pregnant women program participants who smoke referred to the Tobacco Quitline and enrolled/accepted services**

**NPM 14 – A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To ensure supportive programming promoting and/ or facilitating tobacco and eCigarette cessation, referral and follow up.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of pregnant women program participants who smoke referred to the Tobacco Quitline and enrolled/accepted services</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of pregnant women program participants who smoke</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Number of pregnant women program participants who smoke referred to the Tobacco Quitline and enrolled/accepted services	<b>Denominator:</b>	Number of pregnant women program participants who smoke	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of pregnant women program participants who smoke referred to the Tobacco Quitline and enrolled/accepted services								
<b>Denominator:</b>	Number of pregnant women program participants who smoke								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	Data Application and Integration Solution for the Early Years (DAISEY): Web-based comprehensive data collection and reporting system/shared measurement system used by all MCH grantees to capture client and visit/service data								
<b>Significance:</b>	Secondhand smoke is a mixture of mainstream smoke and the more toxic side stream smoke which is classified as a “known human carcinogen” by the US Environmental Protection Agency, the US National Toxicology Program, and the International Agency for Research on Cancer. In addition, women who smoke during pregnancy are more likely to experience a fetal death or deliver a low birth weight baby.								

**Form 11  
Other State Data  
State: Kansas**

The Form 11 data are available for review via the link below.

[Form 11 Data](#)

## State Action Plan Table

State: Kansas

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

[State Action Plan Table - Entry View](#)

[State Action Plan Table - Legal Size Paper View](#)

## Abbreviated State Action Plan Table

State: Kansas

### Women/Maternal Health

State Priority Needs	NPMs	ESMs	SPMs
Women have access to and receive coordinated, comprehensive services before, during and after pregnancy.	NPM 1 - Well-Woman Visit	ESM 1.1	
Women have access to and receive coordinated, comprehensive services before, during and after pregnancy.			SPM 1

### Perinatal/Infant Health

State Priority Needs	NPMs	ESMs	SPMs
Families are empowered to make educated choices about infant health and well-being.	NPM 4 - Breastfeeding	ESM 4.1	
Families are empowered to make educated choices about infant health and well-being.			SPM 4

### Child Health

State Priority Needs	NPMs	ESMs	SPMs
Developmentally appropriate care and services are provided across the lifespan.	NPM 7 - Injury Hospitalization	ESM 7.1	
Developmentally appropriate care and services are provided across the lifespan.	NPM 6 - Developmental Screening	ESM 6.1	
Developmentally appropriate care and services are provided across the lifespan.			SPM 3

### Adolescent Health

State Priority Needs	NPMs	ESMs	SPMs
Communities and providers support physical, social and emotional health.	NPM 10 - Adolescent Well-Visit	ESM 10.1	
Communities and providers support physical, social and emotional health.	NPM 9 - Bullying	ESM 9.1	

### Children with Special Health Care Needs

State Priority Needs	NPMs	ESMs	SPMs
Services are comprehensive and coordinated across systems and providers.	NPM 11 - Medical Home	ESM 11.1	

### Cross-Cutting/Life Course

State Priority Needs	NPMs	ESMs	SPMs
Services and supports promote healthy family functioning.			SPM 2
Professionals have the knowledge and skills to address the needs of maternal and child health populations.	NPM 14 - Smoking	ESM 14.1	
Information is available to support informed health decisions and choices.			SPM 5