Maternal and Child Health Services Title V Block Grant

KANSAS

FY 2023 Application/
FY 2021 Annual Report

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www.kansasmch.org

Note to Reviewers:

Please do not worry about providing comments about formatting, spacing or grammatical errors.

This is a draft version of our narratives and will continue to be refined until submission in August.

Please don't forget to provide input through our online survey (https://www.surveymonkey.com/r/RC7PKYD).

Thank you for your time!

Kansas MCH Block Grant Team

EXECUTIVE SUMMARY

TITLE V MATERNAL & CHILD HEALTH SERVICES BLOCK GRANT PROGRAM

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Title V Overview

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 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." In addition to the MCH conceptual framework and public health essential services, the Title V program depends on many strengths—translated through core values and guiding principles—to promote a strong culture of continuous quality improvement, innovation and growth, and a sustained focus on what matters.

MCH Population

Kansas, spanning 82,278 sq. miles, is divided into 105 counties with 627 cities. The US Census Bureau estimates there were approximately 2,913,805 residents living in the state in 2020. Kansas has a unique geographic layout that ranges from urban to frontier counties based on population density. The population density of Kansas was 35.9 inhabitants per square mile in 2020, an 9.1% increase from 32.9 in 2000. In 20, there was an estimated 35,281 infants or 1.2% of the total population and 829,513 children and adolescents (ages 1-21) representing 28.5%. The number of females in the reproductive/child-bearing age group (ages 15-44) was 562,644, representing 19.3%. In 2019-2020, 20.75% of children ages 0 to 17 (est. 144,547) were identified as having special health care needs. About 20.8% of males under 18 had special health care needs, compared with 20.6% of females.

Assessing State Needs

Kansas continuously assesses the needs of MCH populations through an ongoing Needs Assessment, and the State Action Plan is reviewed during interim years. With a goal to maximize the input of internal and external partners, the 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 including families and consumers. The State Systems Development Initiative (SSDI) staff provide data capacity for informed decision-making. This comprehensive process and broad approach assist with identifying key priorities used to develop an action plan that addresses and improves MCH in Kansas while leveraging resources and partnerships across the state.

Title V MCH Priorities (FFY 2021-2025)

Kansas identified seven priorities with the Title V mission, purpose, legislative requirements, and measurement framework in mind.

Women/Maternal Health
Women have access to and utilize integrated, holistic, patient-centered care before, during, and after pregnancy.

Perinatal/Infant Health
All infants and families have support from strong community systems to optimize infant health and well-being.

Child Health
Children and families have access to and utilize developmentally appropriate services and supports through collaborative and integrated communities.

Adolescent Health
Adolescents and young adults have access to and utilize integrated, holistic, patient-centered care to support physical, social, and emotional health.

Children with Special Health Care Needs
Communities, families, and providers have the knowledge, skills, and comfort to support transitions and empowerment opportunities.

Cross-Cutting #1: MCH Workforce
Professionals have the knowledge, skills, and comfort to address the needs of maternal and child health populations.

Cross-Cutting #2: Families
Strengths-based supports and services are available to promote healthy families and relationships.

Title V MCH Performance Measures (FFY 2021-2025)

Kansas selected five national and four state performance measures to address the priorities outlined above. The national performance measures (NPMs) utilize national data sources to track state-level prevalence rates to determine the impact of activities on the populations serves. States must select at least one NPM for each of the MCH population domains (women/maternal, perinatal/infant, child, adolescent, children with special health care needs). The state performance measures (SPMs) were selected where a NPM was not available or appropriate for the state's identified priorities or objectives. The selected measures are outlined below.

National Performance Measures (NPMs)	State Performance Measures (SPMs)
NPM1: Well-woman Visit (Women 18-44 Years)	SPM1: Postpartum Depression
NPM5: Safe Sleep	SPM2: Breastfeeding Exclusivity
NPM6: Developmental Screening	SPM3: Workforce Development
NPM10: Adolescent Preventive Medical Visit	SPM4: Strengths-based Family Supports
NPM12: Transition To Adulthood	

Title V Activities & Program Highlights by Population Domain

The Title V plan reflects coordination of MCH activities across funding sources, 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 each of the associated population domain narratives for additional details about these and other activities, including applicable data and impacts on health outcomes for women, children, and families.

Women/Maternal & Perinatal/Infant Health

One Key Question® (OKQ): Title V has a partnership with The Power to Decide to implement OKQ, an evidence-based intervention known to prevent unplanned pregnancy and reduce incidence of poor birth outcomes. OKQ® helps a woman uncover her pregnancy intention by encouraging all health providers to routinely ask, "Would you like to become pregnant in the next year?"

Count the Kicks® (CTK): Title V has a partnership with Healthy Birth Day to implement Count the Kicks®, an evidence-based stillbirth prevention campaign that educates providers and patients about monitoring fetal movements during the 3rd trimester of pregnancy.

Maternal Mortality: The Kansas Maternal Mortality Review Committee (KMMRC) is a collaboration among Title V and key partners to review pregnancy-related deaths, identify causes, and implement interventions to prevent future occurrences. The first Kansas Maternal Mortality and Morbidity Report was published in January 2021. Information and data collected from cases resulted in formal recommendations that led to the Fourth Trimester Initiative, focused on quality care and provider communication related to the transition from pregnancy through the postpartum period.

Perinatal Quality & Systems of Care: The Kansas Perinatal Quality Collaborative (KPQC) is partnership with a panel of experts to improve the safety and quality of care for mothers and infants. The Fourth Trimester Initiative, resulting from findings from the KMMRC, is the current quality initiative underway, focused on improving maternal health and preventing severe maternal morbidity and mortality.

Perinatal Community Collaboratives: Title V is committed to supporting expansion and sustainability of the Kansas Perinatal Community Collaborative (KPCC) model with local communities and the broader network of local health care and community service providers, as a consistent and proven delivery system for prenatal care education curriculum. The model brings prenatal education, clinical care, and wraparound services together. Data reveal improvements in preterm delivery, low birth weight, and breastfeeding. Outcomes for mothers and infants participating in a KPCC are improving when compared to state outcomes.

Breastfeeding: Title V strives to provide consistent messaging around breastfeeding and leverage resources at the state and local levels. Title V has a partnership with the Kansas Breastfeeding Coalition (KBC) to align and support breastfeeding across programs including MCH, WIC, Child Care Licensing, Home Visiting, and others. KBC increases the capacity and strengthens the support of local breastfeeding coalitions, provides technical assistance and support for several initiatives, participates in planning for Community Baby Showers, and assists with updating breastfeeding education for providers and parents.

Safe Sleep: Title V has a partnership with the Kansas Infant Death and SIDS (KIDS) Network to reduce infant mortality through state and local safe sleep targeted efforts. Title V supports the KIDS Network to: facilitate a safe sleep culture within Kansas by training a network of Safe Sleep Instructors; develop and provide training for parents, physicians, home visitors, and child care providers; and promote consistent safe sleep messages across the lifespan. KIDS Network also provides technical assistance on the Community Baby Shower model and the Hospital Safe Sleep Certification and Outpatient Provider Safe Sleep Star programs.

Child & Adolescent Health

Early Childhood Systems Building: The Help Me Grow Kansas (HMG) framework promotes integrated, cross-sector collaboration to build efficient and effective systems. This was the foundation of the All in for Kansas Kids Strategic Plan, supported by Title V partnership and aligned with key MCH activities such as: expanding care coordination to primary care provider settings, implementing the Bridges program (support for families transitioning out of Part C/Infant Toddler Services), and expansion of peer supports through Supporting You.

Preventive Medical Visits (Annual Well Visits): Title V is actively engaged in outreach, promotion, and support to increase access to annual preventive medical visits for children and adolescents. Visits are important for access to comprehensive services including screening and immunizations, referral, and diagnosis and treatment when indicated. Title V promotes Bright Futures™ as a standard of care in line with the Medicaid

EPSDT program and is also focusing on expanding school-based health centers to increase access to care, especially for adolescents. Title V provided funding for a statewide license to access the online Bright Futures Tool and Resource Kit, 2nd Edition.

Behavioral Health: Kansas Title V is working to increase focus on behavioral health interventions, healthy social-emotional development, and cross systems collaboration within the State Action Plan objectives. To expand programming and increase effectiveness, the Title V Behavioral Health Consultant position oversees two federally funded projects focused on behavioral health – *Kansas Connecting Communities* (launched October 2018) and *KSKidsMAP to Mental Wellness* (launched July 2019).

Youth Health Initiatives: The *Youth Health Guide* and *WHY (Whole Healthy You) Campaign*, brings attention to health awareness events and supports youth in living healthy – physically, mentally, and emotionally. Additionally, Title V used the Adolescent Health Institute's youth-friendly care tools to support quality improvement strategies and is devoted to providing technical assistance to local agencies to improve adolescent health measures and identify enhancements or improvements to policy. With this support, local MCH agencies will be prepared to clearly state their goals and identify MCH funding needs to meet milestones in future grant applications.

Children with Special Health Care Needs (CSHCN)

Holistic Care Coordination: The Kansas Special Health Care Needs program (KS-SHCN) provides holistic care coordination (HCC) and helps families find, understand, and access services and resources within medical, school, and community systems to achieve optimal child/family health outcomes and empower and prepare parents to support their children. Eligibility for HCC services are expanding to those with medically eligible conditions, regardless of financial status or resources, and families of children three to five years of age who received early intervention through Part C/Infant Toddler Services.

Transition to Adulthood: Throughout the Title V Needs Assessment and implementation of the HCC model, transition planning for youth and adolescents ages 12 and older has been an identified service gap. Not only focused on transitioning from pediatric to adult health care systems but transitioning in all aspects of life (e.g., self-advocacy, health and wellness, health care systems, social and recreation, independent living skills, education), Title V will work with YSHCN to develop goals that meet their needs and help with in self-care and self-advocacy.

Systems of Care for CSHCN: Focus remains on the implementation and advancement of the National Standards for Children with Special Health Care Needs and the Kansas State Plan for Systems of Care for Children and Youth with Special Health Care Needs, a road map developed in 2018 to strengthen services and supports for CSHCN and their families. To support stronger systems, Kansas Title V will continue to seek opportunities to establish local- and state-level datasets to inform about the CSHCN population and their needs.

Family & Consumer Partnerships

Peer-to-Peer Support Network: In partnership with the FAC, Title V launched a peer-to-peer support network, Supporting You, to connect parents and caregivers of CSHCN with peers who have like experiences and/or life circumstances. The network is designed to help individuals connect with one another, share ideas and resources, and gain support where it would most benefit. There are three participating programs: KS-SHCN, School for the Deaf, and FAC. The network is currently working to build a statewide program to support foster, adoptive, and kinship families.

Family & Consumer Partnership (FCP) Program: Title V is building a formal partnership program with families through peer supports, family leadership, and advisory opportunities. This will serve as a framework for local and state Title V programs to assure families are engaged at the level they desire. Upon development of a robust resource toolkit, Title V can offer technical assistance and opportunity to support partners with engaging families in planning, implementation, and evaluation of services, programs, and policy.

IMPACT AND VALUE OF KANSAS MCH

Activities and services funded by the Block Grant are essential to maintaining a strong infrastructure, developing and coordinating systems, and filling identified gaps. Federal funds truly complement state and local funds to support a comprehensive service delivery model that advances the State Action Plan and aims to improve outcomes across the life course. Most federal funds are utilized to support the MCH and SHCN state staff and operations along with local services through aid to local grants/programming. Nonfederal funds are utilized to meet the required federal match through state and local investments across the population domains (newborn screening, local grants, specialty services for SHCN). Local grantees are required to provide at least 40% match for grant funds which results in additional MCH system supports. The charts below display federal vs. nonfederal expenditures by service level and individual/population.

The availability of federal funds coupled with state flexibility continues to assure the health of individuals during critical periods such as preconception, pregnancy and postpartum, childhood, and adolescence/young adulthood. Critical contributions to the state's public health infrastructure are evident through the development, implementation, and ongoing sustainability of efforts aimed at:

- addressing maternal mortality, morbidity, and behavioral health;
- expanding community coordination, clinical care, and supports like home visiting during the prenatal and postnatal periods to include access to group prenatal education birth outcomes model and risk assessment, brief intervention, and referral to services;
- establishing a precedence for family and consumer partnership across all MCH population domains, among both internal and external partners;
- enhancing local communities and the statewide MCH workforce capacity to address health equity and social determinants of health through targeted technical assistance;
- enhancing local communities' capacity to develop school-based health centers to expand access to care for children and adolescents, particularly the well visit; and
- demonstrating value for a holistic approach to care coordination for the children with special health care needs population to drive change among all populations.

Families of CSHCN needs rely on Title V to continue to advocate and expand access to appropriate services. Investments from Title V allow financial assistance to fill gaps in coverage and sustain regional access points for entry into the state/federal program. The flexibility for the program to serve beyond state statutory limitations and consider gap-filling services, continues to increase access to family-centered, community-based, coordinated care.

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 and 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 Bureau of Family Health (BFH), one of six Bureaus in the Division of Public Health, administers the Title V MCH Services Block Grant program. 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 statutes do not mandate comprehensive services for MCH populations except for Children with Special Health Care Needs (CSHCN). 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 services and supports are available to individuals ages birth to 21 with eligible medical conditions, and all ages with conditions diagnosed through the state's newborn screening program. Kansas provides direct services for state-mandated eligibility criteria, care coordination for program defined eligibility criteria, and non-direct services through community partnerships to the broader CSHCN population, as defined by MCHB/HRSA.

KDHE convenes the Kansas Maternal and Child Health Council (KMCHC) and the Title V Family Advisory Council (FAC) to ensure ongoing stakeholder engagement, monitoring of Title V performance and outcomes, and to provide opportunities to obtain input from subject matter experts to support innovation and early adoption of new strategies or initiatives on emerging needs, issues, or trends.

Kansas Demographics

Geography: Kansas, spanning 82,278 sq. miles, is divided into 105 counties with 627 cities.[1]
The U.S. Census Bureau has estimated that there were 2,913,805 residents living in the state on July 1, 2020.[2] 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 391,731. Within that same region also lies Pratt with a population of 6,463. 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 presents an opportunity for sharing resources.

Population Growth/Change: The Kansas total population increased by 8.1% between 2001 and 2020, including a 9.0% increase for males and a 7.3% increase for females.[2] The population increased from 2,913,314 residents in 2019 to 2,913,805 in 2020, a 0.02% increase. In 2020, there were an estimated 35,281 infants living in Kansas or about 1.2% of the total population (2,913,805). Women of reproductive age 15-44 accounted for 19.3% (562,644) of the population.

In 2020, there were 829,513 children and adolescents ages 1-21 years living in Kansas, which represents 28.5% of the population.[3] Based on five-year estimates from the American Community Survey (ACS) for 2016-2020, among children under 18 in households (excluding householders, spouses, and unmarried partners), 71.1% lived in a married-couple household, 7.9% lived in a cohabitating couple household, and for 21.0%, there was no spouse/partner present in the household.[4] According to the 2019-2020 National Survey of Children’s Health (NSCH), 20.7% of Kansas children ages 0 to 17 years (est. 144,547) were identified as having special health care needs (SHCN).[5] The prevalence of SHCN in boys and girls under 18 years was about the same, 20.8% (est. 69,868) and 20.6% (est. 74,679), respectively.

Population Density & Peer Groups (Urban, Semi-Urban, Densely-Settled Rural, Rural, Frontier): The population density of Kansas was 35.9 inhabitants per square mile in 2020,[6] based on data from the 2020 Census. Most counties in Kansas were classified as either frontier counties (less than 6.0 persons per square mile) or rural counties (between 6.0 and 19.9 persons per square mile). Urban counties were considered as those having 150.0 or more persons per square mile, and included six counties (Douglas, Leavenworth, Johnson, Shawnee, Wyandotte, and Sedgwick).

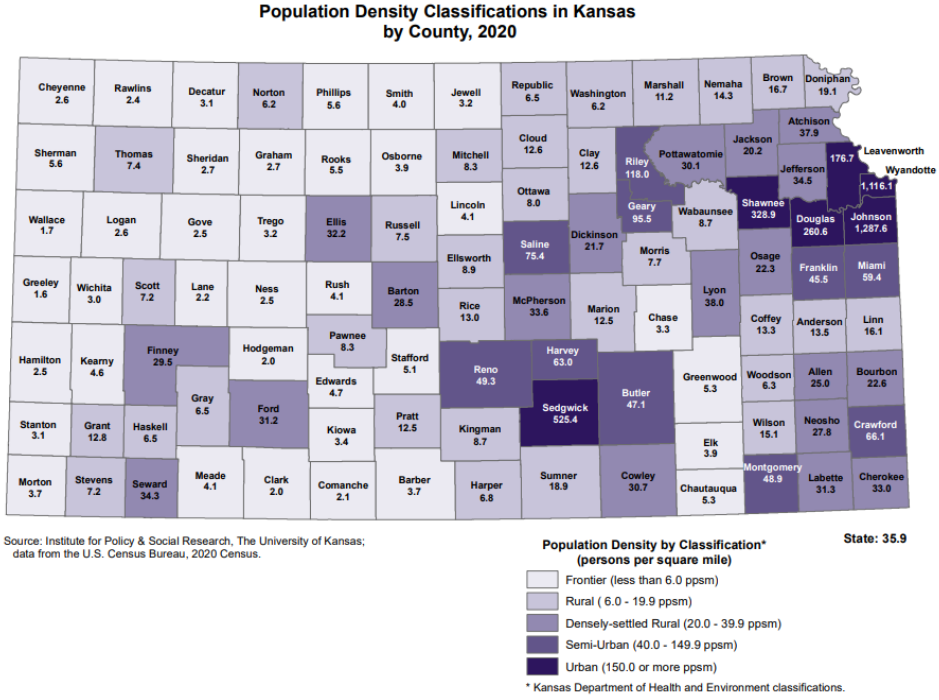
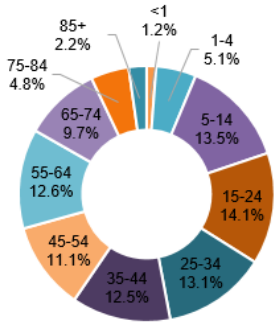


Image Credit: University of Kansas Institute for Policy & Social Research

Age: The median age of Kansans in 2020 was 37.3 years, a 5.4% increase from the median age of 35.4 in 2001.[2] The median ages of males and females in 2020 were 36.0 and 38.5, respectively. Shifts in the population distribution by age from 2001 to 2020 included decreases in the 0-4 age group (by 2.1%), 35-44 age group (by 11.6%), and 45-54 age group (by 12.5%). Increases were observed in the 5-14 age group (by 0.7%), 15-24 age group (by 0.7%), 25-34 age group (by 9.6%), 55-64 age group (by 60.8%), 65-74 age group (by 63.1%), and 75 and over age group (by 12.7%). These changes are likely due at least partially to the aging of the baby boomer population, as well as recent declines in the birth rate.

Distribution of Kansas Population by Age, 2020



Source: Kansas Department of Health and Environment, *Annual Summary of Vital Statistics, 2020*

In 2019-2020, the prevalence of SHCN increased with age, from about 9.1% among children 0-5 years old, to about 23.9% among those 6-11 years old, to 27.4% among those 12-17 years old.[5] The higher prevalence of SHCN among older children is likely attributable to conditions that are not diagnosed or do not develop until later in childhood.

Race/Ethnicity: The Kansas population is becoming more racially and ethnically diverse. Based on Census Bureau data for 2020, 75.1% of Kansans were of non-Hispanic White race, 5.7% were of non-Hispanic Black race, and 12.4% were of Hispanic ethnicity.[2] Among women of childbearing age (ages 15-44), 71.1% were of non-Hispanic White race, 6.1% were of non-Hispanic Black race, 0.9% were of non-Hispanic Native American or Alaska Native race, 4.3% were of non-Hispanic Asian and Pacific Islander race, 3.1% were of multiple races (non-Hispanic), and 14.5% were of Hispanic ethnicity.

Among Kansas children and adolescents (1-21 years) in 2020, 66.2% were of non-Hispanic White race, while about one-third (33.8%) belonged to a racial minority (i.e., either of Hispanic ethnicity, or of non-Hispanic

ethnicity and of any other race including multiple races).[7] Across age groups, the percentage of young children (1-5 years) and young adults (20-21 years) that were part of a racial/ethnic minority was about one-third, at 34.9% and 32.0%, respectively. More than one in six Kansans ages 1-5 years (19.1%), 6-14 years (19.1%), and 15-21 years (17.5%) were of Hispanic ethnicity. In 2019-2020, about 15.0% of Hispanic children were estimated to have SHCN.[5] The estimated prevalence of SHCN among non-Hispanic White children was about 22.1%.

Languages: Based on five-year estimates from the ACS for 2016-2020, among people at least five years old living in Kansas, about 11.7% spoke a language other than English at home.[8] Spanish was spoken at home by about 7.6%. Of those who spoke a language other than English at home, about 4.5% reported that they speak English less than "very well." According to the 2019-2020 NSCH, for about 90.5% of Kansas children, English was the primary language spoken in the home.[5]

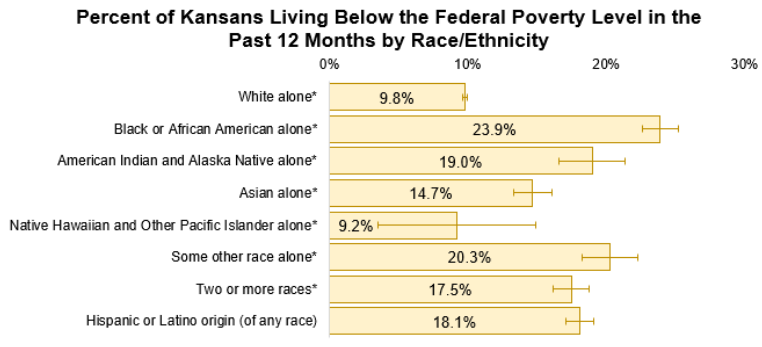
***Nativity*:** An estimated 93.0% of the people living in Kansas were U.S. natives, based on 2016-2020 five-year estimates from the ACS.[8] About 64.6% of those who were U.S. natives were living in the state in which they were born. Approximately 7.0% of residents were foreign-born. Of the foreign-born population, about 41.4% were naturalized U.S. citizens, and an estimated 73.6% entered the country before the year 2010. Most foreign-born residents (excluding those born at sea) were estimated to have come from Latin America (52.2%), followed by Asia (33.1%), Europe (6.7%), Africa (6.0%), Northern America (1.4%), and Oceania (0.5%).

Education: Based on 2016-2020 five-year estimates from the ACS, Kansas compared favorably with the U.S. average in terms of educational attainment, with about 91.4% of people 25 years and over with a high school education or higher, compared to about 88.5% for the U.S.[8] About one-third (33.9%) of Kansans 25 years and over had a bachelor's degree or higher, compared to 32.9% for the U.S. According to the 2019-2020 NSCH, approximately 10.8% of children (1-17) received services under a special education or early intervention plan, compared to 9.4% for the U.S.[5] Among Kansas children with SHCN, the estimated prevalence was 30.8%, compared to 32.2% among children with SHCN in the U.S.

Income/Poverty: Unemployment rose during the beginning of the COVID-19 pandemic and reached as high as 12.2% in April 2020 (seasonally adjusted).[9] More recently, in February 2022, the unemployment rate was 2.5%. As of May 2021, the median annual wage in Kansas was $38,050.[10] The top three occupations by employment were “Office and Administrative Support Occupations” with an annual median wage of $36,890, followed by “Transportation and Material Moving Occupations” with an annual median wage of $36,590, and “Sales and Related Occupations” with an annual median wage of $29,360.

For 2021, the federal poverty level was $27,479 for a family of four with two children, up from $26,246 in 2020.[11] Based on the 2020 Small Area Income and Poverty Estimates (SAIPE),[12] a lower percentage of Kansans lived in households with incomes below the federal poverty level compared to the U.S. overall (10.6% vs. 11.9%). Additionally, a lower percentage of children under age 18 lived in households with incomes below the federal poverty level (13.0% vs. 15.7% for the U.S.).

Based on 2016-2020 five-year estimates from the ACS, about 11.4% of all Kansans had lived in poverty in the past 12 months.[13] The percentage was highest among persons of Black or African American race alone (23.9%). Among Kansas children under 18 years of age, about 13.9% had lived in poverty in the past 12 months. Over half of all children in poverty (52.3%) were in five counties: Sedgwick (23.6%), Wyandotte (12.5%), Johnson (8.0%), Shawnee (5.5%), and Douglas (2.7%). However, rural areas of the state have many counties with high percentages of children living in poverty, as well.



* Includes Hispanic and non-Hispanic persons.
Error bars represent 90% confidence intervals (calculated from provided margins of error).
Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates. Table S1701.

Based on 2016-2020 five-year estimates from the ACS, the percentage of Kansas families living below the federal poverty level in the past 12 months was estimated at 7.6%, compared to 9.1% for the U.S.[14] Among families where the householder had related children in the household, poverty was more common among those with a female householder with no spouse present, compared to married-couple families. Among these families, the estimated percentage in poverty in Kansas (32.6%) was slightly lower than for the U.S. (34.4%).

Kansas Tribes: In 2020, the non-Hispanic Native American population in Kansas was 23,024, or 0.8% of the total population.[2] Kansas is home to four Indian reservations: Iowa, Kickapoo, Potawatomi, and Sac and Fox. American Indian individuals of various tribal affiliations can also be found in the towns and cities across the state.[15] It is not a requirement that someone be Native American to live on the Indian reservations; however, a non-Native American would be unable to build a home or live in tribal housing without the head of household being a tribal member. While many of the families who inhabit tribal lands are of multiple races, the head of household must be a tribal member to utilize tribal housing. In the event the head of household were to pass away or leave, the tribe could request that the non-Native parent and Native child leave tribal housing. The Potawatomi reservation is comprised similarly to that of a checkerboard in which areas of "tribal land" are surrounded by non-Native land, or vice versa.[16]

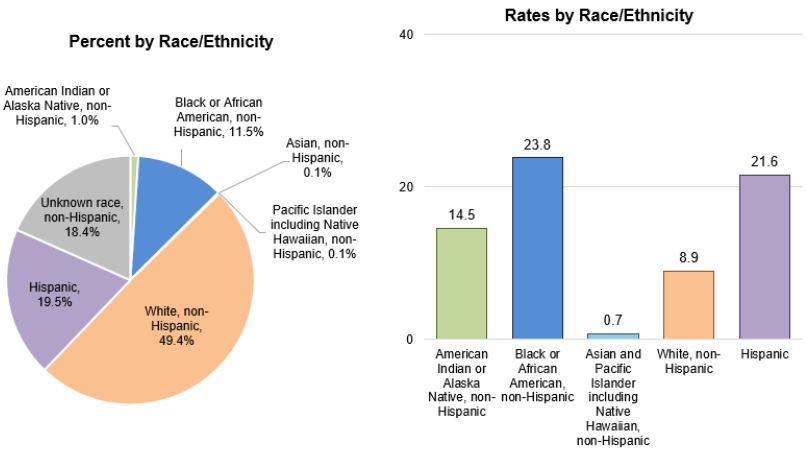
The American Indian and Alaska Native (AI/AN) population is disproportionately affected by many adverse health outcomes, including mental health conditions, suicide, unintentional injuries, obesity, sudden infant death syndrome (SIDS), and diabetes.[17] A recent analysis of nationwide mortality data from 2019 found that the non-Hispanic AI/AN population experienced much higher age-adjusted, cause-specific mortality rates compared to the non-Hispanic White population for many of the 15 leading causes of death, including homicide, chronic liver disease and cirrhosis, and diabetes.[18] Moreover, the AI/AN population may face barriers to accessing health care, such as cultural barriers, income limitations, and geographic isolation.[17]

Health Insurance Coverage & Medicaid/Children's Health Insurance Program (CHIP)

***Health Insurance Coverage*:** Data from the Small Area Health Insurance Estimates[19] show that the percentage of Kansas children under 19 years old without health insurance increased from 5.1% in 2015 to 5.7% in 2019. After a low of 4.5% in 2016, there was a slight increase in the uninsured population under age 19 in 2017 (5.2%), a slight decrease in 2018 (5.0%), then an increase in 2019 (5.7%). The U.S. percentage also increased from 5.0% in 2015 to 5.6% in 2019. In 2019, nearly half (49.8%) of all uninsured Kansas children under age 19 lived 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 where presumably many are not 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 2019-2020 NSCH,[5] in Kansas, 96.3% of CSHCN were reported to have some type of insurance at the time of the survey: 54.1% had private coverage only, while 35.0% had public coverage only.

In 2020, the average monthly eligibility rate for Medicaid and CHIP among Kansans[3,20] was highest for non-Hispanic Black persons at 23.8 per 100 people. The next highest rate, by race/ethnicity, was among non-Hispanic American Indian or Alaska Native persons at 14.5 per 100 people. Among Hispanic persons (of any race), the eligibility rate was 21.6 per 100 people.

Average Monthly Medicaid/CHIP Eligibles by Race/Ethnicity, 2020



Records with missing (blank) information on ethnicity (approximately 12.6% of all records) were categorized with the non-Hispanic category.
Records with missing (blank) information on race (approximately 9.8% of all records) were categorized with the Unknown race category.
Source: KDHE Division of Health Care Finance, CY 2020; U.S. Census Bureau, 2020 Bridged-Race Estimates

Kansas Medicaid: Also known as KanCare, Kansas Medicaid is administered through the KDHE Division of Health Care Finance. Medicaid provides health coverage for traditional Medicaid and CHIP. For most eligible groups, including children, pregnant women, low-income adults, people with disabilities and people with both Medicare and Medicaid dual eligibility, services are provided through a managed care model. Enrollees choose, or are assigned to, one of three managed care organizations (MCOs), who receive monthly payments from the state. MCOs are given incentives to ensure enrollees receive services that help reduce costs over time by improving their health and quality of life.[21]

Contracts with the MCOs require them to provide essential services through Medicaid, including prenatal care, well-child visits, preventive services, hospital care, medication, in home care, community-based services and nursing facility care. The MCOs also must ensure services are available statewide and at Medicaid-required levels. They may provide additional services not traditionally covered by Medicaid to help prevent hospital admissions or institutionalization. Additionally, Kansas has adopted seven Home and Community-Based Services (HCBS) waivers to provide flexibility around additional services not covered by Medicaid or CHIP.[21] See the table that follows for a list of those waiver programs.

Figure 11. Kansas Populations Eligible for Home and Community-Based Services (HCBS) Through Waivers and Their Institutional Equivalents

KANSAS HCBS WAIVER PROGRAMS	INSTITUTIONAL EQUIVALENTS
Autism (children; AU)	Inpatient Psychiatric Facility for Age 21 and Under
Frail Elderly (FE)	Nursing Facility
Intellectual/Developmental Disability (I/DD)	Intermediate Care Facility for Individuals with Intellectual Disabilities
Physical Disability (PD)	Nursing Facility
Serious Emotional Disturbance (children; SED)	Inpatient Psychiatric Facility for Age 21 and Under
Technology Assisted (children; TA)	Hospital
Traumatic Brain Injury (TBI)	TBI Rehabilitation Facility

Source: Kansas 1915(c) waivers

Image Credit: Kansas Health Institute, 2019 Medicaid Primer

Medicaid expansion is a current topic of discussion in Kansas. Kansas is only one of twelve states that has not expanded Medicaid coverage to all adults up to 138% of the federal poverty level. Several legislative initiatives have occurred in recent years, most recently in 2021; however, bills continue to be unsuccessful during regular legislative sessions. Other Medicaid policy initiatives listed below have been the focus for public health and Title V.

- *Postpartum Medicaid Expansion:* As a result of a collaborative effort between Title V and Medicaid, resulting in many conversations over the past two years with legislators and stakeholders the Title V team drafted an impact paper that assisted with getting this policy in place. Extension of postpartum coverage (up to one full year vs. only 60 days) was included in the Governor's signed SFY2023 budget. Medicaid is currently working on State Plan Amendment (SPA) and expects this policy to be in place soon and will retroactively apply coverage effective April 1, 2022.
- *Maternal Depression Screening:* A new policy became effective January 1, 2021, which authorized providers to screen for perinatal mood and anxiety disorders and bill under the child's Medicaid ID at well-child visits. Training and education for providers and technical assistance around billing and coding has been provided. The Behavioral Health Consultant is working with Medicaid to review preliminary data regarding the delivery of these screenings and policy impact.

Kansas' Strengths & Challenges

COVID-19 Pandemic Impact: The pandemic influenced Kansans' healthcare utilization, particularly in 2020 and early 2021, based on data collected over time by the US Census Bureau's Household Pulse Survey. For instance, during the period of March 3-29, 2021, 23% of Kansas adults living in households with children reported that they delayed getting medical care because of the pandemic.[22] Among those who were Hispanic or Latino (any race), the estimate was 34%. Among those who were Black or African American (both Hispanic and non-Hispanic), the estimate was 18%. Meanwhile, 20% of non-Hispanic White adults living in households

with children reported this. More recently, during the period of June 9-July 5, 2021, 13% of Kansas adults living in households with children reported this.

Basic needs, such as food security and housing, have also been a concern during the pandemic. During the period of October 28-November 23, 2020, 20% of Kansas households with children had little or no confidence in their ability to pay the next rent or mortgage payment on time.[22] For the same period, 17% of Kansas households with children sometimes or often did not have enough food to eat in the previous week. More recently, during the period of January 26-February 7, 2022, these estimates were 19% and 10%, respectively.

Health Equity and Disparities: Racial disparities persist in Kansas, particularly in MCH outcomes. The non-Hispanic Black infant mortality rate in Kansas is around twice that of the non-Hispanic White infant mortality rate.[23,24] Non-Hispanic Black persons are also affected by severe maternal morbidity at a significantly higher rate than persons from any other racial/ethnic group.[25]

Percent of Kansas Births with Adequate or Better Prenatal Care by Maternal Race/Ethnicity

Race and Ethnicity	2016-2018	2017-2019	2018-2020
White, non-Hispanic	87.5%	87.6%	87.5%
Black/African American, non-Hispanic	73.6%	73.3%	73.0%
Hispanic	71.3%	72.4%	73.3%
American Indian/Alaska Native, non-Hispanic	71.8%	69.7%	71.1%
Asian/Pacific Islander, non-Hispanic	84.1%	83.7%	83.2%
Other, non-Hispanic	76.8%	77.6%	77.5%

Source: Kansas 2016-2018, 2017-2019, and 2018-2020 three-year averages, Kansas birth data (resident)

Percent of Kansas Births with Low Birth Weight by Maternal Race/Ethnicity

Race and Ethnicity	2016-2018	2017-2019	2018-2020
White, non-Hispanic	6.6%	6.8%	6.7%
Black/African American, non-Hispanic	13.9%	14.3%	14.3%
Hispanic	6.8%	7.2%	7.2%
American Indian/Alaska Native, non-Hispanic	6.7%	6.6%	6.8%
Asian/Pacific Islander, non-Hispanic	8.1%	8.1%	8.7%
Other, non-Hispanic	8.9%	9.5%	9.0%

Source: Kansas 2016-2018, 2017-2019, and 2018-2020 three-year averages, Kansas birth data (resident)

Infant Mortality Rates (Deaths per 1,000 Live Births) by Race/Ethnicity in Kansas

Race and Ethnicity	2014-2018	2015-2019	2016-2020
White, non-Hispanic	4.9	4.7	4.8
Black/African American, non-Hispanic	11.7	11.6	12.9
Hispanic	7.1	7.1	6.9
American Indian/Alaska Native, non-Hispanic	7.7*	7.3*	**
Asian/Pacific Islander, non-Hispanic	4.4	3.1	2.8
Other, non-Hispanic	14.7	13.8	14.8

* Rate is statistically unreliable (Relative Standard Error > 30%).
** Estimate suppressed due to insufficient sample size (numerator < 6).
Source: Kansas 2014-2018, 2015-2019, and 2016-2020 five-year averages, Kansas death and birth data (resident)

Socioeconomic disparities are also prevalent in Kansas. Birth certificate data reveal that Medicaid-covered births are less likely than non-Medicaid-births to have had first-trimester prenatal care during pregnancy.[23] Medicaid-covered births also experience a higher prevalence of low birth weight and preterm delivery.

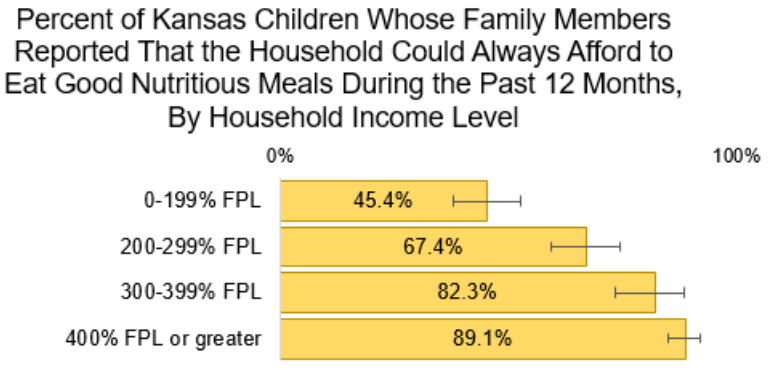
Kansas Birth Statistics by Payment Source for Delivery and Year[23,26]

NOM#	National Outcome Measures	Medicaid Measures	2016	2017	2018	2019	2020	Trend	HP2030	Sources
1	Percent of pregnant women who receive prenatal care beginning in the first trimester	CMS								1
	All		80.8%	81.2%	81.0%	80.9%	81.0%	●	-	
	Medicaid		70.2%	72.1%	71.7%	71.4%	72.3%	●		
	Non-Medicaid		85.8%	85.5%	85.3%	85.0%	85.3%	●		
4	Percent of low birth weight deliveries (<2,500 grams)	CMS								1
	All		7.0%	7.4%	7.4%	7.6%	7.3%	▲*	-	
	Medicaid		8.8%	9.5%	9.9%	9.7%	9.3%	▲*		
	Non-Medicaid		6.1%	6.4%	6.4%	6.7%	6.4%	▲*		
5	Percent of preterm births (<37 weeks gestation)									1
	All		9.1%	9.6%	9.5%	10.1%	10.0%	▲*	**9.4%**	
	Medicaid		10.8%	11.3%	11.4%	11.9%	11.9%	▲*		
	Non-Medicaid		8.3%	8.8%	8.6%	9.3%	9.1%	▲*		
6	Percent of early term births (37, 38 weeks gestation)									1
	All		24.4%	25.6%	26.3%	27.2%	27.4%	▲*	-	
	Medicaid		26.7%	28.3%	28.4%	29.3%	29.3%	▲*		
	Non-Medicaid		23.3%	24.4%	25.3%	26.2%	26.6%	▲*		

Image Source: KDHE Bureau of Family Health, Title V Outcome Measures and Performance Measures

Social Determinants of Health (SDoH): To better address negative trends and disparities in health outcomes, it is important to also understand physical and social determinants that can have a critical impact on one's ability to thrive in their environment. The U.S. Department of Health and Human Services groups SDoH into five areas: Economic Stability, Education Access and Quality, Health Care Access and Quality, Neighborhood and Built Environment, and Social and Community Context.[27] Some of these areas have been discussed previously; however, the examples in this section further illustrate how social determinants affect Kansans. When social determinants overlap, the risk of negative outcomes can grow. Kansas must work to address SDoH across multiple fronts to most effectively create change in communities.

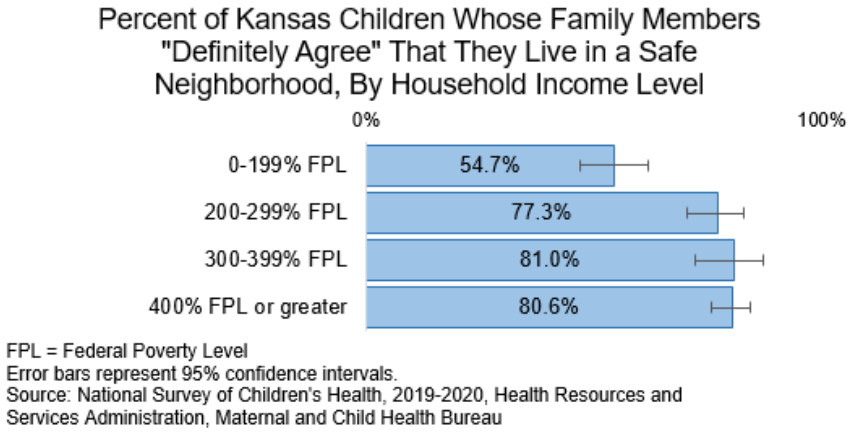
Economic Stability: Financial resources can influence health and well-being. Even families with an income above the federal poverty level may struggle to afford essentials, as an income around twice the federal poverty threshold may be needed to meet basic needs.28 Unfortunately, according to the 2019-2020 NSCH, about four in ten Kansas children with SHCN (40.9%) lived in households with incomes less than 200% of the federal poverty level.[5] An example of the importance of economic stability is access to healthy foods. According to the 2019-2020 NSCH, about 67.7% of Kansas children were part of households that could always afford to eat good nutritious meals during the past 12 months.[5] By income, the percentage was lowest (45.4%) among Kansas children whose household income was at 0-199% of the federal poverty level. The estimate among Kansas CSHCN was only 57.3%.



FPL = Federal Poverty Level
Error bars represent 95% confidence intervals.
Source: National Survey of Children's Health, 2019-2020, Health Resources and Services Administration, Maternal and Child Health Bureau

Neighborhoods and the Built Environment: The safety of a neighborhood can influence family well-being. According to the 2019-2020 NSCH, for 70.6% of Kansas children, a family member "definitely agreed" that the

child lived in a safe neighborhood.[5] However, just over half (54.7%) of Kansas children whose household income was at 0-199% of the federal poverty level lived in safe neighborhoods (based on a response of "definitely agree").



Education Access and Quality: According to the 2019-2020 NSCH,[5] Kansas children living in households with lower income are less likely to have adults in the household who have a college degree or higher education, compared to children living in households with higher income.

Health Care Access and Quality: Access to care has been recognized as a challenge for the MCH population living in both urban and rural geographic areas, but for different reasons. Families in rural areas may face barriers accessing transportation and getting to providers who may be unavailable in their area. Meanwhile, families in more densely populated areas may have a wider availability of services yet may not have time off work or the insurance needed to receive services. In addition to these barriers, the CSHCN population also often experiences reduced access due to the lack of pediatric specialists in the state.

As of April 2022, there were 33 counties with a Geographic Primary Care Health Professional Shortage Area (HPSA) designation, one of which was designated and under review.[29] In 2020, the supply of family medicine physicians per 100,000 population (17.8) was significantly lower in Kansas than the national average (29.9).[30] The supply of obstetricians/gynecologists (7.2)* was higher than the national average (5.7). The supply of pediatricians (6.2)* was lower than the national average (8.4).

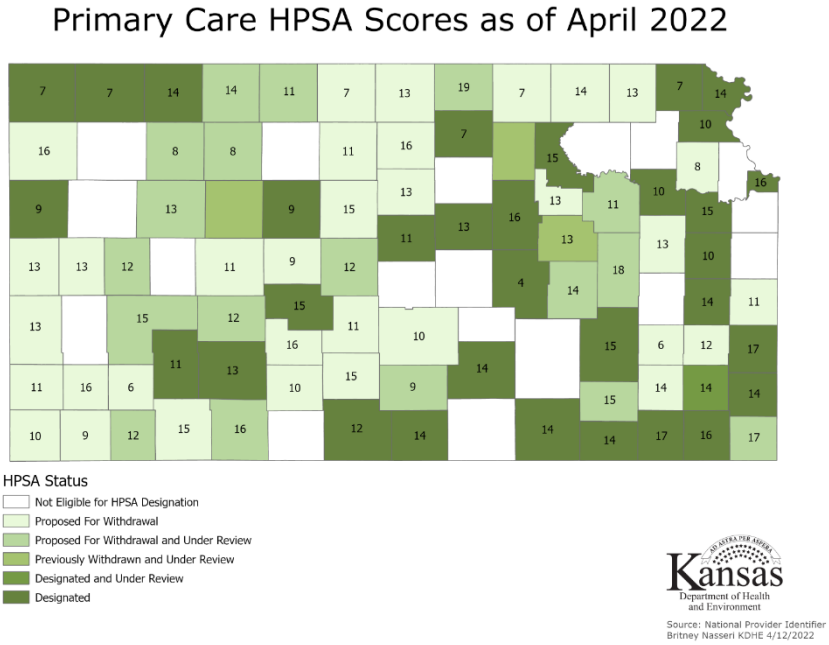


Image Credit: KDHE Office of Primary Care and Rural Health

* Indicator has a confidence interval width >1.2x the estimate and should be interpreted with caution.

Ensuring access to mental health care is also important. Two areas of emerging concern for the MCH population include youth suicide and perinatal depression. The suicide rate among Kansas adolescents ages 15-19 has increased significantly, from 11.6 per 100,000 in 2014-2016, to 19.3 per 100,000 in 2018-2020.[3,24,26] Depression is also common among the pregnant and postpartum population, with 14.3% of Kansans with a recent live birth in 2020 indicated as having symptoms of postpartum depression.[31]

Despite the need for mental health care in Kansas, 68 of the 105 counties in Kansas are designated as mental health professional shortage areas, or mental health HPSAs.[29] Meanwhile, 4 counties are proposed for withdrawal, and 27 are proposed for withdrawal and under review. Due to the shortage of providers, ensuring adequate access to mental health services for Kansas youth will require an innovative approach that increases capacity across a range of medical settings and offers new avenues for care. Kansas is home to more than 700,000 children, all of whom should have access to integrated healthcare. Such integration would require primary care providers (PCPs), including pediatricians, family practice physicians and non-physician PCPs who can screen, diagnose, and treat children and adolescents with uncomplicated mental illness, such as anxiety, depression, and attention-deficit/hyperactivity disorder (ADHD). A reformed model of care would also require the establishment of an expert pediatric mental health care team to provide training, consultation, and support services to PCPs.

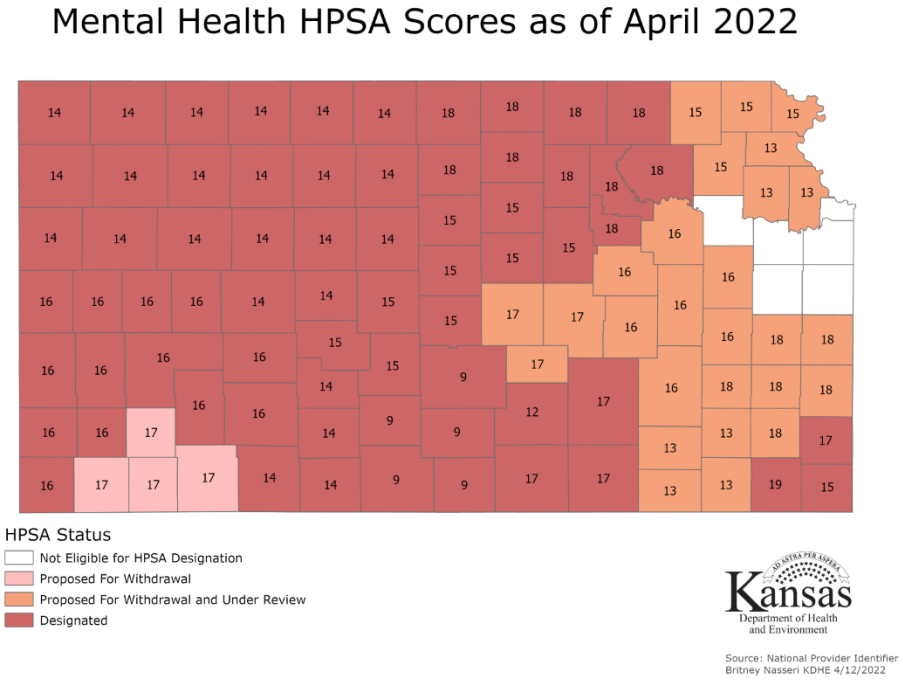
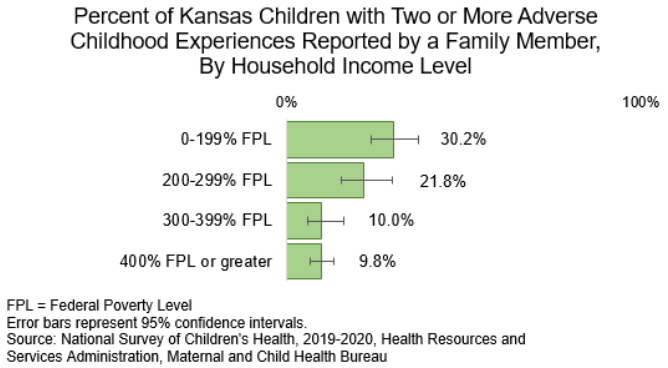


Image Credit: KDHE Office of Primary Care and Rural Health

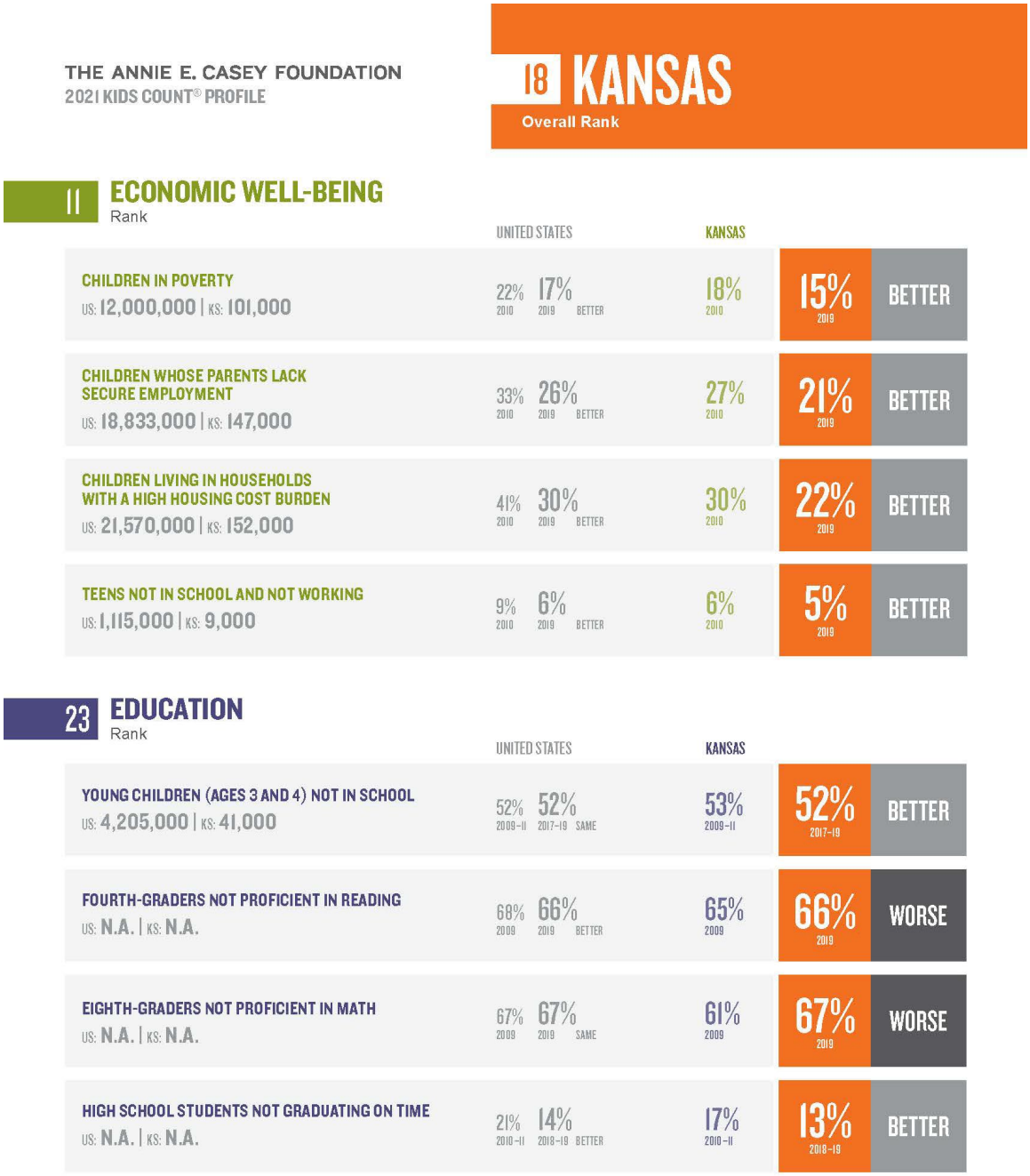
Other factors that can influence health are health literacy and providers' communication with patients. An area where increased health education is needed is in maternal health. Based on a review of pregnancy-related deaths that occurred in 2016-2018, the Kansas Maternal Mortality Review Committee (KMMRC) has emphasized the need for increased "patient education and empowerment" to help prevent future deaths.[25]

Social and Community Context: Social and community factors can influence health and well-being. For instance, adverse childhood experiences, such as incarceration of a parent or guardian, can negatively impact long-term well-being.[32] According to the 2019-2020 NSCH, 19.8% of Kansas children had been reported to have experienced two or more adverse childhood experiences.[5] The nationwide estimate was 18.1%. For Kansas CSHCN, the estimate was 37.9%.



State Rankings: Health ranking systems can help identify areas where Kansas is succeeding in comparison to other states, and areas where the state could improve.

- In 2021, the United Health Foundation's America's Health Rankings® ranked Kansas in the bottom half of states[33] in each of these areas: Physical Environment (39th), Clinical Care (31st), Behaviors (31st), and Health Outcomes (33rd). Kansas ranked 24th in Social and Economic Factors.
- The Annie E. Casey Foundation's (AECF) KIDS COUNT® Data Book uses 16 indicators to rank each state across four domains: (1) Economic Well-Being, (2) Education, (3) Health, and (4) Family and Community.[34] These represent what children need the most to thrive. The 2021 Data Book presents state profiles with trends (comparing data from 2010 with those from 2019, whenever possible), providing a picture of child well-being prior to the COVID-19 pandemic. Kansas ranked 18th for overall child well-being, 11th in economic well-being, 23rd in education, 25th in health, and 24th in family and community. The following images are from the Kansas 2021 KIDS COUNT® Profile.



State Health Agency Mandated Priorities – 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 Bureau of Family Health within the Kansas Department of Health and Environment has been a leader in these efforts.

Financial Assistance for CSHCN: Kansas Law mandates financial supports for health care services for CSHCN pursuant to K.S.A. 65-5a01, based on medical and financial eligibility, provided through the Kansas Special Health Care Need Program (KS-SHCN) and core Title V program. KS-SHCN provides this assistance through nine (9) direct assistance programs, referred to as DAPs. The chart below outlines the services available and eligibility for the DAP. Each of the following DAPs have eligibility criteria and annual maximum assistance amounts. All families who meet medical and financial eligibility for the program can receive support through up to two DAPs each year. More information can be found in the CSHCN Section.

DAP	Support Available	General Guidelines (100% Coverage)
Medication (DAP-Rx)	Prescribed Medication (For medications not covered by insurance)	Up to $10,000
	Nutritional Supplements, Vitamins, or OTC medications (limited to specific medical conditions)	Up to $1000
Medical Equipment and Supplies (DAP-ME/S)	Prescribed Durable Medical Equipment (DME) For clients who qualify at 100% coverage co-pays will be waived. For those who qualify at 50% or 25% coverage please see the co-pay guidance below. *The client must pay a co-pay as follows* *$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
	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
Travel (DAP-T)	Reimbursement at State rate	Up to $1000
Co-Payments/Deductibles/ Co-insurance (DAP C/D/CI)	Co-Payments/Deductibles/Co-Insurance Maximum amount will be based on client's portion of insurance coverage plan.	Up to a Maximum of $6,000
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
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, vision and dental appointments, with established providers. - Up to six (6) specialty care appointments ***Client must pay a $15 co-pay per appointment***	Up to $1000
	Medical Testing: - Laboratory Tests - X-rays	Up to $500 Up to $500
	Specialty tests	Up to $1,500
	Hospitalization/Surgery - Hospital Bill ***Client must pay $500 towards hospital bill*** - Hospital/Surgery Related Service	Up to $4,500 Up to $2,500
	Other Services - Physical, Speech, Occupational Therapy ***Client must pay a $15 co-pay per appointment*** - Interpreter Services (limited to authorized appointments)	Up to $1,200 Up to $700
	Other specialty care services, not listed	Up to $800
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
	Orthodontic Treatment Plan	Up to $7,000
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 with special circumstances may be eligible for additional assistance per program approval. * **PKU clients who are pregnant or nursing (limited to $1,200 per month)**	Up to $9,000 Up to $14,400
	Low-Protein Food Items (limited to individuals 18 or younger)	Up to $1,500
Caregiver Relief (DAP-CR) *Client must be diagnosed with a complex medical condition that requires specialty medical care. Eligibility will be determined by the KS-SHCN program.*	Reimbursement for trained and approved care providers (limited to $250 per month) *Services cannot be reimbursed for primary caregivers**	Up to $2,000

Infant Mortality Reduction: Kansas Title V is a lead partner in convening and facilitating efforts to reduce infant mortality and eliminate disparities in maternal and infant health. Over the past several years, the Title V program has invested in comprehensive approaches to prenatal care and education, tobacco/smoking cessation (before, during, after pregnancy), and pre/early term birth. From concept to reality, the state has worked to integrate initiatives into existing systems to provide the mechanism to achieve current success and future expansion of successful programs. There were 224 infant deaths in 2020, for an infant mortality rate of 7.1 infant deaths per 1,000 live births for Kansas residents.[2] This rate was 33.9% higher than the 2019 rate, which was 5.3 infant deaths per 1,000 live births. This does not meet the Healthy People 2030 target for infant

deaths, which is 5.0 infant deaths per 1,000 live births. The rate for non-Hispanic Black mothers in 2020 was 16.9 deaths per 1,000 live births, which was 3.4 times the rate among non-Hispanic White mothers (4.9 deaths per 1,000 live births). The rate for Hispanic mothers was 7.0 deaths per 1,000 live births. Infant death rates for non-Hispanic Black mothers have consistently remained higher than those of non-Hispanic White and Hispanic mothers for the past twenty years (2001-2020). Rates for Hispanic mothers have been higher than those for non-Hispanic White mothers in most years in the period.

Maternal Mortality Review: Within the population of women of reproductive age, maternal mortality (death of a woman during pregnancy or up to one year after pregnancy) is an indicator that is monitored by KDHE pursuant to K.S.A. 65-177. Kansas maternal mortality data are closely aligned with national trends, as there are clear patterns that can be identified within the data. The following Kansas women are at greater risk of maternal death and therefore remain target populations for prevention efforts: advanced maternal age (35 years or older); Non-Hispanic black women; and women who have lower levels of education, are unmarried (separated, divorced, widowed, or never married), those that have Medicaid or are uninsured, and live in rural areas. Severe maternal morbidity is also monitored by Title V. It is critical to understand the patterns and contributing factors considering these are situations that result in lifelong challenges or death.

Kansas' Systems of Care for Underserved & Vulnerable Populations

A focus of the Kansas Title V program is to provide ongoing leadership to advancing and improving systems of care for underserved and vulnerable MCH populations.

***Aid to Local Funding/Statewide MCH Network*:** To support this effort, KDHE contracts with local public health departments (independent entities) and Federally Qualified Health Centers (FQHCs) across the state to ensure provision of MCH services within a coordinated, family-centered system. When funds are allocated to external programs, the Bureau maintains contracts for the use of funds in support of MCH priorities. Services are delivered in compliance with Title V legislation and in accordance with the KS MCH Manual: dThe manual provides background on the Title V MCH Block Grant legislation/authority, KS MCH program principles, and service guidance and offers a vast appendix of resources related to practice and national performance measures.

The process with local agencies begins with the development of Grant Application Guidance and Reporting Materials annually in December. Materials are available by mid-January to local agencies applying for Title V funding. Due to the pandemic, KDHE wanted to provide local agencies extra time to complete grant applications. The applications opened December 15 with a due date of March 15. The review process informs funding recommendations and involves external reviewers applying guidance and a scoring matrix, a 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. More information about the MCH Aid to Local Program is available online through the Kansas Grant Management System (KGMS) site: https://kgms.ks.gov/.

Title V contracts with 55 local agencies to provide MCH services across the population domains and most local services funded by the Block Grant are delivered by local health departments and safety net clinics (independent entities). These agencies are positioned to provide 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 by the most recent needs assessment.

***Health Equity & Disparities**:* The agency has ramped up the investment into Health Equity with the creation of a dedicated staff member for health equity and the establishment of the Health Equity Action Team (HEAT). Two Bureau staff participate in the HEAT team and are actively involved in initiatives such as health equity training, hiring practices and data collection. To address disparities in the maternal and child health population, Title V has 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)

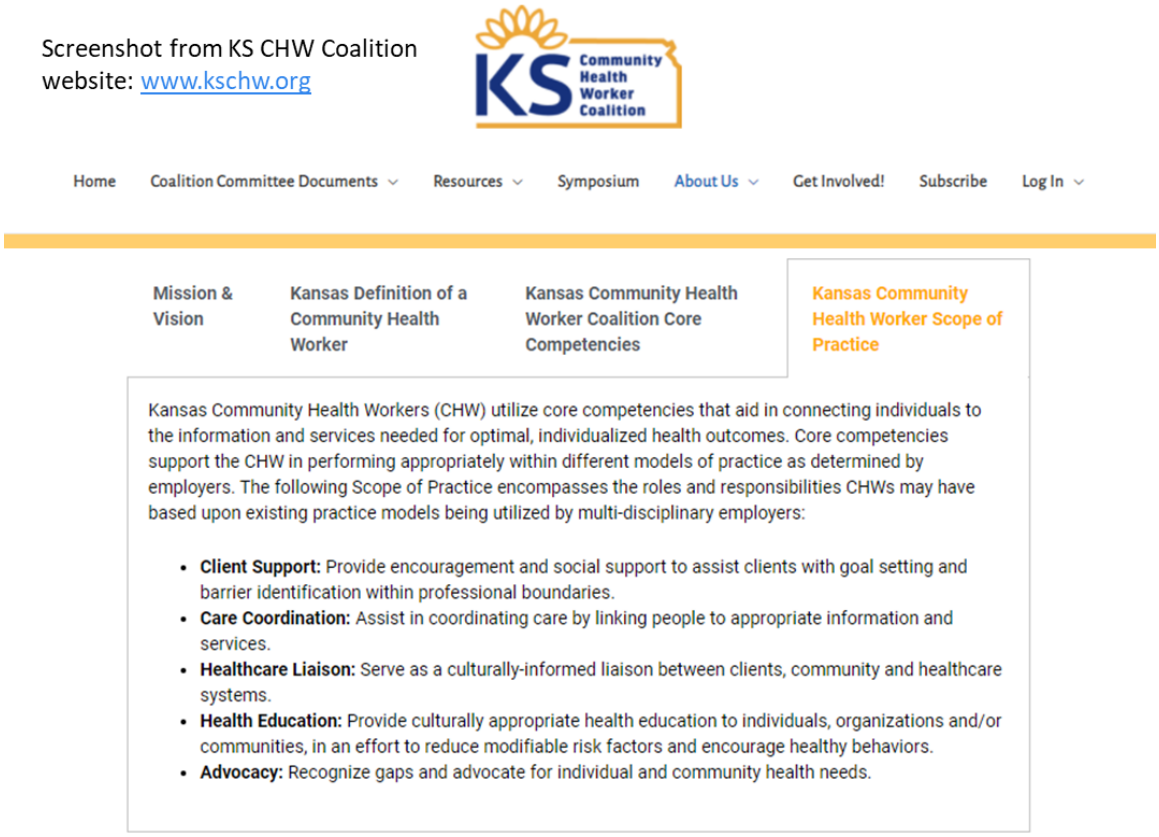
- Collecting quantitative and qualitative data through focus groups to determine impactful activities to address disparities in health outcomes within black and Hispanic communities.
- Increasing access to prenatal education and service access in communities with demonstrated disparities (Kansas Perinatal Community Collaboratives/Becoming a Mom®)
- Providing culturally appropriate prenatal education (bi-lingual curriculum and instructors)
- Providing culturally appropriate breastfeeding support and resources in communities with demonstrated disparities (e.g., Chocolate Milk Cafes [peer support] Black Breastfeeding Coalition, a Latina Breastfeeding Coalition, Spanish language breastfeeding training for home visitors, increased breastfeeding educators and peer counselors of color)
- Assessing the need for health coverage, transportation, housing, food, education, etc. (e.g., holistic care coordination)
- Exploring and implementing telehealth to increase access to care in rural and underserved areas.
- Including an equity lens on all aspects of the Title V State Action Plan and including specific strategies to combat health inequities.
- 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
    - Assuring Medicaid reimbursement for perinatal mood and anxiety disorder screening in multiple settings, including the pediatric setting
- Screening for social determinants through local MCH programs
    - Development of a prescreening tool that aligns across MCH programs that includes screening for SDOH, mental health, substance use, IPV, Tobacco use, pregnancy intention
- Development of a health equity learning collaborative that allows local communities to uncover root causes of a health equity issue in their community, this collaborative called the MCH Opportunity Project is currently in cohort 2
- Raising awareness of health disparities with public education campaigns in partnership with the Kansas African American Affairs Commission
- Expanding the Community Baby Shower model focused on safe sleep to integrate smoking cessation, breastfeeding education, behavioral health and referral to services on site; partnering with managed care organizations (MCOs) to align efforts
- Implementing a centralized, web-based data sharing system (DAISEY) that allows for monitoring outcomes and quality improvement along MCH programs; ongoing assessment if local programs are serving those most in need and in line with the Title V purpose
- Implementing a centralized, web-based data tracking system (Community Check Box) that allows monitoring of activities and initiatives focused on health equity and ethnic and racial minorities
- Supporting development among the MCH workforce through provision of health equity and SDoH trainings to the Family Advisory and Maternal and Child Health Councils

Systems of Care for CSHCN: Kansas aims to assess and address needs of all children and youth with special health care needs and their 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 CSHCN population. The Kansas State Plan for CSHCN provides opportunity to further engage with partners in ways to improve the system of care and collaborate more effectively and efficiently.

Community Health Workers: Title V has engaged heavily in the expansion of the community health worker (CHW) workforce. In partnership with United Methodist Health Ministry Fund (UMHMF), a cross-agency "steering committee" and broader "work group" has been convened to focus on credentialing and payment policies for CHWs. The Bureaus of Family Health and Health Promotion (BFH and BHP) represent KDHE on these groups.

CHWs support individuals by connecting them to the information and services needed for optimal, individualized health outcomes. Established by the Kansas CHW Coalition the following Scope of Practice (SOP) outlines roles and responsibilities of CHWs.

Screenshot from KS CHW Coalition website: www.kschw.org



This scope is distinctly aligned with the holistic care coordination (HCC) model supported through Title V public health. More information about this alignment and how CHW's are being integrated into the HCC initiatives can be found in the Cross-Cutting Report and Plan Narratives.

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NEEDS ASSESSMENT

The Kansas Title V team continued work related to the Title V Needs Assessment and State Action Plan (SAP) in partnership with many internal and external partners, the Kansas Maternal & Child Health Council (KMCHC), and the Family Advisory Council (FAC). Throughout the pandemic response, Title V staff and partners monitored needs of the MCH population and remained focused on the provision of core public health services and supports to help with continuity for families and individuals, and continue discussions around programming, expansion, services, monitoring, evaluation, and improving access to data. Programs and team members have adapted and maintained a focus on addressing local and state needs associated with the pandemic.

This section of the application outlines notable changes to the Title V/MCH organization and capacity to address the needs of MCH service delivery systems, the impact the pandemic has had on MCH populations in Kansas and how Title V is monitoring these needs, stakeholder and public input activities as part of the Kansas ongoing needs assessment process, plans for an interim needs assessment in the coming year, key partnerships and collaborations to advance systems of care for MCH populations, and other promotion and outreach activities.

Changes in MCH Population Health Status & MCH Program Response

Kansas Title V has created tools used by the program to continuously monitor the Title V outcome, performance, and strategy measures.

- *Performance Measure Snapshot:* This document is updated annually and reflects all Title V NOMs, NPMs, and SPMs. The document is shared and discussed with the Title V team and KMCHC throughout the year as it relates to review of the action plan and priority work. The document is made available on websites for stakeholders and the public. A sample of this snapshot is depicted below. The complete file can be found online at https://www.kansasmch.org/guidingresources.asp.

Kansas Department of Health and Environment

Title V Outcome Measures and Performance Measures
Kansas Maternal and Child Health Services Block Grant
2023 Application/2021 Annual Report

KANSAS MATERNAL & CHILD HEALTH

NOM#	National Outcome Measures	Medicaid Measures	2016	2017	2018	2019	2020	Trend	HP2030	Sources
1	Percent of pregnant women who receive prenatal care beginning in the first trimester	CMS								1
	All		80.8%	81.2%	81.0%	80.9%	81.0%	●	-	
	Medicaid		70.2%	72.1%	71.7%	71.4%	72.3%	●		
	Non-Medicaid		85.8%	85.5%	85.3%	85.0%	85.3%	●		
2	Rate of severe maternal morbidity per 10,000 delivery hospitalizations		56.1	56.7	61.8	65.9	71.0	▲*	**61.8**	2
3	Maternal mortality rate per 100,000 live births (5-year average, 2014-2018, 2015-2019, 2016-2020)		-	-	14.8	16.7	19.9	▲	**15.7**	3
4	Percent of low birth weight deliveries (<2,500 grams)	CMS								1
	All		7.0%	7.4%	7.4%	7.6%	7.3%	▲*	-	
	Medicaid		8.8%	9.5%	9.9%	9.7%	9.3%	▲*		
	Non-Medicaid		6.1%	6.4%	6.4%	6.7%	6.4%	▲*		
5	Percent of preterm births (<37 weeks gestation)									1
	All		9.1%	9.6%	9.5%	10.1%	10.0%	▲*	**9.4%**	
	Medicaid		10.8%	11.3%	11.4%	11.9%	11.9%	▲*		
	Non-Medicaid		8.3%	8.8%	8.6%	9.3%	9.1%	▲*		

- *Evidence-based or informed Strategy Measures (ESM) Tracking Snapshot:* This document is updated quarterly for internal use and discussion by the Title V state team. The information is shared periodically with the KMCHC and local agencies providing MCH services in an effort to indicate the status of process measures intended to advance the NPMs.

Using these snapshots, we can easily identify trends and monitor progress related to plan measures and related objectives. The following images outline the statistically significant trends associated the Title V

performance measurement framework. Utilizing these tools, we raise awareness and increase capacity for staff, stakeholders, and partners to identify and discuss emerging issues, target programming efforts, and act as appropriate.

The data snapshots of each MCH population domain below depict the 2021-2025 State Action Plan progress in action. Arrows indicate trends (up/down); stars indicate progress made (yes/no); circles indicate no shifts in trend; triangles indicate a change in data source, objective, or programmatic focus; two hyphens indicate that data are not yet available.

NPM 1: Well-woman visit (Percent of women, 18-44, with a past year preventive medical visit)

ESM 1.1: Percent of women **program participants** (18-44 years) with a preventive medical visit in the past year

2018 – 71.4%
2020 – 72.2%

SPM 1: Postpartum depression (Percent of women who experience postpartum depressive symptoms following a recent live birth)

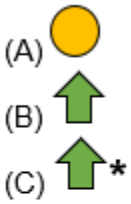
SPM-ESM 1.1: Percent of MCH program participants **screened** for depression and anxiety during pregnancy and/or the postpartum period using the Edinburgh Perinatal/Postnatal Depression Scale (EPDS)

SPM-ESM 1.2: Percent of pregnant/postpartum MCH program participants who **received a referral** in response to a positive screen for depression or anxiety through the Edinburgh Perinatal/Postnatal Depression Scale (EPDS)

2017 – 12.4%
2020 – 14.3%

NPM 5: Safe sleep
(Percent of infants placed to sleep
(A) on their backs;
(B) on a separate approved sleep surface; and
(C) without soft objects or loose bedding)

ESM 5.1: Percent of **Kansas Perinatal Community Collaboratives (KPCC) participants** who placed their infants to sleep (A) on their backs; (B) in a crib/bassinet or portable crib



(A) 2017 – 80.2%
2020 – 82.3%
(B) 2017 – 37.3%
2020 – 46.1%
(C) 2017 – 44.3%
2020 – 54.8%
* **Statistically significant**

SPM 2: Breastfeeding (Percent of infants breastfed exclusively through 6 months)

SPM-ESM 2.1: Percent of **WIC non-Hispanic Black infants** breastfed exclusively through six months

Birth year:
2016 – 31.4%
2018 – 32.0%

NPM 6: Developmental screening (Percent of children, 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year)

ESM 6.1: Percent of children who received a parent completed developmental screen during an infant or child visit provided by a **participating program**

2016 – 41.6%
2019-2020 – 44.3%

NPM 10: Adolescent well-visit (Percent of adolescents, ages 12-17, with a preventive medical visit in the past year)

ESM 10.1: Percent of adolescent **program participants**, ages 12-17, that had a well-visit during the past 12 months

2016 – 79.8%
2019-2020 – 75.6%
* **Statistically significant**

NPM 12: Transition (Percent of adolescents with and without special health care needs [SHCN], ages 12-17, who received services necessary to make transition to adult health care)

ESM 12.1: Percent of youth with special health care needs, ages 12-21, who have **one or more transition goals** achieved on their action plan by the target completion date

With SHCN:

Without SHCN:

With SHCN:
2016 – 16.6%
2019-2020 – 33.5%
* **Statistically significant**

Without SHCN:
2016 – 15.7%
2019-2020 – 20.6%

SPM 3: Workforce Development (Percent of participants reporting increased self-efficacy in translating knowledge into practice after attending a state sponsored workforce development event)	--	Data not yet available for this measure
SPM-ESM 3.1: Percent of participants reporting **increased knowledge** after attending a state sponsored workforce development event	--	Data not yet available for this measure
SPM 4: Family Strengths (Percent of children whose family members know all of the time they have strengths to draw on when the family faces problems)	↑*	2016 – 52.0% 2019-2020 – 56.2% * **Statistically significant**
SPM-ESM 4.1: Number of **MCH participants** receiving holistic care coordination		
SPM-ESM 4.2: Percent of families enrolled in **Special Health Care Needs Care Coordination Program** that have increased their ability to independently navigate the systems of care		

MCH Population Needs Identified as a Result of the COVID-19 Pandemic:

NEW NARRATIVE

COVID-19 Health Disparities: Kansas recently applied for the Centers for Disease Control and Prevention "National Initiative to Address COVID-19 Health Disparities Among Population at High-Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities" grant ($31M). Due to the vast health disparities (e.g., racial inequities; socioeconomic disparities; lack of culturally accessible care; living, working, and health conditions) exacerbated during the pandemic, Kansas identified four strategies to reduce disparities and increase capacity for current and future responses. These include: chronic disease prevention and management programming established in eight communities; expansion of Local Health Equity Action teams (LHEAT); state and county equity-related infrastructure across cross-jurisdictional Districts, including bilingual communication support and health equity champions; and the creation of the Office of Diversity, Equity, and Inclusion (DEI) at KDHE. The Office of DEI will support statewide efforts and create/sustain a culture where DEI frames every public health initiative during COVID and beyond. The Title V MCH Director was instrumental in the development of the project narrative and provided expertise, guidance, and alignment support.

Title V COVID-19 Response Activities: The COVID-19 pandemic affected many people and programs within the state, including programs within the Bureau of Family Health and Title V. The engagement of Title V in initial and ongoing pandemic response efforts has provided a unique view and understanding of the needs of the populations. Additionally, involvement has provided a foundation for the Title V team to monitor and assess health outcomes following the pandemic. The team is prepared to adapt and adjust as necessary to meet the growing needs of families as the aftermath of the pandemic becomes more apparent.

In addition to providing support, technical guidance, and flexibility for our local MCH grantees, individual members of the Title V team were integral to specific COVID-19 response activities outlined below.

- *KDHE Incident Command and Response.* The BFH/Title V MCH Director has been a part of the agency response team since Incident Command was established and the statewide emergency was declared by the Governor in March 2020. Activities include/have included but are not limited to:

- participating in incident command briefings three times weekly, local public health updates/webinars (previously daily, then three times weekly, now once weekly), and weekly calls with providers;
- providing updates to the Governor, State Health Officer/Secretary, and/or response team related to all aspects affecting the MCH populations, with special emphasis on pregnant women, infants, young children, individuals with special health care needs, schools, and child care facilities;
- coordinating the drafting, updating, approving, and posting of COVID-19 guidance for all BFH programs and public health priority areas of work and COVID-19 response (e.g., exposure, testing, vaccine) for a variety of audiences including other state agencies, public health workforce, providers, families, and the public;
- monitoring the impact on pregnancy health and birth outcomes (internally and with MCH partners including members of the perinatal quality collaborative executive team);
- initiating and maintaining collaboration and communication across state agencies as it pertains to developing guidance, proposals/plans, response, accommodations, and more;
- serving as member of the Navigating 2020 Department of Education workgroup focused on developing guidance for schools to safely operate during the pandemic using a variety of methods (in person, virtual/remote, hybrid); and
- participating in ongoing conversations related to allocating/investing federal relief funds originating from a variety of sources and federal legislation focused on public health, child care, and behavioral health.

- *Kansas: Stronger Together*. At the onset of the pandemic, an overwhelming amount of information related to COVID-19 was available in every media outlet. As part of the initial state response, a collaborative effort began across state agencies such as the Kansas Department for Aging and Disability Services, Kansas Department of Health and Environment, Kansas Department of Agriculture, and Kansas Division of Emergency Management to create the Kansas Resource Guide for COVID-19 that was shared widely with state, local, and community partners to increase both knowledge and availability of resources and services during COVID-19. Title V staff were involved in this effort to share accurate and timely information and resources, specifically information and resources for the physical, mental, and emotional well-being of citizens. A primary goal was to alleviate stress and anxiety and reduce the spread of misinformation. The guide included information and resources related to topics such as: COVID-19, Mental Health, Substance Use, Anti-Violence, Parenting, Household, Agriculture, Information, and Business and Legal. The guide, and later a website, phone number, social media campaign, and broader outreach program emerged – all together known as *Kansas: Stronger Together* crisis counseling program. The program is authorized under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act) Crisis Counseling Regular Services Program, funded by the Federal Emergency Management Agency (FEMA).
- *Coronavirus Relief Fund (CARES Act) Programs.* The Title V MCH Director was assigned to a cross-agency workgroup established by the Governor's Office in July 2020 to make recommendations about how to allocate/invest relief dollars. Workgroups submitted proposals to the Strengthening People and Revitalizing Kansas (SPARK) task force; approved recommendations were sent on to the State Finance Council for approval and implementation beginning August 2020. Planning and drafting of proposals was completed collaboratively with other state agency directors from the Children's Cabinet, Department for Children & Families, and Department of Education. Focus was on identifying immediate and ongoing needs of MCH populations and families, with emphasis on the early childhood workforce and young children. Three projects were assigned to the Title V MCH Director and implemented with Bureau of Family Health (BFH) staff and partners.
    - The Child Care Health Consultant Network was implemented in partnership with Child Care Aware of KS and to assist licensed child care providers with mitigating the spread of COVID-19 and continue safe operation. Between September and December 2020, approximately $2.5M in funding was awarded to 440 home and center-based facilities across the state, reaching nearly 12,000 children in care (infant through school age). The program continues with alternate funding.
    - BFH Special Health Care Needs administered the COVID-19 Essential Worker Health Fund (WHF) (http://ksherorelief.com) between August 2020 and January 2021. The fund was established to provide assistance for essential workers (e.g., first responders, medical

personnel, teachers, grocery workers, maintenance workers, military, child care providers) who contracted COVID-19. The program's existing infrastructure was uniquely positioned to implement and oversee the fund which included $3M set aside for early childhood professionals and $5M for other essential workers. Once an individual was eligible, they were linked to a care coordinator who provided the appropriate referrals/linkages/reimbursement. Kansas workers received financial support for medical expenses, lost wages, and miscellaneous expenses incurred due to COVID-19. The program processed 690 applications. Approximately 500 Kansans qualified and received payments totaling $1.6M.

    - The Technology for Families (TFF) program was implemented in partnership with the Children's Cabinet and the University of Kansas Center for Public Partnerships and Research. Existing home visiting programs funded by state agencies were engaged to identify families across the state who were vulnerable for health and social hardships due to a lack of digital connectivity. The local programs then applied for funding to purchase and distribute devices (tablets, laptop computers and mobile phones) as well as internet connection via internet service plans, hot spots, and data cards. A total of 49 programs received more than $750,000 and delivered 1,567 devices and 1,621 instances of connectivity to 1,584 households with 3,280 young children in 71 of 105 counties (35% rural).

- *Infant Toddler Medicaid COVID-19 Policies:* With support and guidance from the Title V Director and the Children and Families Unit Director, the Kansas Infant Toddler Services (ITS) team worked closely with the Medicaid program to reimburse early intervention services provided via telemedicine. This collaboration was critical to supporting sustainability of services during the pandemic. In addition, during spring of 2021, BFH and Medicaid partnered to update the Kansas Medical Assistance Program (KMAP) Manual for Early Childhood Intervention to support correct billing procedures and enhance systems alignment.

Ongoing Needs Assessment Activities

Internal Coordination Efforts: Internal Title V/MCH team meetings are held regularly, coordinated by the MCH Block Grant Coordinator, to ensure the teams remain on target with priority work and relevant efforts. A system was developed by the team for ongoing assessment to track progress with measures and identify program responses based on the data (Ex: develop a TA webinar, conduct site visits, provide resources/materials, and plan a conference or skills building session).

MCH Leadership Meetings: MCH Leadership meetings are convened and coordinated by the Block Grant Coordinator among the Title V MCH and CSHCN Directors and the Children & Families and System of Supports Section Directors. At this time, the Block Grant Coordinator, CSHCN Director, and System of Supports Section Director is represented by one individual. MCH Epidemiologists and Bureau Unit Directors (e.g., Community Partnerships, Title V Consultants) are invited as appropriate to agenda items and leadership discussions. The purpose of these meetings is to ensure communication regarding Block Grant activities and oversight, address systems and cross-section collaboration activities and needs.

Purpose	Key Activities and Discussion Points
Title V Oversight	• Broad monitoring of aligned efforts • Updates and guidance as needed • Monitor Block Grant submission activities
Cross-Section Collaboration / Activities	• Discuss Title V workforce needs (e.g., staffing needs/gaps, training, guidance, supports) • Identify needed support for collaboration activities
System Needs	• Discuss system needs (e.g., new partnerships, fiscal resources, new initiatives, statewide activities)

MCH Coordination Meetings: Convened by Block Grant Coordinator with intentional alignment and coordination with MCH Leadership and the planning teams for the Kansas Maternal and Child Health and Family Advisory Councils. These are action-oriented working meetings among core Title V staff and intended to support transparent, collaborative processes and shared decision-making around the Block Grant and MCH

service delivery systems. Other subject matter experts, program partners, and consultants are invited as appropriate to agenda items.

Purpose	Key Activities and Discussion Points
MCH & Block Grant Core Functions	• Ongoing needs assessment, emerging issues, data/measure trends, disparities/inequities, BG report/application (e.g., guidance, timelines, submission needs, writing assignments, staff support needs) • Aid to Local (MCH & SHCN) network: funding/awards/monitoring and shared decision making • Title V coordination and collaboration needs related to other BFH programming (e.g., ITS, WIC, CCL, NBS, BDS, Title X), other bureaus (BHP, BDCP, BOH, BEPHI), and divisions (DHCF/Medicaid) • Family & Consumer Partnership/Engagement
Monitoring & Evaluation	• Review data trends (e.g., presentations by Epis, data from Title V programming/projects, emerging national data and comparisons with KS, spotlight on disparities by population domain) • SAP Monitoring (high-level, focus on coordination/collaboration) • BG Evaluation Plan (as related to coordination or collaboration activities or how the data reflects our progress) • CCB utilization and sensemaking reflection/needs
Workforce Development	• KMCHC and FAC Meetings (e.g., alignment, agenda development, Council activities/work group feedback; debriefs and action items) • BFH Staff needs (e.g., emerging issues, training needs, expanded skill development) • ATL network and other partner needs, including families/consumers

Key topics of conversation during MCH Coordination meetings this past year include: planning for federal Block Grant review; expansion of family engagement and consumer partnership efforts; revisions and utilization of the Community Check Box; alignment and collaborative review of final new 5-years SAP (including an internal monitoring spreadsheet to share key progress and future plans among the team); special presentation from community partners (e.g., 1-800-CHILDREN); KMCHC and FAC planning efforts; evaluation skills-building workshop; MCH/SHCN Aid to Local funding recommendations; preparations for Block Grant public input processes; among other alignment, partnership, and collaboration discussions.

Stakeholder and Public Input Activities

Kansas Maternal & Child Health Council (KMCHC): The KMCHC serves in an advisory capacity to the Title V Program on ways to improve the health of families in Kansas, focusing on the MCH population. The Kansas Chapter of the American Academy of Pediatrics (KAAP) serves as the lead agency and fiscal agent for the Council. As a professional organization comprised of pediatricians with a professional affiliation to obstetricians, gynecologists, family practice physicians, and other professionals dedicate to promoting improved maternal and child health and delivery of care, KAAP is poised to support Title V in this capacity.

Guided by the Title V Needs Assessment and SAP, the Council strives to assure access to high quality MCH services and improved outcomes for Kansas women, children, and families. The structure of the quarterly council meetings is key to advancing the plan. Each meeting entails large group discussions and presentations on MCH investments/initiatives (e.g., safe sleep, birth outcomes, breastfeeding, school health) and/or workforce development topics (e.g., life course, human trafficking, family and consumer partnership/engagement) as well as small group sessions focused on domain action plans/efforts.

Title V Population Work Groups are critical to the infrastructure of the Council. These small groups are charged with prioritizing focus for the assigned target population, providing recommendations, informing of gaps in service delivery systems, refining objectives and strategies to remain relevant and support effective/efficient MCH services, identifying partnership needs, discussing capacity concerns, among other tasks. The full council membership participates in small groups as part of each meeting. The Council includes seven work groups to include dedicated space and monitoring of each of the seven state priorities under the SAP and the specific

targeted population for each. Each member serves in two groups, one from the core population groups (women/maternal, perinatal/infant, child, adolescent) and one of the cross-cutting groups (CSHCN, workforce development, family supports).

Council membership is comprised of a multidisciplinary team of professionals with expertise in MCH. Membership is divided into four primary membership types: community/state partner, health care provider, family/consumer, and staff. Learn more about the MCH Council, review membership, and access materials and resources online: www.kansasmch.org.

Kansas Family Advisory Council (FAC): The FAC is designed to assure the needs of families and consumers are central to programming, initiatives, and special projects. In other words, making sure the needs of families are first and foremost in our minds in all we do. The main goal is to learn from family and consumer experiences to make better program decisions and run programs with the needs of the family/consumer at the center of what we do. The purpose of the FAC is directly aligned with the purpose of the KMCHC to support partnership and collaboration across these groups. To further support alignment and coordination, the mission of the Title V is carried out in the mission statement for both the FAC and KMCHC.

The FAC expanded dramatically in 2021, from ten active members focused primarily on the CSHCN population, to at the time of this report, thirty-eight members representing each MCH population domain. This supports the vision of the FAC where "individuals and families are (1) engaged in program planning, evaluation, service delivery, and policy development; (2) partners in advocacy; and (3) leaders in their communities." To accomplish this, the FAC will establish five core work groups (Women/Maternal, Early Childhood, Child, Adolescence, and CSHCN) that will provide space for families to focus on specific areas of the Title V SAP. Members of the FAC are valuable partners in the Title V work (read more about the FAC in the Family Partnership Section).

Title V Partnerships and Collaboration in Monitoring & Assessing Title V Activities

KMCHC and FAC: The KMCHC and FAC actively participate in monitoring of the SAP and assists with prioritization and assessment of progress on a regular basis. This is evident in the way agendas are developed, with intent to provide expanded knowledge and understanding of MCH issues affecting populations (large group work) and review of the state action plan (small group work) as it pertained to progress with domain priorities, objectives, and strategies. The small groups are based on the population domains and Kansas priorities and offer a platform for members to learn about progress within the SAP, discuss emerging issues, recommended changes, new partnerships or expanded collaboration opportunities. Summaries of agendas and crucial work performed by each Council can be found in Supporting Documents submitted with this application.

Center for Community Health and Development: In coordination with the KU Center for Community Health and Development (KU-CCHD), the core Title V team is convened to review the data available through the KS MCH Community Check Box, which includes looking at accomplishments entered to date and engaging in a systematic reflection on patterns in MCH activities and indicators, asking questions such as:

- What we are seeing?
- What it means? (e.g., enabling/impeding factors or activities associated with increases/decreases)
- Implications for adjustment

Purpose	Key Activities and Discussion Points
Accomplishment Review	• Discuss Inputs/Process Activities (e.g., quantity/timing, distribution, impacting factors) • Review aggregate accomplishments data (e.g., what can we learn from our activities, actions, and reach) • Evaluate aggregate accomplishments data (e.g., what does the data tell us about reach and impact)
Activity-Level Evaluation	• SAP Monitoring (activity-level, focused on completion and reach of specific activities) • BG Evaluation (as related to coordination or collaboration activities or how the data reflects our progress)

More information about the CCB can be found in the Other MCH Data Capacity narrative.

Community Health Worker Partnerships: From holistic care coordination (HCC), roundtable sessions, a survey, and continued conversations with primary care and care coordination providers, it was identified that HCC can happen within or outside of the primary care setting and that there does not need to be a specific title of the person providing the services. The most important consideration is that the services be available and accessible. Following these findings, and the recognition of the CHW initiative there was an opportunity for integrating the work.

The CHW training and mission were reviewed to assess alignment with the HCC approach. The HCC approach follows the CSHCN care coordination model but is also in alignment with the National Care Coordination Standards for Children and Youth with Special Health Care Needs developed by the National Academy of State Health Policy. CHW curriculum and the Standards were compared to identify alignment. Following comparison of the curriculum and Standards, HCC work has been shifted to focus on the services instead of the service provider, showing that HCC does not need to be done only by one specific provider, and can take place in many different settings.

Title V MCH Promotion & Outreach: Title V continues to promote the MCH block grant services and federal-state-local partnership. The state action plan priority areas and Title V investments are shared widely on an ongoing basis. The MCH website (www.kansasmch.org) and Facebook page (www.facebook.com/kansasmch) continue to gain popularity. Analytics reveal a general increasing trend in terms of page visitors and visits since launch.

PROGRAM PURPOSE AND DESIGN

Vision & Commitment

The KS Title V program demonstrates strong commitment to coordinating and collaborating beyond mandated work such as reducing infant mortality and providing services to individuals with special health care needs. The state is truly committed to addressing the emerging and ongoing needs of all MCH populations and continuously focusing on quality improvement. This commitment drives development of integrated systems of care, assessment for community level MCH initiatives, family and consumer engagement, and service coordination through innovative approaches to ensure families receive the right support and services they need to thrive. There is increased focus on behavioral health as part of whole-person health and addressing the needs of MCH populations impacted by issues such as substance use, anxiety, and depression. Transforming systems to better serve individuals and families in our state 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, especially for those most vulnerable and at risk.

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 outcomes and drive priority activities is at the core of the KS system. Activities are supported and made possible through strong leadership, a committed team, and epidemiology capacity.

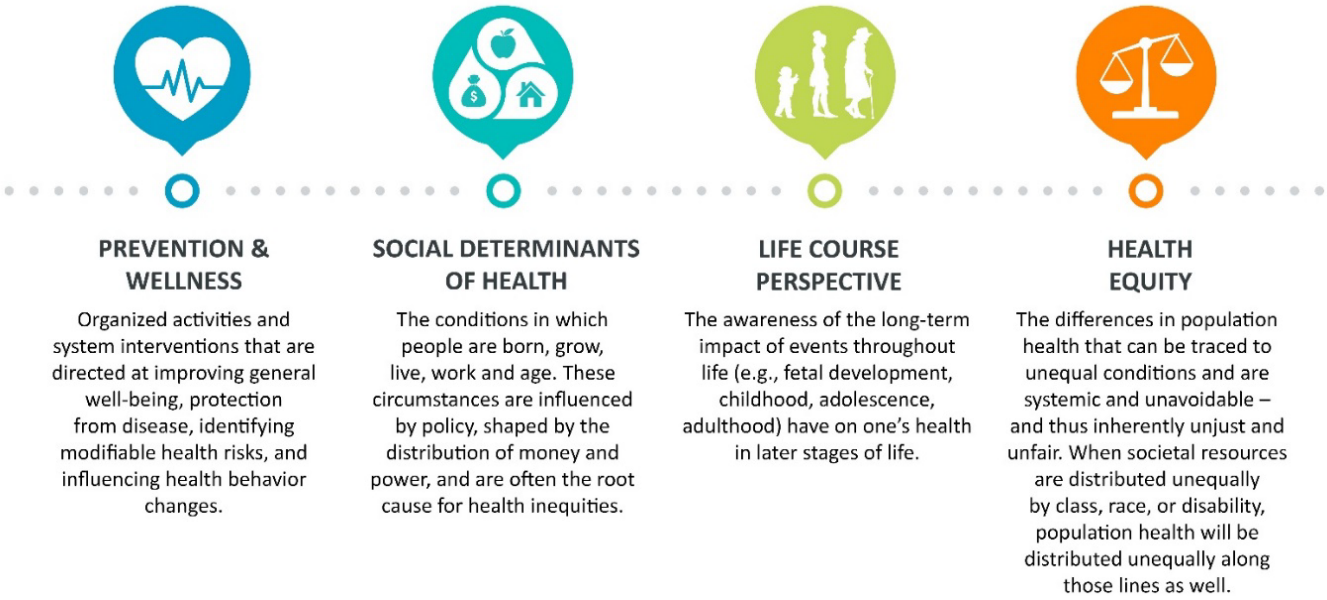
MCH Conceptual Models in Kansas

Title V recognizes and understands the connections between priorities across MCH population domains. Kansas' approach is supported by the tangible and intangible elements of collaboration, relationship building, and innovation. Four overarching themes have been identified as **guiding principles** that impact MCH work. 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.

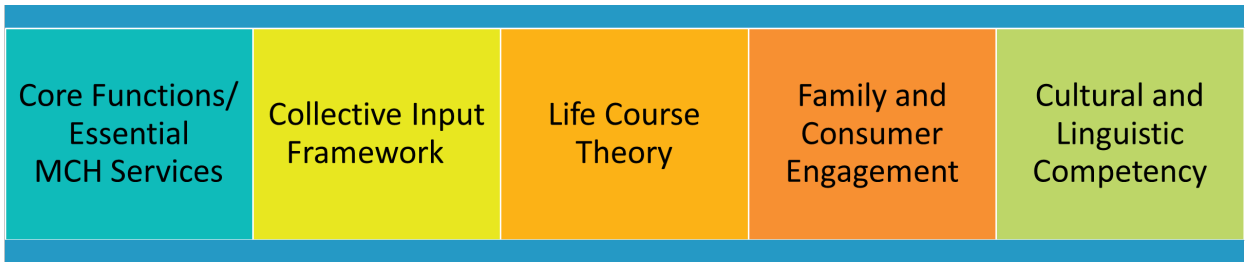
KS Title V Guiding Principles

The Title V Program depends on the following **core values** when approaching all phases of work: planning, design, implementation, and ongoing assessment/monitoring/evaluation.

KS Title V Core Values



Kansas Title V applies the following **conceptual models** in our approach to addressing the priorities, needs, and challenges of target populations.



Core Public Health Functions/Essential MCH Services: Striving to assure everyone has the same opportunity to achieve optimal health and well-being, the Kansas Department of Health and Environment (KDHE) mission, *"To protect and improve the health and environment of all Kansans"* is directly aligned with the purpose of the 10 Essential Public Health Services and core public health functions of assessment, policy development, and assurance. The essential services promote policies, systems, and community conditions. They were established to provide a framework for public health entities to follow that supports the breakdown and eradication of systemic and structural barriers that have resulted in health inequities (e.g., poverty, racism, discrimination). Kansas follows this framework and the MCH service delivery pyramid regarding the provision of direct health services, coordination of enabling services, and the infrastructure of public health services and systems.

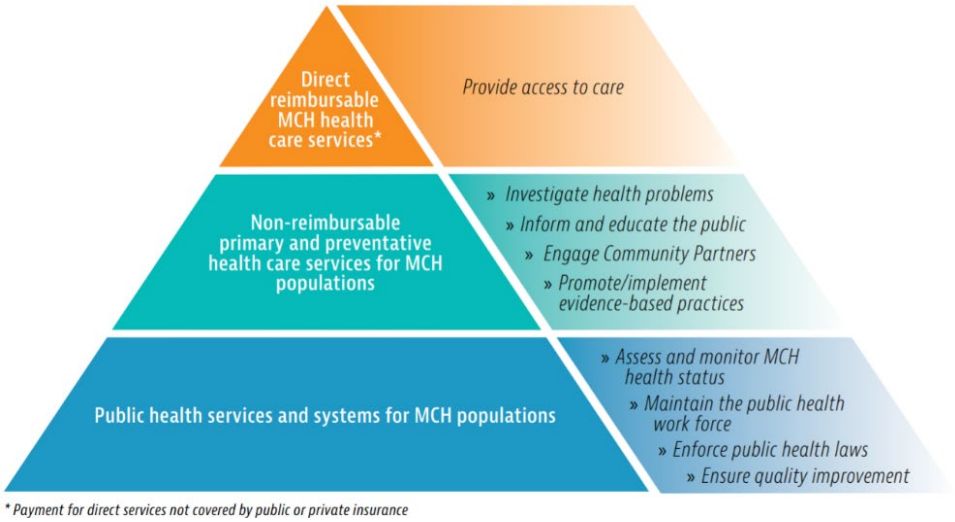


Image Credit: MCH 2025 Title V Needs Assessment

Collective Impact Framework: This framework is modeled throughout program development, implementation, and assessment activities to approach complex partnerships, collaboration efforts, or community support needs. Considering the focus on cross-system collaborative work, Title V has intentionally aligned five-year needs assessment processes and community collaboratives (e.g., KS Perinatal Community Collaboratives) with this framework to support significant and lasting social change. Kansas Title V leadership models the core belief that a one-size-fits-all solution/single policy/individual government entity/specific organization or program cannot meet the complex needs of the population alone. Rather, through coordination and collaboration across agencies and organizations, where each engaged partner agrees to a common agenda, shared measurement, and alignment of efforts, we can realize improvements to problems we face as a society.

Life Course Theory: Essential to approaching health and related services from a life course approach (e.g., integrated continuum, social and environmental "interplay," across the life span) is a focus on four key concepts: timeline, timing, environment, and equity. Recognizing that what happens today influences one's health in the future, critical periods of development and transitions across the life span set a trajectory for the life phase that follows (i.e., timing), community and environment affects one's health (i.e., environment), and social determinants impact health just as much as genetic makeup or personal choice (i.e., equity). Kansas applies these concepts to MCH service delivery and promotes this framework among partners and grantees, encouraging them to systemically and strategically address social determinants of health and create plans to reduce disparities across population groups and generations.

Family & Consumer Engagement: There are many frameworks at the state and national levels that focus on engagement and partnership of families and consumers. Each offers various components that may be valuable to the work we do and supports our efforts to engage and partner in different ways, including foundational principles, quality standards, engagement strategies, and evaluation/assessment approaches. The table to the right provides a crosswalk of the key content supporting the Title V vision for family and consumer partnership across five notable frameworks.

Framework	Key Content
Levels of Family Engagement in Title V	Levels of Engagement *Input, Advisory (Self), Advisory (System), Leadership Roles*
Kansas Family Engagement and Partnership Standards for Early Childhood	Guidance for Engagement *Families as…Foundation, Communicators, Advocates, Partners, Community Members*
Standards of Quality for Family Strengthening and Support	Quality Standards for Family Support *Family Centeredness, Family Strengthening, Embracing Diversity, Community Building, Evaluation*
A Framework for Understanding the Elements and Developing Interventions and Policies	Continuum of Family Engagement *Consultation, Involvement, Partnership and Shared Leadership*
A Framework for Assessing Family Engagement in Systems Change	Assessment Tools for Engagement at the Systems Level *Commitment, Transparency, Representation, Impact*

Cultural & Linguistic Competency: Kansas believes that building relationships and partnerships with those we serve is essential to ensuring needs are met. Communication and interactions must be responsive to the individual experiences and perspectives (e.g., abilities, culture, education, race/ethnicity, gender, age,

language and literacy, religious affiliation, sexual orientation, socioeconomic status, values). Decreasing health disparities and improving equitable access to services and care is possible when communities exhibit cultural (including linguistic) competence through intentional actions related to program design, delivery, and evaluation. Title V staff and partners receive support to engage in workforce development activities to build strong MCH leaders who apply knowledge and skills associated with this MCH Leadership Competency. Kansas applies these beliefs and actions during ongoing organizational assessments, family/consumer engagement efforts, public health service delivery, and measurement and evaluation activities.

Addressing MCH Population Needs Through Title V Leadership

Title V in Kansas serves in a variety of leadership roles (e.g., convener/facilitator, collaborator, partner/funder) to address the needs of the MCH populations. Our vision and strategic, intentional approach have not only significantly contributed to building and sustaining relationships over the years, leading to growth and success, but have also positioned the Title V program to face ongoing challenges and emerging issues.

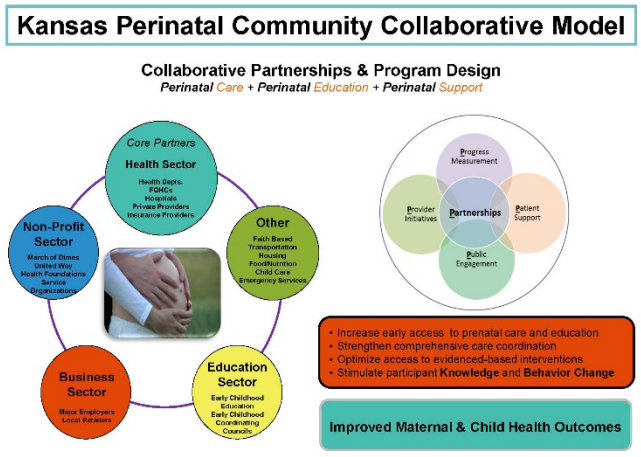
- *Title V as a Convener*: Engaging stakeholders, providers, and consumers/families is essential to success. Title V often facilitates the convening of stakeholders across service delivery systems that engage and interact with women, children, and families. Communication is critical to planning and addressing the needs of MCH populations.
- *Title V as a Collaborator*: A major focus of Title V and BFH policy and program initiatives is collaborative relationships. Commitment to collaboration is evident across engagement and participation in a variety of statewide initiatives in a collaborative role, to support alignment and integration of MCH practices, principles, and initiatives with related partners and programming and to ensure coordination of the health components of the MCH system. Collective impact is the framework.
- *Title V as a Partner*: Partnerships are essential to the delivery of high-quality MCH services and establishment of an equitable and competent system to address the needs of the population. Organizational partnerships support expanded capacity across communities and systems. All partnerships are mutually beneficial. Some partnerships involve formal agreements and funding to address gaps and services.

The state Title V team provides expertise, gathers feedback, and makes connections to maximize the effectiveness of the overall system. Title V strategically partners with state-level organizations to target priorities and implement the action plan (as described throughout the domain sections). Our partners support this approach and has proven time and again they stand ready to work on issues when called upon.

Title V is truly the leading vision for MCH in Kansas, with all other initiatives targeted to populations across the life course providing targeted efforts and focus on special needs and issues. MCH stakeholders have a successful history of working together, and the Title V funding has been a catalyst for positive, innovative systems change.

Title V Partnerships & Collaboration = Access & Delivery of Quality Services

Kansas Perinatal Community Collaboratives: The Kansas Perinatal Community Collaborative (KPCC) model assures comprehensive and coordinated perinatal supports through shared risks, resources, and rewards. Bringing prenatal education and clinical prenatal care together to create a comprehensive program model helps communities leverage existing resources (e.g., staff, space, patients/clients, programmatic and educational materials, toolkits) and funding to more effectively serve a common set of perinatal clients. When the KPCC model is implemented, perinatal systems of care are redesigned and institutionalized as partners come together to meet local needs. The model and affiliated programming is targeted at communities with demonstrated birth outcome and infant mortality disparities, both racial/ethnic and socioeconomic.



Following the release of the Kansas Blue Ribbon Panel on Infant Mortality recommendations in 2010, the March of Dimes (MOD) Greater Kansas Chapter developed a community collaborative model in partnership with KDHE that was designed to implement the Becoming a Mom/Comenzando bien® (BaM/Cb) basic prenatal education curriculum. This serves as the foundational prenatal education component of the collaborative model to ensure program fidelity across communities. During the several years, resources needed for statewide expansion with protections of program fidelity and a MOD trademark agreement have been developed and include:

- Supplemental prenatal education content;
- Guidance documents and training videos;
- Standardized program resources such as session slides/PowerPoints, lesson plans, activity plans and supplemental handouts;
- Promotional material templates; and
- A private website portal to provide direct access to these resources.

All supplements to the MOD curriculum have been translated to Spanish in partnership with the KU School of Medicine-Wichita, Department of Pediatrics and a workgroup with representation from five Spanish dialects. These tools and resources have provided the mechanism for statewide expansion and support both growth and future sustainability. Local community sites interested in establishing this model are required to enter a memorandum of understanding with KDHE/Title V in order to gain access to training and programmatic resources. Title V has established referral and evaluation systems to support collaboration and outcome measurement among sites, in partnership with the University of Kansas Center for Public Partnerships and Research. Shared measurement is made possible by DAISEY.

Kansas Title V has invested extensive resources to position the state and communities for this model, with the primary goal to expand in both rural and urban communities and build capacity for existing collaborations. Driven by private and public partnerships at both state and local levels (e.g., Title V MCH, Medicaid, private foundations, local health departments, federally qualified health centers, clinical providers, local hospitals, community and faith-based organizations), this model supports permanent MCH infrastructure, leveraged and shared resources, changes in the prenatal care delivery system, a vehicle to identify community needs, a standardized evaluation and shared measurement system, and new opportunities for achieving community collective impact and improved birth outcomes. This can also serve as the backbone for dissemination of targeted public health programming and affords communities with a successful vehicle for future sustainability. Standardization of screening, referral, education, and outcome measurement processes has been pivotal to Kansas expansion efforts. KPCC initiatives and activities are integrated strategically throughout in the State Action Plan Domain Narratives to reflect the reach and impacts this model across the life course.

Local MCH Grantees: In addition to partnerships with state-level organizations working directly with communities, Title V contracts with local health agencies offering a wide range of MCH services, including home visiting. Reach for these services can change from year to year based on local community needs and capacity. The services delivered by local agencies are designed to address ongoing needs and those identified by the most recent needs assessment. Most local programs funded in part by the Block Grant are delivered by local health departments and safety net clinics (independent entities). These agencies are positioned to provide core public health services in addition to MCH, so the delivery system has the advantages of convenience and comprehensive care.

Title V contracted with 61 local agencies in SFY22, serving 67 counties. We continue to see a decrease in applicants over the years due to competing priorities at the local level for community organizations. Ensuring coverage and access to supports and services is a priority for the State Title V program. The funding structure and approach will need transformed to address this long-standing issue. Unfortunately, not all local MCH lead agencies can provide the services that we know make a difference such as: home visiting, the KPCC birth outcomes model, and holistic care coordination.

To assure Title V is supporting widespread access to evidence-based, high-quality services, we are committed to a comprehensive review of our aid to local structure. This will help identify opportunities for statewide reach and address findings from two separate statewide needs assessments (Title V and Early Childhood Systems) that noted access to services and programming across the state is not equitable. These activities highlighted

things we already knew: there are large health inequities in the state, and inequities are exacerbated by social determinants of health. Many families indicated through the early childhood systems work (supported by the Preschool Development Grant – PDG) that they are "barely surviving," and this was before the COVID-19 pandemic. Families should not have to fight to get their basic needs met, worry about where their next meal is coming from, or how they will be able to work because they can't find child care. Fighting to survive often worsens "diseases of despair" and we have seen huge increases in behavioral health concerns such as mental health disorders, substance use, excessive alcohol use, suicides, and intimate partner violence.

Systems of Care for CSHCN: Title V strives to expand upon and support a cohesive, integrated, and supportive system of care (SOC) for children with special health care needs (CSHCN) and their families. The Kansas State Plan for Systems of Care for CSHCN is intended for agencies and organizations serving CSHCN and stakeholders, including parents, caregivers, and individuals, in supporting Kansas to achieve the Standards for Systems of Care for CSHCN to strengthen collaboration, support systems integration and improve service delivery for CSHCN. Kansas engaged in and has adopted the National Standards for Care Coordination for CSHCN as the foundation for activities to expand holistic care coordination to all MCH populations.

Title V believes that expanded partnerships and strong collaboration are needed to improve and integrate systems of care for CSHCN. It remains evident that this cannot be met by one program, state agency, non-profit organization, or national entity alone. It will take all working together, in tandem and in collaboration, to assure a quality system of care for children and youth with special health care needs. The National Standards and related state plan are only guiding documents for CSHCN partners, to help support actions and priorities. It is desired that all CSHCN-serving agencies, organizations, and providers will see their role and shared responsibility in building and cultivating partnerships across systems, essentially improving outcomes and supports for families within a well-functioning system of care, so that CSHCN and their families can thrive and succeed in our communities. Title V is committed to engaging in these vital conversations and establishing a shared vision for systems of care for CSHCN.

MCH Integration Toolkits: To better assist local communities in serving populations, Integration Toolkits are being developed for identified priority areas within the MCH State Action Plan. They are intended for use in the public health setting, as well as being shared with community partners and providers who are serving the same MCH population across different settings. Through collaborative efforts focused on targeted interventions, we can begin improving outcomes for the MCH population in local communities and across the state, leading to greater collective impact.

The toolkits are designed to be a collection of resources, brought together into one centralized location, to assist in work around targeted Title V priorities. Resources include the latest research, recommendations, opinion statements and practice guidelines, as well as numerous tools, templates, and training opportunities. Toolkits are based on sound research and recommendations from leading experts in the field and are created in collaboration with many state and local partners that have a shared interest in providing coordinated and comprehensive services to women and families before, during, and after pregnancy. The toolkits can be found online at https://www.kdhe.ks.gov/457/MCH-Integration-Toolkits.

TITLE V MCH WORKFORCE

The Bureau of Family Health (BFH) has experienced, committed, and visionary staff. The MCH team is key to building partnerships at the state level and providing support to local communities and families. Title V funding supports critical positions that provide leadership and support for facilitation of conversations and activities necessary to address the needs of MCH populations. The majority of Title V funded agency staff are located in downtown Topeka, directly adjacent to the State Capitol. MCH Block Grant funds provide salaries for approximately 22% of the staffing in the Bureau (administration, SHCN and MCH staff, and Epidemiologists).

The Title V program understands the importance of staffing at all levels, across sectors, and within multiple parts of the system to impact change. This understanding is evidenced by Title V's support within the state health agency, through existing state-level coalitions, and private and public partners. Innovative approaches to shared staffing, when and where appropriate, has supported success. In addition to funding core Title V MCH and SHCN staff/programming, a small amount block grant funding supports the BFH Child Care Licensing Program to advance state action plan objectives targeted to early care settings (breastfeeding, oral health, physical activity). Within the Division of Public Health, other bureaus that receive regular support include Community Health Systems (BCHS) (local workforce development, training, capacity building, systems development) and Epidemiology and Public Health Informatics (BEPHI) (Vital records data sharing, analysis, reporting). MCH and SSDI funding supports two full-time MCH epidemiologists within BEPHI who 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 Epi position is specifically assigned to work with Medicaid (data sharing, review/analysis, application and impact on programmatic efforts and state and local initiatives). Beyond the agency Title V staff, hundreds of local MCH experts, staff, providers, and family leaders make up the broader workforce. Read more about the Title V workforce, program partnerships, and collaboration in other sections.

As the Kansas vision has become even more expansive and collaborative in nature, recruitment and retention of qualified staff has become even more of a priority. There are many initiatives led by Title V that impact both state and community policies and systems. Therefore, focus has been in recruiting (and retaining) the right people to sustain and expand efforts. Position descriptions are updated regularly, and interview questions/processes reflect the needs of the program. For example, questions related to behaviors, lived experience, and understanding of issues facing public health/MCH populations, health equity, and health disparities have been incorporated. Professional development plans and opportunities support professional and personal growth beyond what is "expected" as part of the agency's performance review process.

All BFH staff, including Title V team members, complete the CliftonStrengths assessment upon hire to discover their strengths and learn how to develop their talent (utilizing their strengths). Supervisors and managers are encouraged to establish coaching plans and supports for employees to maximize ability and plan programmatic activities by utilizing various team members' strengths. All staff are encouraged to post their top five strengths in their office or cubicles and refer to them often. The team regularly engages in training and professional development activities around how to best utilize their strengths. In addition to utilizing this assessment with Bureau staff, all Kansas Family Advisory Council members receive a copy of the CliftonStrengths book and are asked to complete the assessment, which is used to support distribution across the four domains: executing, influencing, relationship building, and strategic thinking. BFH is partnering with Gallup, Inc. to take team strengths to a new level.

The MCH Navigator and online MCH Self-Assessment are utilized and fully integrated into professional development planning and performance reviews for all state MCH staff and local staff. Local MCH program staff must complete MCH trainings (MCH 101 and MCH Orientation) through the Navigator within three months of grant award or hire. Local program staff delivering certain messages or services, including education, are required to complete other related trainings (e.g., tobacco, breastfeeding, safe sleep, care coordination). Ongoing training requirements for local MCH staff include technical assistance calls/webinars throughout the

year led by the state MCH team and the annual Governor's Public Health Conference. Home Visitors are required to attend state-sponsored annual training. Other courses selected for professional development must be identified on the "personalized learning plan" as a result of completing self-assessment.

The National Center for Education in Maternal and Child Health (NCEMCH), who oversees the MCH Navigator, provided a report of professionals in Kansas who have taken the online self-assessment from 2014-2020. This provides valuable information about the workforce and serves as a snapshot of demographics and knowledge/skills across the MCH Leadership Competencies. The following chart analyzes the Kansas knowledge and skill scores for each of the 12 MCH Leadership Competencies. As outlined in the report, these are in line with national data trends–cultural competency had the largest gap in knowledge and skills and policy had the lowest knowledge and skills scores across competencies.

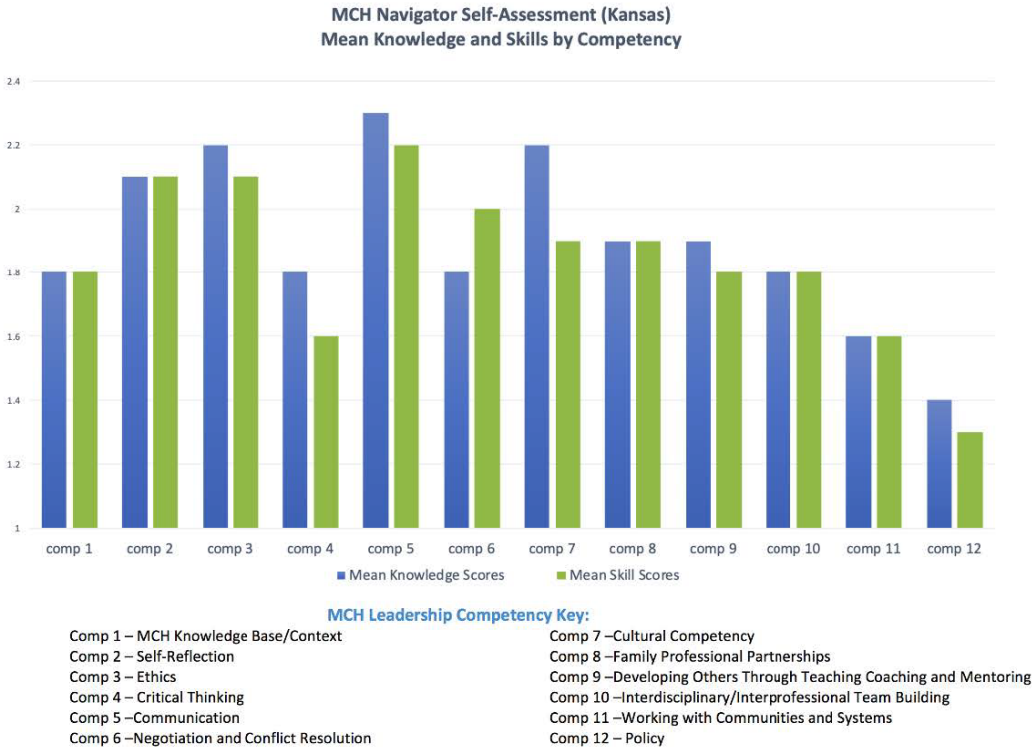


Image Credit: MCH Navigator Kansas Workforce Snapshot, Self-Assessment Data 2014-2020

Recruitment & Retention: During the 2019 Bureau Reorganization, dedicated capacity through the Administration and Policy Section was established to support recruitment, orientation/onboarding, workforce development, and staff retention. Following the 2019 State of Kansas Employee Survey disseminated by the Governor, the Bureau identified a specific need to work on recruitment and retention of a qualified workforce. Some bright spots from the BFH survey results:

- 97.7% of employees believe that the work they do furthers the agency's mission.
- 91.7% of employees believe that their immediate supervisor appreciates their work.
- 87.2% of employees believe that their work is evaluated fairly.
- 83% of employees reported being satisfied to very satisfied with their current position.
- 80% of employees would like to finish their public service career with KDHE.

While the data was overwhelmingly positive, there were some areas that presented opportunities for improvement, specifically regarding communication, compensation/benefits, equipment/resources, and rewards/recognition.

- 46.8% of employees believe communication between work units/divisions is good.
- 8.5% of employees do not feel they are reasonably compensated for the work they do.
- 52% of employees felt their workload/caseload was manageable.
- 66.7% of employees reported having received adequate training to do their job.
- While most BFH employees (91.7%) felt that their immediate supervisor appreciated their work, only 62.2% felt that senior managers appreciated their work.

Upon review of the Bureau-level data, the Administration and Policy Team proposed the following project objectives to build a culture of support and mentorship, focus on effective communication, and foster collaboration across Sections and Programs. The goal is to assure all team members have the tools and resources necessary to be successful in their positions, be afforded professional growth opportunities, and see a clear pathway for advancement.

To date, several conversations have taken place and tools have been developed to support supervisors during the recruitment, hiring, and orientation processes. Specifically, a standard Bureau orientation process was established for program managers and leadership to assure a more intentional approach to orientation to BFH and programs as well as the use of peer mentors to help navigate those first days and weeks on the job. Additional proposed strategies include: an annual assessment or review of position descriptions and position manuals; standardized separation interview (separate from any formal human resources exit interview processes); and ongoing recruitment strategies (e.g., interaction with candidates, screening criteria/scoring, interview questions).

To date, supervisors have begun utilizing the new BFH Orientation Checklist and Onboarding Tool. Plans are underway to partner with Gallup, Inc. to implement a package of strengths-based workplace efforts to improve organizational wellness and help employees thrive. Some of the targeted investments include discovery of employees' strengths, exploring how to utilize strengths in work and life, and coaching for supervisors/managers. The future involves establishing and connecting peer learning groups.

Development & Training Activities: In addition to required agency training programs like Public Health Quality Improvement, the Bureau and Title V state staff participate in annual training events that apply to all staff in the Bureau. Trainings/topics have included Change Cycle, Leadership, Mindset, and more. During the first annual BFH staff-development event, the BFH Rules of Engagement (image below) were developed and continue to be used today in new staff orientation, coaching, and staffing/leadership discussions around challenges and decision making.

The BFH annual staff development event will continue to address ongoing and new staff training needs. Future considerations for training topics include: cultural competency and humility, health equity and disparities, Medicaid policies, Quality Improvement (cycles/data collection), program evaluation, drafting aim and outcome statements, monitoring sub-recipients, care coordination, substance use and mental health, trauma-informed systems of care, family and consumer partnership, public health assessment/evaluation (data-driven decision making), and telehealth. In addition, there is special emphasis on training the local workforce on these same topics, especially the importance of data-driven decisions and use of data to advance public health, including sharing data and integrating systems.

Training for Care Coordinators and Community Health Workers: During the start of the holistic care coordination (HCC) model expansion, it has been recognized that CHWs are doing HCC work. Because of this, the CHW workforce has become a valuable partner to MCH systems. Special health care needs (SHCN) care coordinators are being encouraged to complete the CHW certification process during 2022. The CHW workforce is also being promoted with the HCC pilots as primary care practices can hire CHWs to provide care coordination services. The CHW certification process is 100 in-class hours and 60 service-learning hours for a total of 160 hours. The training is made up of 12 modules focused around the 12 core competencies:

1. Self-Awareness
2. Service Coordination and System Navigation
3. Education to Promote Health Behavior Change
4. Advocacy
5. Individual and Community Capacity Building
6. Effective Communication Strategies
7. Cultural Responsiveness
8. Documentation and Reporting
9. Professionalism and Conduct
10. Public / Community Health Concepts and Approaches
11. Individual Assessment
12. Community Assessment

Along with encouraging CHW certification as an option for care coordinators, there will also be an HCC training developed framed around the National Care Coordination Standards for Children and Youth with Special Health Care Needs. HCC work has been framed round these standards but speaks to them in a general manner that is valuable to all populations. The training will be six modules: Screening, Identification, and Assessment; Shared Plan of Care; Team-Based Communication; Child and Family Empowerment and Skills Development; Care Coordination Workforce; Care Transitions.

Local MCH Workforce Development

In support of local staff, the KDHE MCH staff hosted a COVID-19 listening session where grantees had the opportunity to share how they are responding to the urgent needs during the pandemic. The local MCH grantee workforce has faced many challenges throughout the pandemic and almost all grantees have reported staffing shortages due to quarantines, high turnover rates, and burn out. This has been especially problematic when trying to accommodate for vacancies related to COVID-19 (e.g., quarantine, hospitalizations, caring for loved ones affected) and unrelated to COVID-19 (e.g., maternity leave, medical leave). Local grantees have also struggled with hiring and staff turnover, leading to long-term vacancies. Additionally, some even reported that during the pandemic, their funding (and staffing) was reduced for traditional services, while others added new staff who were unable to be properly trained due to the high demand of COVID-19 responsibilities. The majority of MCH grantees reported having to shift staffing, or completely re-focus from MCH activities to COVID-19 response (e.g., contact tracing, testing, administering vaccinations, special drive-thru events, telehealth visits). As such, staff morale has suffered, increased stress has been endured, and the burden of the pandemic weighs heavily on the emotional and mental health of those still working within the local public health agency.

Addressing Anticipated Training Needs: Title V staff will host monthly “Lunch and Learn” webinars to support ongoing engagement and technical assistance around topics relevant to the Title V State Action Plan, specifically to support knowledge acquisition, skill development, and increased comfort to address the needs of MCH populations. All sessions will be recorded and posted on the MCH Workstation (see next section for more information about this tool), allowing staff to access the information if they are unable to attend. The following are the planned session for the coming year.

Maternal & Child Health:
Third Thursday Webinar Series

Join the Kansas Department of Health and Environment's Maternal and Child Health Team, along with subject matter experts from across the state, for monthly learning opportunities! These sessions will focus on providing information about initiatives and resources that can be applied to maternal and child health work in your community. Attend them all or join as your schedule allows! Register for individual sessions by clicking on the links, below. **All sessions will be held on the third Thursday of the month from noon – 1 p.m. CT.**

Maternal Warning Signs
August 19, 2021 - Register here

Youth in Crisis: Adolescent Suicide Prevention
September 16, 2021 - Register here

Perinatal Behavioral Health Services and Resources
October 21, 2021 - Register here

Adolescent SBIRT: Resource Guide and Toolkit Overview
November 18, 2021 - Register here

Tobacco Cessation During Pregnancy and Postpartum
December 16, 2021 - Register here

How to Build and Sustain a Perinatal Community Collaborative
January 20, 2022 - Register here

Supporting Kansas Families Through School-Based Health and Population-Based Approaches to Serving Children with Special Health Care Needs
February 17, 2022 - Register here

Women's Health Resources: Addressing Barriers to Preventive Care
March 17, 2022 - Register here

Month of the Young Child: Increasing Literacy While Reducing Screen Time
April 21, 2022 - Register here

KSKidsMAP: A Resource for Responding to the Pediatric Mental Health Crisis
May 19, 2022 - Register here

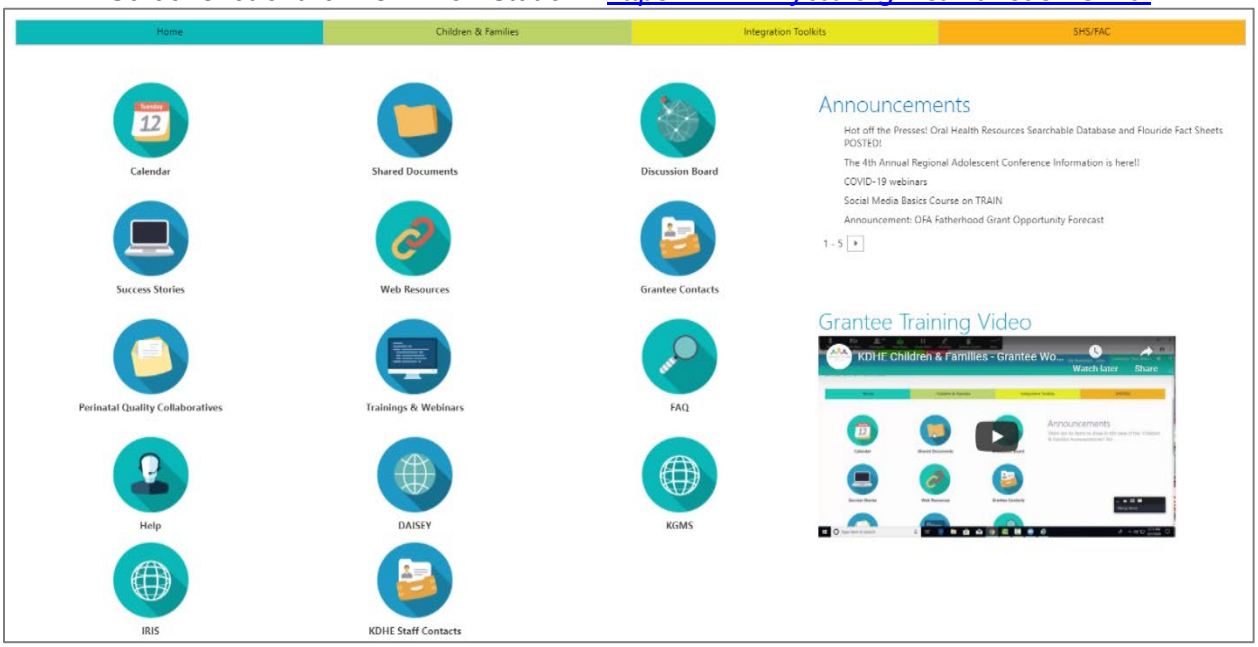
Consumer and Family Engagement: Essential for Maternal and Child Health
June 16, 2022 - Register here

MCH Opportunity Project: Health Equity Outcomes and Takeaways
July 21, 2022 - Register here

Regional meetings will be provided for local MCH grantees across all six regions to build stronger, supportive relationships during SFY23. Tentative agenda items include a review of data currently being collected, with an emphasis on quality and identified gaps and needs. Facilitated conversations will allow regional grantees to share successes and lessons learned regarding data and program implementation as well as client engagement and recruitment. There will be an opportunity for individual grantees to connect with their individual program consultants from KDHE to seek individualized technical assistance. Ongoing webinars and additional TA opportunities will be driven by grantee needs, emerging issues, and staff concerns related to data trends and program reports.

MCH WorkStation: A collaborative SharePoint application within the Community Check Box (CCB), commonly referred to as the WorkStation, continues to be utilized to enhance training and technical assistance while increasing statewide connections and collaboration among program staff and grantees. The WorkStation for MCH grantees offers shared access to resources, a calendar, videos, discussion boards, contact lists, and more. The platform has proven to be useful for grantees to troubleshoot challenges with one another.

Screenshot of the MCH WorkStation - https://www.myctb.org/wst/KansasMCH/cf



FAMILY PARTNERSHIP

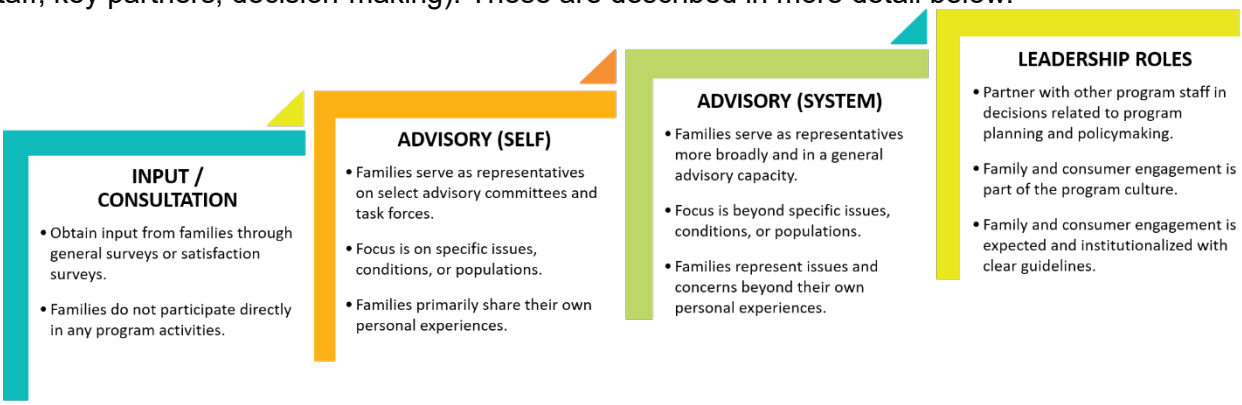
*"Kansas invests in **family/consumer engagement** and **partnership** to affirm that the family and consumer voice is a critical component to moving services in the right direction."*

Families and consumers provide firsthand knowledge and insight to areas that state program staff may not consider; they also make suggestions on how to create positive changes for the MCH populations, especially CSHCN. The Kansas Title V Program provides opportunities for meaningful engagement and leadership at varying levels of involvement and intensity to fit the needs of consumers and families.

Kansas Family Engagement Frameworks

The *Framework for Understanding the Elements and Developing Interventions and Policies* outlined in the MCH Block Grant Guidance describes the continuum of patient and family engagement at different levels in the health care system. This provides foundational support to the impact and effects that patient and family engagement can have on a higher quality and more efficient health care system. In addition to this, there are several other frameworks at the state and national levels that focus on engagement and partnership of families and consumers. Each offers various components that may be valuable to the work we do and supports our efforts to engage and partner in different ways. The framework components include foundational principles, quality standards, engagement strategies, and evaluation and assessment approaches. An overview of the frameworks is included below; a crosswalk can be found in the Program Purpose and Design section.

Levels of Family Engagement in Title V MCH & CYSHCN Programs: Kansas Title V strives to support family and consumer engagement at all levels, as outlined by the Levels of Family Engagement in Title V developed by the Association of Maternal and Child Health Programs (AMCHP), and released in a 2016 AMCHP brief. These levels of engagement include input or consultation (e.g., programmatic and community input surveys or focus groups); advisory opportunities (e.g., self/family level, broader systems/community-level); and leadership (e.g., staff, key partners, decision-making). These are described in more detail below.



The 2016 brief also outlined the fact that the CSHCN MCH population domain has historically engaged families and consumers at a much greater rate than other population domain areas (e.g., women/maternal, perinatal/infant, child, adolescent).

Kansas Family Engagement & Partnership Standards for Early Childhood: The Kansas Family Engagement and Partnership Standards for Early Childhood guide early childhood programs, providers, communities, and educational system on effective engagement. The standards were developed by the Kansas Parent Information Resource Center (KPIRC) in partnership with Title V. They are designed to help others view families as:

- Foundation: All families are recognized and promoted as their child's first and most influential teacher.

- Communicators: Early childhood provider and families have effective and ongoing communication.
- Advocates: Families actively engage as an advocate and decision-making for their child.
- Partners: Successful partnerships exist between families and professionals based upon mutual trust and respect.
- Community Members: Families are active participants in their communities and connect to resources and services.

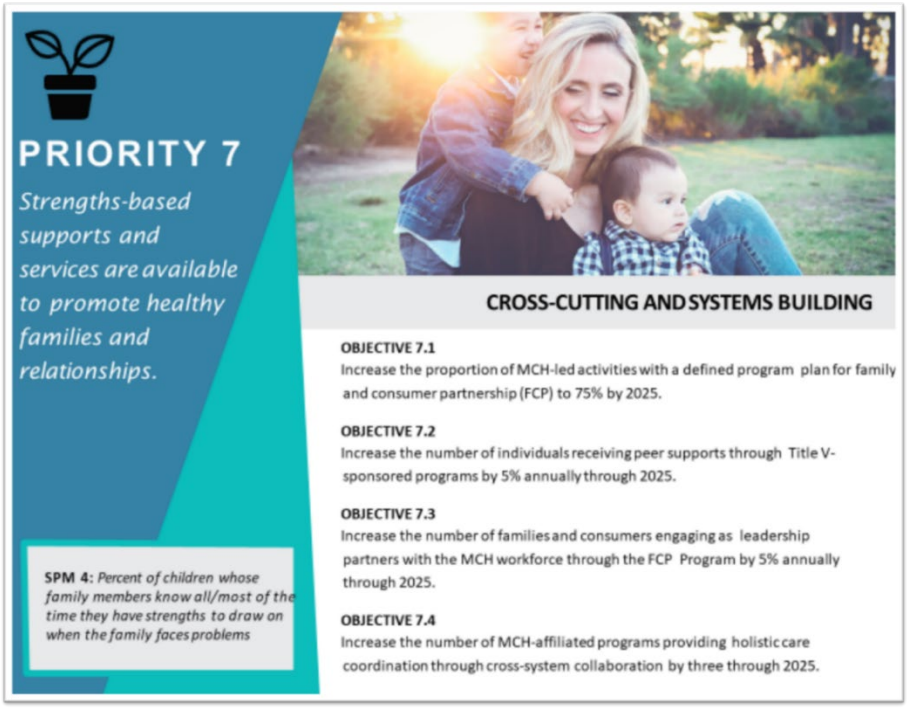
The document references the six key factors from the National Association for the Education of Young Children (NAEYC) definition of family engagement and the School Readiness Framework, specifically, how these intersect and are supported by the Standards. In addition to outlining the Standards, there are also examples of what those may look like in practice and a full set of assessment worksheets to help programs identify how well they aid community stakeholders in assessing their current strengths and opportunities for grown within each of the five standards.

Standards of Quality for Family Strengthening & Support: Developed by the National Family Support Network (NFSN) Title V has begun focused work on alignment and integration of the Standards of Quality for Family Strengthening and Support. This started with the inclusion of these Standards in the 2025 Needs Assessment, upon recommendation from the Title V Family Advisory Council (FAC) and was a major influencer in the development of Priority 7, *Strengths-based supports and services are available to promote healthy families and relationships*. These Standards focus on building strong families, supporting families, and assuring family engagement in program practices by establishing "a common language to promote quality practice across many different kinds of programs that work with families."

A Framework for Assessing Family Engagement in Systems Change: Developed by Family Voices, this framework strives to assess family engagement as it relates to systems change. There are four domains for promoting and ensuring meaningful and sustainable family engagement at the systems level: Commitment (e.g., engagement as a core value); Transparency (e.g., access to information); Representation (e.g., reflecting diversity of population served); and Impact (e.g., identifying changes resulting from family engagement). Key criteria for each domain was offered to support interested organizations in program and staff assessment and program planning.

Awareness & Commitment: Bureau of Family (BFH) Health & Core MCH Team

It is well known that when families are strong, connected, and healthy, the family members and the community in which they live, thrive. In 2020, Kansas selected a new cross-cutting priority specifically focused on family engagement and supporting families from a strengths-based perspective.



The Kansas Title V program prioritizes family engagement and demonstrates this commitment through time and resources, and is distinctly poised to strengthen self-efficacy and self-determination among families by assuring: MCH-led activities and services (informed by family needs and desires, centered on the family voice, and representative of diverse values and ideals); family/consumer peer support opportunities; family/consumer leadership activities;

and expansion of holistic care coordination services across Title V populations. This further solidifies the long-standing priority that Kansas has had on family engagement and consumer partnership.
The Title V MCH and CSHCN Directors have set clear expectations that families be engaged at all stages (design, planning, implementation, evaluation) in an ongoing, continuous way. Input from consumers is utilized in making decisions around program implementation, program updates/revisions/improvements, and priority areas for focus in the future. Staff are asked to think critically around advancing and enhancing consumer and family engagement across programs. Additionally, the MCH Domain Consultants also have family engagement activities within their job responsibilities to build in an *integration* component centered on consumer and family engagement.

With the creation of the System of Supports Section in early 2020, the Family and Consumer Partnership (FCP) Program was developed. Additional capacity was added in fall 2020 with a full-time FCP Program Coordinator to support the following key program activities.

Peer Supports

- Supporting You
- Caregiver Resource Website *(partnership with LEND)*

Supporting You is a peer-to-peer support program designed by parents for parents.

SUPPORTING YOU
A Peer Support Network

The goal is to connect people who share experiences to support one another around a specific topic or need. This program is for those that want to learn from another with a similar experience.

Learn more at www.supportingyoukansas.org/

Advisory

- Expanded FAC
- PDG Family Leadership Team

The **Family Advisory Council** is a group of family leaders that work to assure the needs of families and consumers are central to programming, initiatives, and special projects. In other words, making sure the needs of families are first and foremost in our minds in all we do.

FAC
Family Advisory Council

Learn more at kansasmch.org/fac

Leadership

- Title V Delegate
- Family Leadership Program *AMP (Alumni, Mentorship, Policy)*

The **Family Delegate** advises Title V programs, policy change, and family education efforts.

The **Family Leadership Program** provides a pathway for families to build upon their lived experiences and grow as leaders in the MCH field.

Learn more at www.kdheks.gov/fcp

Technical Assistance

- Family & Consumer Engagement Toolkit
- MCH Change Academy

The **Family and Consumer Engagement Toolkit** will assist interested programs and partners to create family-driven programming, actively engage families at all levels, inform partnership strategies, and evaluate family strengthening & support activities.

The **MCH Change Academy** will provide training and skills-building resources to support strong family leaders as part of the MCH workforce.

Learn more at www.kdheks.gov/fcp

Learn more at www.kdheks.gov/fcp

For more information, contact Heather Smith at Heather.Smith@ks.gov or 785-296-4747

KANSAS MATERNAL & CHILD HEALTH

Measuring Family Engagement: The levels of family engagement in MCH activities is tracked through the MCH Community Check Box (CCB), a web-based tool that supports evaluation of the implementation of the action plan and monitors progress towards MCH goals and outcomes.

Family Engagement Strategy Guide: In collaboration with the Kansas Children's Cabinet and Trust Fund (KCCTF) and the University of Kansas Center for Public Partnerships and Research (KU-CPPR), Title V assisted in the development of a strategy guide to help ensure that family voices are included and elevated in decision-making for the early childhood care and education (mixed delivery) system. This a major component of the All in for Kansas Kids Strategic Plan and the Preschool Development Grant Birth to 5 (PDG B-5). There are two goals in the plan focused on supporting families through empowerment and informed decision-making. The following is an excerpt from the internal "Strategy Guide" document related to Family Engagement.

Strategic Plan Connection

Goal 2: Community-Level Coordination - *Communities are empowered and equipped to create the best environments to raise a child.*

- **Tactic 2.2.1** Identify parent or family groups that exist within the community and seek feedback on their needs and suggestions for increasing family representation in community decision-making about programs and services.
- **Tactic 2.2.2** Respond to the cultural, ethnic, racial, language, and socioeconomic characteristics and preferences of families to create equitable family engagement opportunities at the community level.
- **Tactic 2.2.3** Include family representatives from the local community on coalitions and/or advisory councils, and as program evaluators, co-trainers of pre-service or in-service training sessions, mentors for other families and professionals, grant and application reviewers, and participants in needs assessment processes.

Goal 3: Family Knowledge and Choice - *Families have what they need to make informed decisions and can get services where they live and work.*

- **Tactic 3.1.4** Provide unique opportunities for families to engage with providers in their communities through events such as community baby showers, health fairs, and back-to-school nights.
- **Tactic 3.2.1:** Respond to the cultural, ethnic, racial, language, and socioeconomic characteristics and preferences of families to create equitable family engagement opportunities at the state level.
- **Tactic 3.2.3** Use family engagement initiatives such as the Kansas Family Advisory Team, Parent Leadership Advisory Council, Head Start Policy Councils and Parent Committees, and the annual Parent Leadership Conference48 to strengthen family voices in leadership, including but not limited to gaining insights into child development and the family's role in supporting development and learning, reviewing proposed policies, and informing programs.
- **Tactic 3.2.4** Identify and replicate effective family engagement strategies from across Kansas, including compensation for families, engaging family representatives as members of statewide task forces and advisory boards, and as participants in the planning, development, delivery, and evaluation of programs.

Additional goals of the strategy guide include: 1) approaching family engagement through an equity lens; 2) investigating and addressing disparities in diverse family representation across the state of Kansas; and 3) increasing alignment and collaboration among state agencies regarding family and consumer partnership. To accomplish these things KDHE, KCCTF, and KU-CPPR will work with the Family Leadership Team (FLT) to implement the following strategies:

- Better understand diverse family needs, challenges, and preferences
- Research and identify best practices and innovative strategies
- Explore partnerships and tools to increase representation among family engagement opportunities throughout state
- Directly engage family leaders in coordination with KDHE and other partners
- Increase alignment and commitment to family engagement among state agencies

- Develop directory of existing statewide and regional councils, coalitions and committees with family leadership focus
- Develop and disseminate family engagement tools and resources for families and professionals
- Create resource hub for family engagement resources and opportunities

Families Participate in MCH Efforts as Council Members, Professionals, & Experts

Individual parents and/or parent groups are represented in place-based communities, serving as a conduit of information, communication, and outreach to other families. Peer to peer connections build engagement and social supports, a protective factor to support family well-being. Formally, families can serve in two advisory council roles at this time: Family Advisory Council (FAC) and the Kansas Maternal and Child Health Council (KMCHC). As the FAC has expanded beyond only the one targeted population group (i.e., CSHCN), so have leadership opportunities through serving as a Co-Chair to one of the five targeted population work groups. Collectively, the ten Co-Chairs serve as the FAC Executive Committee.

Family & Consumer Engagement Supports: Title V has adopted a Consumer Reimbursement policy, in which family or consumer participants in state meetings are eligible to receive a consultant fee (hourly or daily), travel reimbursements, and child care costs for in-person meetings attended. These are available for all meetings in which a family leader serves in a formal membership role. It is evident that this has not been common practice among family engagement efforts outside of Title V and it has been integrated in as part of the Strategy Guide and will be included as a crucial part of the FCP Toolkit.

Family Advisory Council (FAC): Consumer engagement is a guiding principle of the Title V program. At its core this principle stems from the philosophy "nothing about us without us," so buy-in from those directly affected by changes occurs frequently. It is an expectation of the Title V Director that new initiatives, policy changes, or special projects will engage families and obtain feedback on the added value of the effort during the development and through the implementation phase. Kansas is dedicated to expanding family and consumer engagement across all MCH populations, not only among CSHCN families, as has historically been the case.

The FAC serves to advise the Title V Program and the Secretary of KDHE and others on ways to improve the health of families, focusing on the MCH population. The FAC brings together family/consumer leaders with a broad range of lived experiences related to programming and supports. FAC members provide insight on personal and lived experiences; advise on the best methods to reach and communicate with families; inform engagement efforts across BFH and at all levels; inform strategies and activities to address population needs; create a network of community change agents to improve MCH health outcomes and serve as an ambassador to community service systems; and consult with the Title V programs on the development of the annual MCH Block Grant Application, five year needs assessment, and other program plans identified.

As described in the Needs Assessment Update section, the FAC continued a transformation and expansion in the last year. Throughout 2021, the FAC members (All MCH populations) engaged in various discussions and engagement to elevate the work of MCH, including sharing a lot of feedback on what it means for an organization to truly partner and listen to those they provide services for when helping to frame out a new Family & Consumer Partnership Toolkit. The FAC website is available at www.kansasmch.org/fac.

The FAC is comprised of five core work groups (Women/Maternal, Early Childhood, Child, Adolescence, and CSHCN) to represent the Title V populations served. Each work group will develop an annual action plan (i.e., Work Group Charter) aligned with the scope of their group with actionable objectives and tangible outcomes to advance the Title V State Action Plan (SAP). These groups are described below.

- *Woman/Maternal*: Representing women, ages 18 to 45 years, this group will focus on addressing the strategies and objectives found under the Women/Maternal Health and Perinatal/Infant Health priorities within SAP.
- *Early Childhood (birth-5)*: Representing the views of parents/caregivers of children birth through Kindergarten entry, this group will focus on strategies and objectives under the Perinatal/Infant and Child Health priorities within the SAP. This group will also monitor the work of the All in for Kansas Kids State Plan, facilitated through the Kansas Children's Cabinet and Trust Fund.
- *Child (6-11)*: Representing the experiences of parents/caregivers of children, ages 6 to 11, this group will focus on strategies and objectives outlined in the Child Health priority in the SAP and monitor the work of the All in for Kansas Kids State Plan.
- *Adolescence (12-21)*: Representing parents/caregivers of youth and young adults, ages 12 to 21, this group will address strategies and objectives found under the Adolescent Health priority in the SAP.
- *CSHCN (birth-22)*: Representing the needs of children with special health care needs (CSHCN) and their families, birth through adulthood, this group will focus on addressing strategies and objectives under the CSHCN priority in the SAP.

The following additional groups are desired to be established in the future, to address additional MCH populations.

- *Special Initiative Work Groups*: Comprised of existing Council members to support special projects that may need development or extra insight/care.
- *Youth/Young Adults*: Comprised of youth and young adults from various backgrounds, service systems (e.g., teen parenting programs, disability services, school-based health care), and social experiences (e.g., health care access issues, bullying, mental health, transition).
- *Fatherhood*: Represents the father perspective to advance activities that support fathers across Title V programming.

Each work group selects two members to serve as co-chairs to facilitate the discussion and assure the group is making progress towards their defined goals and objectives. These members will also make up the FAC Executive Committee. The Executive Committee serves as a proxy for the full membership in between Council meetings to support membership recruitment and orientation, review activities across Council work groups, make formal recommendations to KDHE, and periodically review/suggested revision of Council bylaws, meeting organization/structure, and input on Council agendas.

This approach also establishes a foundation for future implementation of the FCP Toolkit (described in further detail in the Cross-Cutting domain narrative) and offer opportunities for MCH programs to engage families and consumer with lived experiences at all levels: as program evaluators, co-trainers, interns, paid staff or consultants, mentors, grant reviewer, active participants in assessment processes, and more.

Organizationally, the System of Supports Section Director and FCP Coordinator serve as Council staff, and the Executive Committee will provide oversight of FAC operations, make recommendations for bylaw revisions, and bring key issues to the table. Other Title V staff engage with each work group as subject matter experts and support the advancement of FAC planned activities and objectives.

It is desired to maintain a diverse membership roster like that of the KMCHC (e.g., geographic regions, family experiences, racial/ethnic backgrounds, ages and medical needs of children), which is being monitored closely as the expansion takes place. It is desired to assure this diversity not only across the full Council, but also within the work groups as much as possible. To assist with recruiting members, six core membership benefits are promoted.

- *Advocacy Training:* overview of legislative policy processes to support individual interests in advocating for their families or communities at the local, state, or national level
- *Leadership Skills*: opportunities to serve in leadership roles in the FAC structure (e.g., Executive Committee, Work Group Leaders, New Member Orientation, Alumni & Mentorship Program); training on the MCH core competencies; engagement with the StrengthsFinder Assessment
- *Peer Supports:* opportunities to learn from and get to know one another are integrated into meeting agendas throughout the day
- *Conference Opportunities*: support to attend leadership conferences (e.g., AMCHP, Family Voices, Family Support Network)

- *Program Planning/Policy*: input, feedback, guidance, and support to Title V program planning and policy development
- *Making a Difference in the Community*: support and encouragement to engage in other community initiatives to support their interests

Individualized resources, guidance, and/or special training may be provided to support an FAC member's participation in other community initiatives. In the past, this has included members participating in local peer support groups, community projects and charitable organizations, research and advocacy efforts associated with their child's condition, and other state agencies or systems groups, such as part of the Managed Care Organization (MCO) Consumer Groups. Several FAC Alumni now serve on the Kansas Council for Developmental Disabilities (KCDD). 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.

Kansas Maternal & Child Health Council (KMCHC): At the present time, the Council includes four representatives dedicated to serving in the role of a family/consumer member. Recruitment for additional members is ongoing and the goal is to have at least two family member representatives for each domain group (total of eight). Families are provided an orientation prior to a member's first meeting where they receive a notebook with information about Title V, the State Action Plan, and overview of MCH data. Prior to and immediately following meetings, family members are invited to join in a "debriefing session" to answer questions, clarify discussions, and provide additional information they may need. Support is available between council meetings for questions when needed. This support continues to be effective in keeping families engaged and confident in their role on the Council. More can be found online at https://www.kansasmch.org/aboutus.

Alumni & Mentorship Program (AMP): AMP was developed in 2016 for members who leave the Council due to term limits or personal reasons but desire involvement at some level. The alumni group provides opportunities for these seasoned and motivated family leaders to remain engaged and/or see the impact of their contributions. Additionally, Title V hopes to nurture their investment and expand the cross-cutting community of Title V family and consumer partners with these leaders. The AMP program has been the most widely utilized part of this program. Any member who has served for at least one year is eligible to participate in the Alumni program. The Mentor program was designed to assist new members in learning about the FAC and their role as a member. Former or current members who have served two or more years as an FAC member can participate in a mentor capacity.

Family Delegate Program: The AMCHP Family Delegate appointment process was initiated by the CSHCN 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. More about future changes to the Delegate program can be found in the Cross-Cutting Plan Narrative in this Application/Report.

Strengthening & Advancing Family Partnership

Title V is committed to family/consumer engagement, partners, leadership, and mentorship. This includes both opportunities for family leaders and the consumers/families served by MCH programs. This supports the engagement of training activities and opportunities to support the MCH workforce in embracing and engaging in family engagement locally and at the state level. The alignment with the frameworks outlined previously, MCH staff and local grantee technical assistance trainings and webinars will be made available as implementation of the Standards of Quality for Family Strengthening and Support begins. There are three implementation tools available in utilizing these Standards, all of which will be implemented as part of the Family and Consumer Partnership Program, as well as with Supporting You participating programs.

Tools were first introduced to MCH partners and stakeholders as part of the Title V 2021-2025 Needs Assessment. Plans for implementation can be found in the Cross-Cutting narrative.

- *Program Self-Assessment Tool*: To be used by program teams to determine how well the program is engaging families. Initiated by management/leadership, direct and administrative staff, parent leaders, or other stakeholders.
- *Staff Self-Reflection Checklist*: To be used by program staff, individually, to determine how well they embrace and adopt family engagement as a value added for their work.
- *Standards Participant Survey*: A survey (available in English, Spanish, and Chinese) for program participants to provide input on how well the program is doing with providing family strengthening and support services.

Impacts of Family Partnership

The primary impact of family partnership over the years is evident in the shift of the provision of Title V services. In addition, there is clear investment, commitment, and dedication of the Kansas Title V leadership and staff to assuring the family voice is central to services and activities of the programs. This is solidified in the adoption of a new priority, specifically focused on assuring families are supported, engaged, and provided opportunities for leadership development.

MCH EPI WORKFORCE CAPACITY

Within the Bureau of Family Health (BFH), there is commitment and staffing to assure the timely collection and reporting of MCH data to inform program planning and implementation. As outlined in previous sections of this application, the Kansas Title V program is focused on data-driven decision making as the foundation to improving outcomes and establishing priorities and objectives to address the needs of the MCH population. Activities are supported and made possible through strong leadership, a committed team, and epidemiology capacity.

The core Title V MCH Data Support Workforce within BFH consists of two MCH Epidemiologists and one data analyst, with additional capacity through a second data analyst focused on the data available through the screening and surveillance unit (e.g., newborn screening, birth defects). The Screening & Surveillance Unit Data Analyst position was created to offer capacity in connecting data from the newborn screening and birth defects surveillance programs with other critical MCH data sets. In addition to the staff listed, there are other Bureau of Epidemiology and Public Health Informatics (BEPHI) experts that partner with the Title V program to provide support from the Office of Vital Statistics, Maternal Mortality Review Committee, and Pregnancy Risk Assessment Monitoring System (PRAMS) data collection and/or analysis.

The existing staffing and partnership structures are designed to support interfacing with epidemiological work conducted in other Bureaus inside the agency and with other organizations and efforts across the state. All MCH data support positions are dedicated to assuring the utilization of data to drive public health programming and initiatives, evidence-based practices, and improved outcomes. These positions assist programs with assessments and evaluations, conduct assessments, and address epidemiologic needs of the BFH. One epidemiologist is focused on working with Medicaid related to alignment of shared work/goals, data sharing, review/analysis, and impact on programmatic efforts.

MCH Data Support Workforce

To enhance/strengthen the current Kansas MCH data capacity, MCH Epidemiology could use an adjustment by adding a MCH Epidemiology Health Officer with the criteria/requirements 1) a doctoral degree or medical doctor with a master's degree in epidemiology or related field, and 2) education or training related to MCH. These criteria/requirements in conjunction with 1) the passion to work on MCH, 2) the experience working on MCH or on MCH issues, 3) the public health leadership experience, and 4) the knowledge and experience working on a multi-disciplinary team to accomplish common goals and projects are crucial.

Furthermore, MCH Epidemiology Section should be composed of:

1. MCH Epidemiologists
2. PRAMS Epidemiologist (including bringing the PRAMS program to BFH)
3. Oral Health Epidemiologist
4. MCH Data Analysts (co-supervise with MCH program staff)
5. Centers for Disease Control and Prevention (CDC) MCH Epidemiology Assignee
6. Council of State and Territorial Epidemiologists (CSTE) Fellows
7. Maternal and Child Health Bureau (MCHB) Interns

Epidemiologists: Title V works with BEPHI and co-locates two full-time MCH Epidemiologists with the BFH team.

Jamie Kim, MPH - 1 FTE	***Funded through State Systems Development Initiative (SSDI)***
MCH/Title V Experience	Served as an MCH epidemiologist at KDHE since 2003; began public health career in 1995 as a KDHE infectious disease epidemiologist
Education	Master of Public Health, Wichita State University (in association with the University of Kansas) Bachelor of Science in Chemistry, Wichita State University
Program Expertise	Serves as the SSDI Project Director. Lead epidemiologist. Provides expert epidemiologic, scientific, and technical leadership in designing and conducting epidemiologic investigation. Provides advanced professional analytical work in the surveillance, detection, research, and statewide needs assessment for the MCH population; skilled in developing and designing methods of collecting, analyzing, and disseminating data. Provides oversight of MCH monitoring and evaluation activities and performing appropriate research in MCH. Utilizes 25+ years' experience in SAS & SUDAAN programming to support high-quality and comprehensive data analyses.
Primary Work Assignments	Provides epidemiological support to Title V (broadly) as well as multiple sections in the Bureau (System of Supports, Children and Families, Nutrition and WIC Services) • Pregnant women and infants (e.g., infant mortality, Perinatal Periods of Risk approach, maternal morbidity and mortality, maternal opioid-related diagnoses, neonatal abstinence syndrome, substance use, teen pregnancy, family planning) • Birth defects surveillance • Newborn screening • Health disparities in children due to disability status • WIC (Women, Infants, and Children) program • Medicaid/Title XIX • Child care licensing key indicator study

Brandi Markert, MS- 1 FTE	***Funded through Title V MCH***
MCH/Title V Experience	Joined MCH team in January 2022, transferring from serving as the epidemiologist for the Kansas Pregnancy Risk Assessment Monitoring System (PRAMS), within the KDHE Bureau of Epidemiology and Public Health Informatics, Vital Statistics and Data Analysis section. Through previous position, gained relevant experience in MCH epidemiology by analyzing and evaluating PRAMS and vital statistics data, including using the Perinatal Periods of Risk (PPOR) approach.
Education	Master of Science, Epidemiology, University of Texas Health Science Center in Houston Bachelor of Science, Cell Biology, University of Mary Hardin-Baylor
Program Expertise	Conducts advanced descriptive and comprehensive analyses of primary and secondary epidemiological data related to MCH (e.g., PRAMS, BRFSS, live birth, fetal death, linked live birth/infant death data, etc.), interprets, and prepares reports to address state- and local-specific information for use in policy and program development. Experienced in survey data collection and implementation. Utilizes SAS and SUDAAN for statistical analysis.
Primary Work Assignments	Contributes to writing of the Title V Block Grant and evaluation of Title V measures. Provides epidemiological support to Title V (broadly) as well as multiple sections in the Bureau (System of Supports, Children and Families, Nutrition and WIC Services) • Pregnant women and infants (e.g., infant mortality, Perinatal Periods of Risk approach) • Aid-to-Local grant funding • Kansas Perinatal Community Collaborative's prenatal education course, which utilizes March of Dimes' Becoming a Mom® curriculum

Data Analysts: The BFH shifted funding and staffing responsibilities to support the addition of two full-time data analyst positions in recent years. One is dedicated solely to Title V. Unfortunately, both positions were vacated in May 2021. Immediate supervisors are strategically reviewing the position descriptions to elevate these positions to provide added supports to programming and alignment across two sections – Children and Families and System of Supports Sections.

VACANT, MCH Data Analyst - 1 FTE	
Funded through the Title V MCH Block Grant	
Primary Work Assignments	Provides data management, analysis, and reporting support to Title V and programs within the Children and Families Section. Serves as the primary point of contact for data housed in multiple systems with emphasis on local-level MCH program data stored in DAISEY.

VACANT, Screening & Surveillance Data Analyst - 1 FTE	
Funded through the State Newborn Screening Fee Fund	
Primary Work Assignments	Provides data management, analysis, and reporting support to programs within the Screening & Surveillance Unit (e.g., newborn screening, birth defects surveillance). Serves as the primary point of contact for data housed in the shared Welligent/Auris database and case management system. Monitors data feeds from the Office of Vital Records (OVR), the public health laboratory (KHEL), and the KS Health Information Network (KHIN).

Professional Development & Ongoing Trainings

It's expected that any MCH Epidemiologist will hold a Masters-level degree (e.g., MPH, MS) and show experience as an applied epidemiologist (preferred experience is three years or more). However, it is noted that even the most skilled epidemiologists need dedicated orientation to MCH Services and the Title V Block Grant. The Title V MCH Director jointly supervises MCH Epidemiologists with a BEPHI manager that reports to the State Epidemiologist.

The Title V Director has established a training plan (orientation/onboarding, initial and ongoing training) for all new MCH Epidemiologists, providing a solid foundation to support knowledge and understanding of the block grant and various data sources the MCH Epidemiologist will be expected to access, utilize, and analyze in their work.

Initial & Ongoing Training: Onboarding materials for a new MCH Epidemiologist are numerous. At the national level they include, but are not limited to: Title V Legislation, HRSA Title V Block Grant Main and Resource Pages, Title V Glossary, Title V Block Grant Federal Guidance, Title V Block Grant Appendix/Supporting Documents, Federally Available Data, State Snapshot, National Performance Measures Dashboard, AMCHP resources and toolkits, and MCH Navigator assessments and courses. At the state level they include: the state's application/annual report, needs assessment, action plan, snapshots, data trends, MCH aid-to-local program information and related documents/websites, and Kansas MCH websites. Information about the MCH Council is also provided, as the MCH Epidemiologists are active members.

The following data sources are all aligned in some way with the Title V priorities and measurement framework, therefore specific emphasis is placed on a solid understanding of how these data are utilized through the ongoing needs assessment and Block Grant reporting activities. Other community/local, state, and national datasets may be included at any time.

- Vital Statistics
- Hospital Discharge
- Medicaid Claims
- Census Bureau Data (e.g., American Community Survey [ACS] Public Use Microdata Sample [PUMS])
- Behavioral Risk Factor Surveillance System (BRFSS)
- DAISEY (Data Application and Integration Solutions for the Early Years) – KS MCH Shared Measurement System
- Pregnancy Risk Assessment Monitoring System (PRAMS)

- National Survey of Children's Health (NSCH)
- Data Resource Center for Child & Adolescent Health
- Kansas Communities That Care (CTC) Survey

Additionally, a new MCH Epidemiologist learns about previous projects by reviewing prior epidemiologists' assignments. The Title V MCH Director advises new epidemiologists to participate in the Training Course in MCH Epidemiology and supports MCH epidemiologists attending conferences for professional development such as AMCHP, Council of State and Territorial Epidemiologists, among others.

Annual Training: MCH Epidemiologists are expected to engage in ongoing professional development, beyond engaging in the BFH activities (e.g., StrengthsFinder, BFH All-Staff Event) and agency activities (e.g., Quality Improvement, Accreditation, Health Equity). It is expected that MCH Epidemiologists will engage in each of these during their tenure in Kansas MCH, however it is noted that each offering will be assess relevancy and capacity at the time of the offering.

- HRSA Title V TA Meetings*
- HRSA TVIS Trainings*
- CityMatCH Training Course in MCH Epidemiology* (expected in the first year, unless not offered)
- Association of Maternal & Child Health Programs (AMCHP) Conference
- CityMatCH Conference (Epi)*
- Council of State & Territorial Epidemiologists (CSTE) offerings

*Those noted with * above are required for all MCH Epidemiologists.*

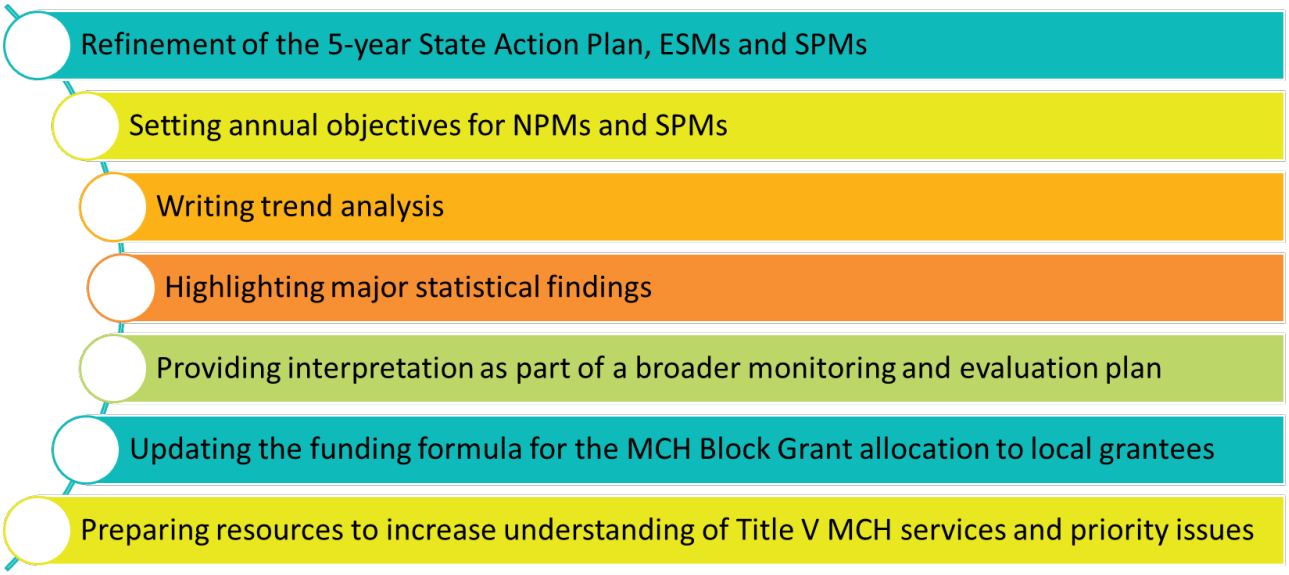
Resources: MCH Epidemiologists are encouraged to engage with the AMCHP Epidemiology and Evaluation team to support their understanding and application of evidence-based strategies, quality data, valid and reliable measures, and effective data translation and communication.

- AMCHP Epidemiology and Evaluation Resources
- CDC Preconception Health Indicators (CSTE Resource)
- Life Course Approach & Indicators/Metrics (AMCHP Online Tool)
- Infant Mortality (AMCHP Toolkit)
- Children Special Health Care Needs (AMCHP CSHCN Systems of Care)
- Assessing Family Engagement (Family Voices FESAT)

STATE SYSTEM DEVELOPMENT INITIATIVE (SSDI) OVERVIEW

The SSDI Project Director, lead MCH Epidemiologist since 2003, and the other epidemiological supports (e.g., second MCH Epidemiologist, Data Analysts) provide extensive support throughout the statewide MCH needs assessment process and ongoing throughout the five-year plan period. Specifically, the SSDI Grant provides capacity and support to improve our ability to share and link MCH data to drive public health practice and programming. Cross-program data sharing provides the foundation for special projects, and data analysis allows program staff to determine the efficacy of program activities. Published products and data analyses can be found at http://www.kdheks.gov/c-f/mch.htm.

As part of the ongoing epidemiologic support, the SSDI grant and project director continue to assist with:



SSDI Contributions to Linked MCH Datasets

Kansas has the capacity to access in a timely manner and link data from multiple sources to support MCH programs (e.g., birth, death, Medicaid, WIC, hospital discharge, newborn metabolic screening, newborn hearing screening, birth defects, Behavioral Risk Factor Surveillance System [BRFSS], Youth Risk Behavioral Survey [YRBS]). There is annual linkage of birth to infant death, Medicaid (mother-infant dyads), WIC, hospital discharge (mothers only; no mother-infant dyads, due to limited identifying information for the infant), birth defects, newborn metabolic screening, and newborn hearing screening data. Newborn metabolic screening, newborn hearing screening, and birth defects information systems (including Kansas Health Information Network - KHIN) are integrated into one electronic system called Auris, which is linked with birth records and receives automated daily birth record information (selected variables). This provides an opportunity to address longitudinal research questions or track and follow children across multiple programs over time. The Kansas State Department of Education and KDHE's Bureau of Health Promotion (BHP), in partnership with local school districts, conduct the YRBS. KDHE's BHP conducts BRFSS.

As evidenced by information on Form 12, Title V has access to data from:

- Vital Records (birth and death)
- Medicaid
- WIC
- Newborn Screening (bloodspot, hearing, heart)
- Hospital Discharge
- Pregnancy Risk Assessment Monitoring System (PRAMS)

SSDI Role in Title V Assessment, Monitoring, & Reporting

Participation in the Title V performance measurement framework provides a solid foundation for Title V assessment and monitoring and supports the annual reporting expectations. Kansas strives to implement the following expanded assessment, monitoring, reporting, and evaluation activities. Much of this work is led by the SSDI Project Director, with support from the other members of the epidemiological and MCH teams.

Evidence-Based or -Informed Strategy Measures (ESMs): Kansas has selected to establish ESMs for each of the state's national and state performance measures (NPMs/SPMs). The SSDI Project Director and MCH Epidemiologist conduct a thorough review of the ESM and utilizes the ESM Evidence Checklist for each to determine the evidence base for the measure. Additionally, for each ESM, the quantifying outputs are examined, and a baseline value is identified to assure that it is feasible to adequately monitor and measure for improvement. In the coming year(s) Kansas Title V intends to continue expanding on the use of ESMs and establish internal ESMs for the majority (if not all) of the objectives outlined in the State Action Plan (SAP). This aligns with a long-term goal to establish a formal evaluation for the Title V program in Kansas.

Monitoring Activities: Title V utilizes the Community Check Box (CCB) Evaluation System to support efforts around monitoring and evaluation. The SSDI Project Director and MCH Epidemiologist assure up-to-date indicator data is in the CCB to support trend analysis and our internal team "sense making" activities. The added capacity of the SSDI Grant allows for more intentional and strategic assessment of our accomplishments and programmatic activities and what impact this has on our long-term outcomes. In addition to state program staff entering into the CCB, a select group of Title V contract partners have been asked to begin entering their contract activities for monitoring. It is desired that other grantees will begin entering their activities into the CCB in the coming year(s). This will provide a more cohesive and complete picture and allow for more robust monitoring of objectives as related to grant activities. More information on this initiative can be found in the next "Other MCH Data Capacity Efforts" section of this Application.

As part of the state's monitoring efforts, the SSDI Project Director and MCH Epidemiologist produce a "Data Snapshot" to visibly show the trends associated with all national outcome and performance measures and the alignment with measurements in the Medicaid system.

Evaluation: In partnership with the University of Kansas Center for Community Health and Development (KU-CCHD), who specializes in supporting community health through collaborative research and evaluation, Title V has established an agreement for the KU-CCHD to assist in implementing a MCH Monitoring & Evaluation (M&E) System, using the MCH Community Check Box (CCB) Evaluation System, which includes a formal evaluation plan and report associated with each of the objectives in the Title V State Action Plan. The SSDI Project Director, MCH Epidemiologist and other MCH epidemiological and program staff will determine specific outcome measurements for each of the objectives.

Title V staff participated in a workshop hosted by KU-CCHD that included foundational information that focused on helping staff better understand evaluation and what it can mean for Title V and MCH programming moving forward. The overall objective was to begin framing our own formal evaluation plan. The workshop content included: evaluation design, applying evaluation principles, describing measures of success, describing improvements and change, identifying key stakeholders.

The KU-CCHD team supports Title V in establishing a formal evaluation plan utilizing the "Evaluating the Initiative" toolkit in the Community Toolbox, designed to help community programs develop an evaluation. The KU-CCHD will adapt as needed and work with our team in the coming year(s), specifically aligning with the intent and purpose of the SSDI Grant and engaging the SSDI Project Director to support long-term evaluation efforts for the Kansas Title V Block Grant.

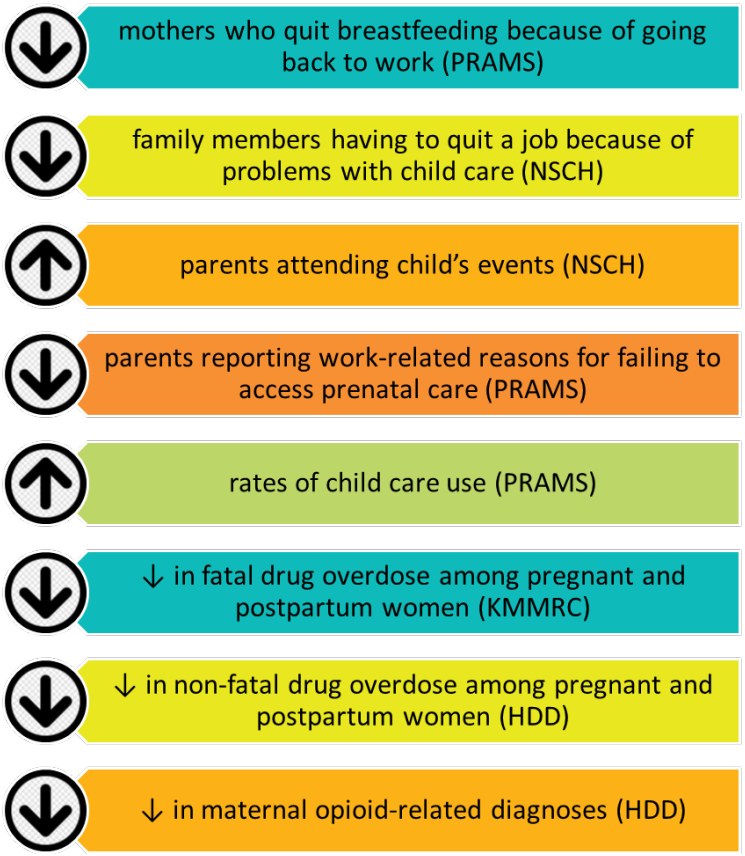
Key SSDI & Title V Activities

The Kansas SSDI team, composed of the SSDI Project Director, MCH Epidemiologist, and Data Analyst, actively participate during MCH Leadership (monthly), MCH Coordination (monthly), and KMCHC (quarterly) meetings to provide emerging, persisting or ongoing needs in response to staff requests and related to our own

projects and local requests for data, what we learned about the measures over the course of the year related to the needs assessment, and any priorities shifting. SSDI provides capacity and support in the following data initiatives to enhance the Title V access to other MCH health data that can inform programming, assessment, and monitoring during and between formal needs assessment periods.

Block Grant & Ongoing Needs Assessment: As part of the ongoing epidemiologic support, SSDI continues to assist with: refining the 5-year State Action Plan, ESMs and SPMs, setting annual objectives (linear forecasts) for each NPM and SPM, writing trend analysis, highlighting major statistical findings and providing interpretation, developing funding formula for the MCH Block Grant allocation to local health departments and grantees, and preparing the resources/tools to increase knowledge and understanding about the Kansas Title V MCH federal-state partnership, services, block grant, and the state's priority issues for 2016-2020. SSDI shares data and set the stage as to the current state of MCH in Kansas; using the MCH measurement framework, discusses about the trend and current status for NOMs, NPMs, ESMs and SPMs; and identifies where we need to take note/pay attention to the negative and opportunities to improve.

The SSDI Project Director and MCH Epidemiologist, as part of the Kansas Power of the Positive (KPOP) (http://www.kansaspowerofthepositive.org/) Data Team, involve/contribute in designing a Protective Factors Dashboard that will track population-level data capturing parent's experiences of increased protective factors and decreased risk factors. Once the questions are collected and/or data use agreements completed, the anticipated result will be a constellation of indicators that help the coalition track progress and measure the impact of family friendly work place conditions. Examples of the data points that are/will be provided via the Dashboard and trends that we hope to see (and utilize as part of the needs assessment) are provided below.



Maternal Morbidity & Mortality: With epidemiological support from SSDI and staff support from the CDC ERASE Maternal Mortality grant, in June 2022, Title V released/published the second annual report for maternal mortality, including severe maternal morbidity (SMM). Three infographics (SMM, pregnancy-associated deaths, and pregnancy-related deaths) and an easy to read Kansas Maternal Mortality Review Committee (KMMRC) Annual Report Summary were developed. Published products can be found at https://kmmrc.org/reports/.

Kansas Perinatal Community Collaborative (KPCC) Annual Reports: The MCH Epidemiologist continues to work with Vital Statistics to link the 2020 program data with birth record data for the 2020 evaluation report. The 2020 Becoming a Mom® State Aggregate Report will be completed in Fall 2022. The goals of this process were to:

a) assess the feasibility and benefit of linkage process; and
b) identify how data quality changed in KPCC outcomes data when supplemented with available birth record data.

Five measures were captured for the initial pilot linkage process: gestational age, low birth weight, induced deliveries, cesarean deliveries, and breastfeeding initiation. From the linkage process, there was nearly a 50% increase in the possible records available for analysis. Based on the 2019 linked data showed a significantly lower preterm birth rate (4.4%) than for Kansas births overall (10.1%), a slightly lower rate of low birthweight, and a slightly higher rate of breastfeeding initiation. KPCC sites had a statistically higher percentage of induced births, but with the linkage there was also a significant decrease in the reported induction rate, which may indicate overreporting. This indicates an opportunity for further education about induction in the KPCC programs.

Medicaid-Birth Record Linkage: After several trials to link data, and a revision of the states' Medicaid Management Information System (MMIS), the birth, hospital, and Medicaid data linkage has been completed for five years and will be performed on an ongoing basis. The efforts included reprocessing calendar year 2015 linkages of the three datasets using data from the new Kansas Medicaid Management System. Record linking for calendar years 2016 through 2019 has also been completed. Due to a staff turnover, the current plan is to evaluate the 2016-2019 record linkage/matching process and carefully document in programs, output, data dictionaries, and reports. This includes retaining statistical program logs, keeping track of the provenance of input datasets, and documenting all decisions made concerning methods and their application. Based on the previous years' linking efforts about 25% of resident births were covered by Medicaid. The linked files will enable SSDI and other agency staff to perform analyses to review hospital coverage as well as information from five claims table: (1) pharmacy, (2) inpatient care, (3) professional services, (4) dental, and (5) outpatient. In order to evaluate non-pregnancy related healthcare, the SSDI program has access to eligibility information for females (ages 0 to 55) and males (ages 0 to 22) as well as claims information from the five claims tables. This will enable SSDI to better assess Medicaid-covered health care between pregnancies and post pregnancy.

Minimum/Core Indicators: SSDI has advanced the use of the Minimum/Core (M/C) Dataset indicators. Whilst the Kansas Title V team continues work related to the Title V Needs Assessment and State Action Plan in partnership with many internal and external partners, KMCHC, and the Special Health Services Family Advisory Council, the primary focus involves monitoring progress and measures/trends, discussion areas of work that have been in the plan since inception but not executed, and emerging issues for Title V populations not reflected in the plan. MCH team meetings are held monthly to review the state action plan, measurement framework data/trends, and work on partnerships and alignment related to objectives and strategies within each priority. This is to ensure we are on target with priority work and relevant efforts. A system is developed by the team for ongoing assessment to tract progress with measures and identify program responses based on the data (e.g. develop a TA webinar, conduct site visits, provide resources/materials, and plan a conference or skills building session). Example documents used by the program to continuously monitor the Title V measures are Performance Measure and Evidence-based or informed Strategy Measure (ESM) Tracking Snapshots, which include the majority of the M/C Dataset Indicators.

SSDI Minimum/Core (M/C) Indicators

Core/National Dataset (C/NDS) – 8 indicators	Core/State Dataset (C/SDS) – 13 indicators
• Total Preterm Birth	• Pregnancy Weight Gain
• Very Preterm Birth	• Newborn Bloodspot Screening
• Tobacco Use During Pregnancy	• Infant Back Sleep Position
• Multivitamin/Folic Acid Use Before Pregnancy	• Immunization by 2 Years (Medicaid Only)
• Exclusive Breastfeeding at 3 Months	• Immunization by 13 Years (Medicaid Only)
• Access to Medical Home	• Emergency Department Visits 0-19 Years (Medicaid Only)
• C-Section Among Low Risk Women	• Asthma Hospitalizations Under 5 Years
• WIC BMI 2-5 Years	• Nonfatal Injury Hospitalizations 0-9 Years
	• Nonfatal Injury Hospitalizations 10-19 Years
	• Motor Vehicle Injury Hospitalizations 0-14 Years
	• Motor Vehicle Injury Hospitalizations 15-19 Years
	• VLBW Infants born at Level III+ Centers

Minimum/National Dataset (M/NDS) – 24 indicators	
• Infant Mortality	• Adolescent Mortality 10-19 Years
• Black/White Infant Mortality	• Suicide 15-19 Years
• Low Birth Weight	• Injury Mortality 15-19 Years
• Very Low Birth Weight (VLBW)	• Motor Vehicle Mortality 0-14 Years
• Newborn Hearing Screening	• Motor Vehicle Mortality 15-19 Years
• Any Breastfeeding at 6 Months	• Teen Birth 15-19 Years
• Immunization of 19-35 Month Olds	• Adolescent Chlamydia 15-19 Years
• CSHCN Medical Home Access	• Young Adult Chlamydia 20-24 Years
• CSHCN Adequate Health Insurance	• Access to Health Insurance
• CSHCN Community-Based Services	• Medicaid Eligibility Standards
• CSHCN Transition to Adult Life	• State-level Poverty
• Child Mortality 1-9 Years	• State-level Child Poverty

A few specific examples of describing the use of M/C Dataset indicators to promote data-driven decision-making, linkage of state MCH databases (KPCCs pilot linkage project), and contribute to public reporting (e.g., infographics, online public facing data dashboards, fact sheets, presentations) include:

- Maternal Child Health Domains Profiles
- Data Maps
  - Infant Mortality Maps
  - Sleep-Related Unexplained Infant Death Maps
- Provider Resources
  - Preconception Health Guide
  - Stillbirth in Kansas
  - World Preeclampsia Day
  - Preterm Birth Infographic
  - National Breastfeeding Month Action Alert
  - Baby Safety Month Action Alert
  - National Newborn Screening Month Action Alert
  - Health Disparities Data ("Did You Know" – Spotlight on Black Maternal Health)

MCH DATA CAPACITY

The Kansas Title V program demonstrates strong commitment to coordinating and collaborating beyond mandated work and addressing the emerging and ongoing needs of all MCH populations while continuously focusing on quality improvement. Title V goals are infused in, and supported by, the entirety of the Bureau's work across programs, funding sources, resources, and shared infrastructure. This commitment drives development of integrated systems of care and assessment for community level MCH initiatives.

Shared Measurement & Data Monitoring Systems

Data Application & Integration Solutions for the Early Years (DAISEY): BFH has been working with the University of Kansas Center for Public Partnerships & Research (KU-CPPR) (https://cppr.ku.edu/) since 2015 to: 1) implement and support a secure, HIPAA compliant web-based system (DAISEY); 2) train and provide technical assistance to 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. DAISEY supports Title V's vision for shared measurement and integrated community-level MCH initiatives. Increased data capacity allows the program to demonstrate the impact of coordinated, essential MCH services on improved outcomes. DAISEY is available free to all local grantees and is the required centralized collection system for MCH services.

A website was developed at the time of launch to provide a centralized access point for users to find information and resources such as training, printable forms, data dictionaries, user guides, and technical briefs. KDHE and KU staff provide extensive training and technical assistance through webinars, individual phone instruction, on-site training, and recorded navigational videos. A DAISEY Helpdesk email is available to provide direct technical support for system users.

DAISEY's data and analytics infrastructure continues to be enhanced, with focus shifting from *data collection* to *using data* to drive decisions and quality services. Customized, visual reports in DAISEY allow users and

KDHE to review data quality, meet compliance reporting, and implement program improvements through review of clients served, services provided, education provided, and referrals made/completed. DAISEY reports help local agencies and KDHE easily demonstrate the need for MCH services and share the impact of their programs at the community, regional, and statewide levels.

The DAISEY Data Dictionary is available online at https://kdhe.daiseysolutions.org/find-answers/. During the pandemic, an additional question was added to the KDHE Program Visit Form for both adult and the infant/child/adolescent encounters. The new question is to determine whether or the visit occurred in person or remotely. There are multiple response options to select from: In-Person; Virtual, phone only; Virtual, video chat (Skype, Zoom, Facetime, etc.). KDHE will be able to use this to assess the client encounters during and after the pandemic.

Integrated Referral & Intake System (IRIS): Title V is partnering with KU to implement IRIS, a web-based community referral system to support best practices in social service referral and coordination among community partners. Its primary purpose is to enable service providers to make, receive, track, and respond to referrals. Data collected will provide insight into what's working and not working at the local level for families as far as connecting to needed services.

In Kansas, there has been a concerted effort to align systems in public health, early childhood, family supports, behavioral health, and social services at the state and community level. IRIS is an important tool in this work, as the referral tool and community-based implementation model has served to bridge the technical and adaptive gap between systems to engage individuals and families and get them connected to the services to address their unique and often complex needs. Local public health is a cornerstone in communities and the value of local public health engaging in IRIS is great. Often local public health is the entry point into the system of care for our most vulnerable populations. A foundational role of local public health is to connect families to other needed resources and supports in the community. Local public health is critical in identifying goals and needs based on risk factors for families and connecting them to wrap around services. Local public health is often the HUB of the wheel in which other community organizations, or the spokes, spread from. IRIS is an efficient, low cost way for local public health to communicate with other providers, make those connections for families, and close the feedback loop, to ensure that families truly are connected to the supports that they need. It also allows other organizations within the IRIS network to see what local public health has to offer and to refer into the public health system as well.

In many instances, we find that strong referral networks are not in place to support comprehensive needs of families. Additionally, all community members, including providers, are not aware of all the wrap around services that their community has to offer. When a system such as IRIS is in place, organizations can start to see a map of their community. They are easily able to recognize what services are available to families and make those connections. IRIS allows organizations to easily track referrals made, to ensure that families do get connected to the services they need. It is often hard or nearly impossible for a family in crisis to try to navigate their way through a complicated system, IRIS can help alleviate some of that stress from a family. A referring organization can see if and when services are available, rather than directing a family to a resource that may not be accepting new patients or has eligibility criteria that the family does not meet. That can save many fruitless phone calls and frustration for the referring organization and the family.

Kansas Title V communicates our support for local partners engaging in IRIS with both broad and targeted messaging for IRIS. When we engage in new projects, such as pilot projects, we always try to ensure that IRIS is part of the equation if the providers do not have another means of referring and connecting. We encourage all partnering organizations to be involved in a local IRIS community to support holistic care if another platform is not already in use. Our approach supports meeting communities where they are, so if a community has

already engaged in a referral system that is robust, offers bi-directional referrals and closes the feedback loop, and that system is working for the community, then that is ok. But, if a system is not in place, then we will encourage the community to adopt IRIS. We have provided financial support for communities to adopt IRIS as part of a larger grant or pilot projects, but we encourage communities to work together collaboratively to develop a plan for start-up and maintenance for long-term sustainability.

Aid to Local Funding: The MCH Epidemiologist and Teen Pregnancy Targeted Case Management/Pregnancy Maintenance Initiative (TPTCM/PMI) Program Manager worked to identify potential changes to the TPTCM/PMI funding formulas to better reflect the populations served within each grantee county, including several funding formula options for consideration. The TPTCM ATL formula is now utilizing more up-to-date Medicaid data for teen pregnancies to better account for the target population in respective service areas. The funding formula criteria for each are outlined below.

Program	Funding Formula Criteria
TPTCM	• females ages 12 to 21 years on Medicaid • overall population of females ages 12 to 21 years • county teen pregnancy rates in ages 10 to 19 years
PMI	• overall population of females ages 15 to 44 years • uninsured females ages 18 to 64 years • county infant mortality rates

MCH Community Check Box (CCB): Monitoring the State Action Plan: Title V has been utilizing the MCH Community Check Box (http://communityhealth.ku.edu) since 2017. The monitoring tool was developed by the KU Center for Community Health and Development. CCB captures, characterizes, and communicates state action plan activities/accomplishments. The information collected is used for learning, improved collaboration, quality improvement, and monitoring the extent to which state and local partners are building capacity and acting to address the plan priorities and measures. Title V tracks how these activities may be influencing key indicators such as maternal and infant mortality. Sensemaking sessions take place quarterly with the Title V and KU teams.

TITLE V INVOLVEMENT IN STATE-LEVEL EMERGENCY PREPAREDNESS & RESPONSE

The emergency operations plan is referred to as the Kansas Response Plan (KRP), revised 2017. The KRP establishes a unified, cross-agency approach to incident management to support coordination, efficacy, and efficiency in the state's capacity to prevent, protect against, mitigate, respond to, and recover from terrorism, major natural disasters, and other emergencies. The KRP is designed to support county and federal emergency response plans. This document provides guidance and policy direction on interfacing with county emergency operations plans and the Federal Interagency Operational Plans and is based on the fundamentals within the National Incident Management System.

The KRP is comprised of fifteen emergency support functions (ESF), of which Public Health and Medical Services is ESF 8 and is led by the Bureau of Community Health Systems at the Kansas Department of Health and Environment (KDHE). ESF 8 provides information to support coordinated health and medical activities conducted in response to disasters or emergencies, specifically MCH-related needs such as the behavioral health needs of survivors and responders, medical needs of "at risk" populations (e.g., pediatrics, pregnant women, children with special health care needs, individuals from diverse cultures).

In addition to the statewide KRP, the KDHE Emergency Readiness Initiative Plan outlines the various roles and responsibilities of staff within the Incident Command System (ICS). Given the breadth of services, supports, and programming provided through the Bureau of Family Health, the Bureau Director, also the Title V MCH Director, serves as "Deputy KDHE Commander" and the System of Supports Section Director, also the Title V CSHCN Director, serves as a "Behavioral Health Branch Director" during ICS response activities to assist and support day-to-day responsibilities and various functions within the ICS depending on the situation. It is also not unlikely that other Title V subject matter experts could be added to the formal ICS staffing list, as was the case in the recent Zika public health emergency. BFH/Title V staff are involved in the review and revision of the state emergency operation plans, including the KDHE Emergency Operations Guide. Staff also participate in tabletop "readiness" exercises internal to the agency.

Additionally, the agency's Continuity of Operations Plan (COOP) ensures the provision of critical public health services to the MCH population during an emergency or disaster event and timely and efficient coordination of MCH personnel and resources before, during, and after an event. Within the Bureau of Family Health, the COOP outlines the specific maternal and child health emergency response needs as related to the primary functions of the Bureau (including critical public health infrastructure and programming); key personnel and required training/certification for each function; plans for accessing records and equipment; staff contacts and an order of succession; and the key stakeholders in which communication must be established.

Participation in Emergency Preparedness Planning Activities

When KDHE's ICS is activated, the KDHE Commander is the ultimate authority on anything and everything related to that incident and serves with guidance from the KDHE Secretary. Underneath the KDHE Commander are Officers (Public Information/Political Liaison Officer, Safety Officer, Department Liaison Officer) who provide subject matter expert support to the KDHE Commander at the Commanders direction. Under the KDHE Commander and taking care of functional areas are the Operations, Planning, and Logistics/Administration Sections which are led by Chiefs. These sections perform functional tasks related to the incident in the achievement of operational objectives, goals, and implementing direction from the KDHE Commander. Other supporting units like human resources and legal are typically called in for brief periods of time, usually in the Logistics/Administration Section, to provide specific subject matter activities for that Section Chief and the KDHE Commander. All agency staff participate in agency planning and preparedness in some way, more extensive at times depending on the type and duration of an emergency, to enhance statewide preparedness for addressing potential short- and long-term impacts of disasters and emerging threats on the MCH population.

Data Assessment & Surveillance

Training: All employees at the agency have the following outlined in their position descriptions: “Perform other duties as assigned including serving as a member of the KDHE Disaster Response Team as needed to assure the agency's public and environmental health response is adequately staffed during and immediately following natural and/or manmade disasters, infectious disease outbreaks, and/or acts of terrorism.” As such, all employees are required to complete the ICS trainings within the first 90 days of hire. In recent years, the agency has provided other preparedness trainings around topics such as self-defense and situational awareness, active shooter response, and CPR/First Aid.

Communication Plans: The COOP outlines internal and stakeholder communication plans associated with activation and response of the plan. Individual Bureaus are required to complete Annex B to the plan, which outlines five sections (1) Functions (includes key personnel and required training or certification for each function), (2) Records and Equipment, (3) Bureau Order of Succession, (4) Staff Contact Sheet, and (5) Stakeholders. Internal protocols are established to determine communication plans for each program related to staff and stakeholder contacts.

Coordination with Other PH Programs: Ongoing planning and coordination is necessary across public health programs. The Bureau of Family Health routinely works with the surveillance programs to identify needs and respond (dangerous exposures for pregnant women, birth defects/patterns that could be attributed to investigations, high blood lead levels in young children, etc.). The child care program has emergency disaster guidelines which go into effect during any local or state declaration of emergency and cooperation with other programs, including but not limited to Immunizations, is necessary. In the past, the KS Special Health Care Needs Program has participated in the agency’s Extreme Weather Work Group to assure the needs of people with disabilities were considered during extreme heat and cold seasons in Kansas.

COVID-19 Pandemic Response (Jan. 2020 to present)

The COVID-19 pandemic specifically elevated the need for agency staff to monitor and engage in emergency planning and preparedness at all levels, beyond the agency’s COOP planning activities. Throughout the pandemic response, the Title V MCH Director was instrumental in emergency operations and support to the agency, the Governor’s Office, and the Federal Emergency Management Agency (FEMA).

Kansas enacted many executive orders during the pandemic, including: temporarily prohibiting evictions and foreclosures; expanding telemedicine and addressing licensing requirements; conditional and temporary relief from certain motor vehicle carrier rules and regulations; requiring continuation of waste removal and recycling services; temporarily suspending driver’s license and vehicle registration expirations; allowing certain deferred tax deadlines and payments; extending unemployment benefits to help ensure the protection of Kansas families; relief for child care facilities continuing operation; and more.

Title V staff proactively monitored all guidance provided by the Centers for Disease Control and Prevention (CDC), national experts, and epidemiologists and infectious disease subject matter experts at KDHE. Based on these sources, Title V staff developed guidance for providers and staff as well as the MCH population. Content/guidance was developed for topics including but not limited to service provision for pregnant and perinatal populations (exposure, testing, vaccines, etc.), delivering home visiting services via telehealth, crisis/behavioral health, and safe operation of child care facilities. The guidance is updated episodically based on evolving recommendations and made available on the KDHE COVID-19 Resource Center. Title V stayed abreast of evolving recommendations related to maternal and child health and created resource guides for providers inclusive of these frequent updates. These efforts alleviate the burden on local providers to regularly search for updated recommendations during the pandemic and ensure best practice recommendations are being operationalized related to Title V services.

Title V worked closely with the other KDHE Bureaus and the Kansas Department of Emergency Management (KDEM) to make sure families have access to supports/benefits such as the Emergency Food Assistance Program, the Supplemental Nutritional Assistance Program, Temporary Assistance for Needy Families, and Child Care Assistance. Resources for how to connect to crisis centers, including mental health and substance

use treatment facilities, were developed. A community resilience toolkit and scripts for public health contact tracers to utilize provided suicide prevention resources. Additionally, the Title V program worked closely with our local MCH agencies to use funding in innovative ways to help support families in their communities during the pandemic, such as using MCH funds to purchase technology and minutes for family cell phones so they could participate in telehealth activities and the purchase of “quarantine kits” for families in need (e.g., activities for families to enjoy together, coloring books, jump ropes, sidewalk chalk).

TITLE V PARTNERSHIPS

Title V is heavily focused on collaborative partnerships and demonstrate strong commitment to coordinating with others to address emerging and ongoing needs of MCH populations. Both formal and informal collaborative relationships exist that support the Title V work.

Collaborative Work & Relationships

Partnerships at the state and local level ensure coordination within the MCH health care delivery system. The state MCH team provides expertise, gathers feedback, facilitates partnerships and conversations, and makes connections to assure access to services and maximize the effectiveness of the health system. Title V services contracts with local agencies to provide family centered, community based, and culturally competent services/care to MCH populations across the state. Local funding awards are based on MCH population data (census as source), plans, performance, collaboration, and potential to impact.

The Title V vision leads the way and provides direction for all we do in Kansas across the life course, from birth through adulthood. The program prioritizes the intentional alignment of federal-state-local initiatives; interaction with state advisory groups (especially MCH Council, Family Advisory Council, Perinatal Quality Collaborative, PRAMS Steering Committee, Maternal Mortality Review Committee); and regular communication with public and private local agencies and organizations such as public health departments, safety net clinics (FQHCs), primary care settings, hospitals, community mental health centers, social service agencies, and school districts. Strong linkages have been identified across plans and needs assessment findings. BFH staff continue to better align and coordinate with other programs and initiatives with specific roles to address the maternal and child health population.

Title V strategically works to set priorities, goals, objectives, and identify linkages among other core programming that serves MCH populations. Specifically, progress has been made related to reproductive health and family planning with new activities, resources, and interventions in place, and shared priorities with WIC and Child Care (e.g., breastfeeding, oral health, smoking cessation).

INTERNAL AGENCY PARTNERSHIPS

All overseen by the BFH/Title V MCH Director

- Birth Defects Surveillance (BDS)
- Breastfeeding Peer Counselors
- Child Care Licensing (CCL)
- Early Childhood Comprehensive Systems (ECCS)
- Early Hearing Detection and Intervention (EHDI)
- Early Intervention/Infant Toddler Service (ITS) – Part C of IDEA
- Kansas Connecting Communities (KCC)/Maternal Depression and Other Behavioral Disorders
- Maternal Mortality Review Committee MMRC)
- Maternal, Infant and Early Childhood Home Visiting (MIECHV)
- Newborn Screening (NBS) - blood spot and heart
- Pediatric Mental Health Care Access/KSKidsMAP
- Perinatal Quality Collaborative (PQC)
- State Systems Development Initiative (SSDI)
- Supplemental Nutrition for Women, Infants, Children (WIC)
- Title X/Family Planning

State Health Department Programs

Bureau of Health Promotion (BHP): MCH programs work closely with BHP on chronic disease risk reduction, tobacco cessation, injury prevention (e.g., Safe Kids Kansas), suicide prevention, and substance/opioid use prevention/response. MCH staff have been active in the development/implementation of the state's injury prevention plan; adolescent driving safety; physical activity in early care settings; and preventing and addressing Adverse Childhood Experiences (ACEs). BHP also facilitates key activities for the agency around credentialing, training, and expansion of community health workers (CHW) which Title V has been heavily involved in to align holistic care coordination activities.

Bureau of Epidemiology & Public Health Informatics (BEPHI): As described previously, Title V works with BEPHI related to core MCH epidemiological supports. This collaboration has resulted in implementing the Pregnancy Risk Assessment and Monitoring System (PRAMS), launching maternal mortality review, and enhancing birth defects surveillance. Epidemiologists serve lead roles with the Perinatal Periods of Risk (PPOR) Analysis, Fetal and Infant Mortality Review (FIMR) processes, local public health system assessments, and developing/monitoring the State Health Assessment and Improvement Plan.

Bureau of Community Health Systems (BCHS): In partnership with BCHS, Title V supports development, training, capacity building, and systems development across the public health and MCH workforce (e.g., annual Governor's Public Health Conference, MCH pre-conference). The KS Special Health Care Needs (KS-SHCN) program participates on the Emergency Medical Services for Children (EMSC) Advisory Council to support partnership and collaboration across the EMSC and Title V grants.

Bureau of Oral Health (BoH): Title V partners with BoH and other organizations such as Oral Health Kansas to promote and support good oral health and dental care across the life course. Specifically, BoH Director, also the Medicaid Dental Director, participates in the needs assessment process and provides input on the MCH State Action Plan. Targeted work continues to focus on integrating screening and sealant services into local programs/services, expanding school-based health services beyond dental services already in place on site, and consistent messaging across all public health programming at the local level, including prenatal education.

Bureau of Disease Control & Prevention (BDCP): Title V and BDCP are strong partners as it relates to women's health (e.g., immunizations; reproductive health/wellness; STI prevention and intervention during adolescence, preconception, pregnancy, and postpartum periods). As shared priorities and identified needs emerge as a result of the pandemic, there are plans to partner in establishing maternal health care managers to address both general needs, as well as those associated with COVID-19 vaccinations and treatment.

Other Public, Private & Governmental Organizations Serving the MCH Population

In addition to the robust partnerships outlined throughout this application with local health departments to provide technical assistance and funding support, the additional Title V partnerships are critical to the overall MCH service delivery.

Early Childhood Systems: Since 2019 Title V has been actively involved in the comprehensive, cross-agency early childhood systems initiative (referred to as All In For Kansas Kids). Established as a result of a robust Needs Assessment and Strategic Plan, and supported by Preschool Development Grant Birth through Five (PDG B-5) funding from the Department of Health and Human Services (HHS), this unprecedented opportunity for statewide collaboration is focused on building a coordinated system to support early childhood. The BFH and Title V Director participates on the State Directors Team, with leadership from the Kansas Children's Cabinet and Trust Fund, Kansas State Department of Education, and Kansas Department for Children and Families. The approach and collaboration are based on a blueprint organized into three building blocks: Healthy Development, Strong Families, and Early Learning, consistent with the Cabinet's Blueprint and MCH State Action Plan.

Kansas Tribes: KDHE continues its work to build relationships with the four Kansas tribes and will build from information learned during the two focus groups focused on tribal youth health needs conducted during the Title V Needs Assessment. Title V will include guidance for specific cultures and health services around health

care transition planning and seek more conversation from youth and young adults in the tribal community as work continues in the upcoming years.

Public Health/Health Professional Education Programs: In support of public health education, Title V works with undergraduate programs at state Regents Institutions and the MPH program at the University of Kansas. Health professionals play an active role in development and implementation of the MCH State Action Plan and programs, including a strong presence on the KS Maternal and Child Health Council (the current chair is a pediatrician at the School of Medicine in Wichita. Title V has a strong partnership with the Kansas State University Research and Extension Office, with a specific focus on adolescent health. Recently, the CSHCN Director has expanded a partnership with the Leadership Education in Neurodevelopmental Disorders (LEND) program and are currently working on establishing a formal partnership agreement to compliment strategies under both grants.

Other State & Local Public & Private Organizations Serving MCH Populations

Title V works with the State Primary Care Association (Community Care Network of Kansas – CCN) and FQHCs to help meet the needs of women and children. FQHCs are funded to provide MCH and CSHCN services and have served as lead agencies in HRSA-funded projects, such as efforts to improve the health and well-being of pregnant/postpartum women and establish school-based health centers.

Other organizations that have not been previously mentioned include the Kansas Hospital Association, Kansas Academy of Family Physicians, philanthropies including the Kansas Health Foundation and the Kansas United Methodist Health Ministry Fund, Kansas Breastfeeding Coalition, Oral Health Kansas, Child Care Aware, Kansas Child Care Training Opportunities, and Families Together (Family-to-Family Health Information Center), along with many other state and community-based organizations.

HEALTH CARE DELIVERY SYSTEM

Title V and Title XIX (KDHE Division of Health Care Finance/Medicaid) are working to identify and address disparities among Medicaid beneficiaries. A strong focus has been on use of the Medicaid-linked birth data set and areas where measures and programming align, such as disparities in prenatal care and birth outcomes. Title V assists Medicaid to identify and address reporting and other program requirements related to childhood immunization status, live birth weight, well child visits, and chlamydia screening.

Title V-Title XIX Intra-Agency Agreement (IAA)

The Title V-Title XIX IAA, established in 2016, outlines the formal partnership. The partnership has evolved over the years but not grown and strengthened to the level needed. The agreement was reviewed in 2019 and amended to further define and detail the relationship between Title V and XIX as it relates to Maternal Mortality Review. The amendment resulted in direct access to data needed to conduct case reviews.

Although communication has improved and progress has been made, there have been delays with implementing and advancing aspects of the Medicaid alignment, integration, and data sharing. These very real challenges are likely due to significant and repeated changes in leadership positions (Secretary, State Health Officer, Health Care Finance Division Director, Medicaid Director, Medicaid Medical Director) since December 2017. The Medicaid Director and Secretary changed again in January 2019; the Medicaid Medical Director and Medicaid Director (again) in May 2020. A new Medicaid Director was named in July 2020 and Division Director shortly after in 2020. The Medicaid Medical Director remains vacant. Despite the past challenges and recent events (key vacancies, COVID-19 pandemic), agency leadership continue to embrace, understand, and support the need for increased collaboration and communication, including data sharing. Overall, the IAA has potential but isn't fully operationalized or institutionalized.

A crosswalk of Title V and Title XIX priorities and measures was included in the IAA to show alignment potential; the alignment was updated in June 2021. A crosswalk of the adult and children's CMS quality measures was also completed to support stronger partnerships between the two programs. (partial document screenshots below).

Medicaid & Maternal & Child Health (MCH) Alignment: Priorities & Measures

Medicaid Pay for Performance Measures

The State implemented a pay-for-performance (P4P) program to incentivize high performance. The State will withhold a portion of the payments due to KanCare health plans each month. At the end of the year, the State will assess whether or not each health plan has met the required performance target. If they have, the health plan will receive the payments back. If they do not, the State will retain the withheld payments.

KanCare[1]	Title V [2]	
Measure	*Priority*	*Measures*
Timeliness of Prenatal Care - PPC	Priority 1 – Women have access to and utilize integrated, holistic, patient-centered care before, during, and after pregnancy.	NOM 1 – Percent of pregnant women who receive prenatal care beginning in the first trimester
Childhood Immunization Status – Combination 10 - CIS		
DTaP Vaccine – by age 2	Priority 2 – All infants and families have support from strong community systems to optimize infant health and well-being.	NOM 22.1 – Percent of children, ages 19 through 35 months, who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) (DTaP, Polio, MMR, HiB, HepB, Varicella, PCV)
IPV Vaccine – by age 2		
MMR Vaccine – by age 2		
HiB Vaccine – by age 2		
Hepatitis B Vaccine – by age 2		
VZV (chicken pox) vaccine – by age 2		
Pneumococcal conjugate vaccine – by age 2		
Hepatitis A Vaccine – by age 2		
Rotavirus Vaccine – by age 2		

Influenza Vaccine - by age 2	Priority 2 – All infants and families have support from strong community systems to optimize infant health and well-being.	NOM 22.2 – Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza
Immunizations for Adolescent – Combination 2 - IMA		
Meningococcal Vaccine – by age 13	Priority 4 – Adolescent and young adults have access to and utilize integrated, holistic, patient-centered care to support physical, social and emotional health.	NOM 22.5 – Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine
Cervical Cancer Screening – CCS	Priority 1 – Women have access to and utilize integrated, holistic, patient-centered care before, during, and after pregnancy.	NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year
		ESM 1.1 – Percent of women program participants (18-44 years) with a preventive medical visit in the past year

Sources:
1. 2020 KanCare Evaluation Annual Report. Retrieved from: https://www.kancare.ks.gov/docs/default-source/policies-and-reports/annual-and-quarterly-reports/annual/kancare-annual-report-to-cms-year-end-12-31-20.pdf?sfvrsn=d894511b_4
2. National Outcome Measures and National Performance Measures: Kansas Maternal and Child Health Services Block Grant 2021 Application/2019 Annual Report. Retrieved from https://www.kdheks.gov/bfh/download/KS_TitleV_PrintVersion_FY21.pdf

NPM: National Performance Measure
NOM: National Outcome Measure
ESM: Evidence-based/informed Strategy Measure

2021 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)

The Affordable Care Act (Section 1139B) requires the Secretary of Health and Human Services (HHS) to identify and publish a core set of health care quality measures for adult Medicaid enrollees. The law requires that measures designated for the core set be currently in use. In January 2012, HHS published an initial core set of for voluntary use by Medicaid. The core set was last updated for 2021.

CMS [1]	**Title V** [2,3]	
Measure	*Priority*	*Measure*
Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)	Priority 6 – Professionals have the knowledge, skills, and comfort to address the needs of maternal and child health populations.	NPM 14.1 – Smoking during Pregnancy and Household Smoking
		ESM 14.1.1 – Percent of pregnant women program participants who smoke referred to an evidence-based program enrolled/accepted service
Cervical Cancer Screening (CCS-AD)	Priority 1 – Women have access to and utilize integrated, holistic, patient-centered care before, during, and after pregnancy.	NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year
		ESM 1.1 – Percent of women program participants (18-44 years) with a preventive medical visit in the past year
Breast Cancer Screening (BCS-AD)	Priority 1 – Women have access to and utilize integrated, holistic, patient-centered care before, during, and after pregnancy.	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
PC – 01: Early Elective Delivery (PC01-AD)	Priority 1 – Women have access to and utilize integrated, holistic, patient-centered care before, during, and after pregnancy.	NOM 7: Percent of non-medically indicated early elective deliveries
Prenatal and Postpartum Care: Postpartum Care (PPC-AD)	Priority 1 – Women have access to and utilize integrated, holistic, patient-centered care before, during, and after pregnancy.	NOM 24 – Percent of women who experience postpartum depressive symptoms following a recent live birth
		SPM 1 – Percent of women who experience postpartum depressive symptoms following a recent live birth

Sources
1. 2021 Core Set of Adult Health Care Quality Measures for Medicaid and CHIP (Adult Core Set). Retrieved from https://www.medicaid.gov/medicaid/quality-of-care/downloads/2021-adult-core-set.pdf
2. National Outcome Measures and National Performance Measures: Kansas Maternal and Child Health Services Block Grant 2021 Application/2019 Annual Report. Retrieved from https://www.kdheks.gov/bfh/download/KS_TitleV_PrintVersion_FY21.pdf

NPM: National Performance Measure
NOM: National Outcome Measure
SPM: State Performance Measure
ESM: Evidence-based/informed Strategy Measure

2021 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) included provisions to strengthen the quality of care provided to and health outcomes of children in Medicaid and CHIP. CHIPRA required Health and Human Services (HHS) to identify and publish a core measure set of children's health care quality measures for voluntary use by State Medicaid and CHIP programs. On December 29, 2009, the Secretary posted for public comment in the Federal Register, an initial core set of 24 children's health care quality measures for voluntary use by Medicaid and CHIP programs. The core set includes a range of children's quality measures encompassing both physical and mental health. The core set was last updated for 2021.

CMS[1]	**Title V**[2]	
Measure	*Priority*	*Measure*
Timeliness of Prenatal Care (PPC-CH)	Priority 1 – Women have access to and utilize integrated, holistic, patient-centered care before, during, and after pregnancy.	NOM 1 – Percent of pregnant women who receive prenatal care beginning in the first trimester
Live Births Weighing Less Than 2,500 Grams (LBW-CH)	Priority 1 – Women have access to and utilize integrated, holistic, patient-centered care before, during, and after pregnancy.	NOM 4 – Percent of low birth weight deliveries (<2,500 grams)
Developmental Screening in the First Three Years of Life (DEV-CH)	Priority 3 – Children and families have access to and utilize developmentally services and supports through collaborative and integrated communities.	NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
		ESM 6.1 – Percent of children, ages 9 through 35 months, who received a parent-completed developmental screen during an infant or child visit provided by a participating program
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents (WCC-CH)	Priority 5 – Communities, families, and providers have the knowledge, skills, and comfort to support transitions and empowerment opportunities.	NPM 10 – Percent of adolescents, ages 12 through 17 with a preventive medical visit in the past year
		NOM 20 – Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)
		SPM 3 – Percent of children ages 6 through 11 who are physically active at least 60 minutes per day
Child and Adolescent Well-Care Visit (WCV-CH)	Priority 5 – Communities, families, and providers have the knowledge, skills, and comfort to support transitions and empowerment opportunities.	NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year
		ESM 10.2 – Percent of adolescent program participants, ages 12 through 17, that had a well-visit during the past 12 months
Immunizations for Adolescents (IMA-CH)	Priority 5 – Communities, families, and providers have the knowledge, skills, and comfort to support transitions and empowerment opportunities.	NOM 22.2 – Percent of children, ages 6 months through 17 years, who are vaccinated annual 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.

Sources
1. 2021 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set).Retrieved from https://www.medicaid.gov/medicaid/quality-of-care/downloads/2021-child-core-set.pdf
2. National Outcome Measures and National Performance Measures: Kansas Maternal and Child Health Services Block Grant 2021 Application/2019 Annual Report. Retrieved from https://www.kdheks.gov/bfh/download/KS_TitleV_PrintVersion_FY21.pdf

NPM: National Performance Measure
NOM: National Outcome Measure
SPM: State Performance Measure
ESM: Evidence-based/informed Strategy Measure

Title V-Title XIX Partnership Impacts

Title V continues to build on activities and progress that have provided a strong foundation for the partnership. Key activities have reduced some barriers and paved the way for a new precedence of partnership, data sharing, and collaboration.

Title V/Title XIX Partnership Opportunities

- Appointment of a Medicaid Program Manager on the Kansas MCH Council (KMCHC)
- Ongoing engagement/discussion about maternal and child health services
- Ongoing discussions between Title V CSHCN Director and Home and Community Based Services Director related to Appendix K COVID-19 policies
- Vital Statistic/Medicaid data linkage
- Recurring opportunities to present to the MCOs regarding MCH measures targeting the Medicaid population disparities
- Leveraging Medicaid funding to support expanding access to prenatal education, maternal depression screening, LARC, and substance use screening, education, referral, and treatment
- Access to the KS Eligibility Enforcement System (KEES) to reduce burden for staff working to confirm Medicaid and other benefits (e.g., KS-SHCN, maternal mortality, EHDI).

There are several initiatives that will continue to be pursued to advance systems of care for the MCH population. The slide below outlines some of the current work with status related to key policy areas.

Medicaid & BFH/MCH Shared Work – Key Activities

- Goal: Expand MCH services covered based on public health evidence/data/findings
  - Focus has been on home visiting, care coordination/navigation, and prenatal education
  - Reviewing alternatives to cover bundled services for pregnancy and postpartum periods
- Goal: Expand telehealth reimbursement policies for virtual early intervention (Part C/tiny-k) services to
  - Focus has been on virtual services during public health emergencies
  - Ensure policies extend beyond public health emergency declaration timeframes
- Goal: MCO utilization of IRIS (platform for community referral) to seamlessly connect to services beyond those offered by the MCO
  - Meetings with United HealthCare (UHC) to exchange information about services, participant needs, and referrals
  - UHC Care Coordinators actively connecting beneficiaries to local MCH programs and using IRIS
  - Title V working to get the UHC community to join the broader community-based IRIS network

Kansas Pediatrics Supporting Parents (PSP)

In partnership with the national PSP team and consultants, a new policy was implemented to cover maternal depression screenings under the child's plan. PSP Phase 2 goal is to "Improve young children's social and emotional development in pediatric primary care by strengthening care coordination practices delivered through Kansas Medicaid." There were three project focus areas: Systems Alignment, Payment Policy, and MCO Contract Procurement. Title V remains involved in discussions for each these areas, despite formal project support ending in December 2020. The team developed a timeline spanning from 2020 through 2022.

STEP 1: Systems Alignment

Proposed Goal: Leverage lessons learned and momentum created through existing care coordination models. Focus on cross-system alignment, partnership, and collaboration necessary to provide quality holistic care coordination services.

Key Alignment Opportunities:

- *Medicaid:* Existing MCO service coordination; incorporate strong elements from KanCare 2.0
- *Public Health:* Title V Maternal and Child Health (MCH) holistic care coordination programs (primary care, special health care needs); Kansas Perinatal Community Collaboratives; Community Health Workers/Navigators
- *Early Childhood Systems:* Help Me Grow; Bridges (transitions from early intervention/Part C)

STEP 2: Payment Policy

Proposed Goal: Design a payment policy focused on ensuring and enhancing holistic care coordination for young children to support social and emotional development through public health, pediatric primary care, and Medicaid managed care utilizing the existing infrastructure to increase access for families and improve collaboration for providers.

STEP 3: MCO Contract Procurement

Proposed Goal: Propose contract language for the next MCO re-procurement that:

(1) Expands the definition and scope of service coordination that health plans must provide (holistic focus); and
(2) Assures quality strategies aimed at pediatric populations to:
   a. Increase performance on child quality measures;
   b. Enhance rates of developmental, vision, hearing, and maternal depression screenings/evaluations; and
   c. Improve select performance on existing perinatal and child health measures.

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Drafted October 2, 2020

Community Health Workers & Medicaid

As a result of the recent activities surrounding the PSP recommendations, the community health workers (CHW) short- and long-term payment strategies, credentialing, and Medicaid procurement, and expansion of holistic care coordination (HCC) efforts, the following shared objectives have been noted:

- Create a system of care for all families to receive supports in navigating health, community, social, and family needs.
- Create a pathway for a high quality, trained workforce to provide these supports (e.g., training, credentialing).
- policies to assure adequate reimbursement to provide these services to families across systems.

BFH and BHP are partnering to support a cohesive and integrated approach that show the intersection of work in the state around care coordination. As a supplement to this policy memo, a robust and collaborative Medicaid payment policy will be included that allows for payment of care coordination, as a service line, for various provider types (including CHWs, home visitors, and other care coordinators) in both public and primary care settings. It is anticipated to include existing Medicaid services under the "Care Coordination" service through OneCare Kansas (OCK), the legislatively mandated health homes initiative. Per the OCK Program Manual, Care Coordination is done through "appropriate linkages, referrals, coordination, collaboration, and follow-up for needed services and support."

In addition to the policy recommendations outlined in the memo, the team intends to focus on the recommendations from the PSP work, to "Amend the Contract to Address Service Coordination for Preventive Care." Title V is currently monitoring progress on re-procurement to support public health's role in amending the RFP to reflect that MCOs must provide service coordination to all enrollees, considering national standards aimed at pediatric populations for care coordination.

Other Title V-Title XIX Activities

Navigating Kansas Medicaid & the Insurance System: Local MCH agencies assist clients in navigating insurance systems (public/private/Medicaid). Many facilitate on-site enrollment of MCH clients and screen for insurance status/coverage at each encounter. If uninsured, Medicaid eligibility is reviewed and a referral is made, when appropriate. Staff assist individuals/families to complete the application and submit to Medicaid, when needed. For those who do not qualify for Medicaid, private Marketplace information is provided along with contact information to a Navigation Specialist.

Kansas Special Health Care Needs (KS-SHCN): KS-SHCN works collaboratively with Medicaid/MCO to assure dually enrolled clients receive appropriate services and quality case management/care coordination (addressed in the IAA). MCOs share data monthly around authorized Medicaid services to the KS-SHCN Care Coordinator, allowing them to assist clients in getting appointments scheduled, fill prescriptions, communicate with providers, and other supports. KS-SHCN coordinates with MCO care coordinators around gaps or barriers in services. KS-SHCN routinely presents to the MCOs and Medicaid partners to discuss varies challenges in meeting the needs of the SHCN population.

PRIORITY 1: Women have access to and utilize integrated, holistic, patient-centered care before, during, and after pregnancy.

Domain: Women & Maternal Health

NPM 1: Well-woman visit (Percent of women, ages 18-44, with a preventive medical visit in the past year)

ESM: Percent of women program participants (18-44 years) with a preventive medical visit in the past year

SPM 1: Postpartum Depression (Percent of women who have recently given birth who reported experiencing postpartum depression following a live birth)

ESM: Percent of MCH program participants screened for depression and anxiety during pregnancy and/or the postpartum period using the Edinburgh Perinatal/Postnatal Depression Scale (EPDS)

ESM: Percent of pregnant/postpartum MCH program participants who received a referral in response to a positive screen for depression or anxiety through the Edinburgh Perinatal/Postnatal Depression Scale (EPDS)

2021 WOMEN / MATERNAL HEALTH ANNUAL REPORT

Local MCH Reach: During SFY2021, 58 of 67 grantees (87%) provided services to the Women & Maternal population.

NPM 1: Well-woman visit (Percent of women, ages 18-44, with a past year preventive visit)

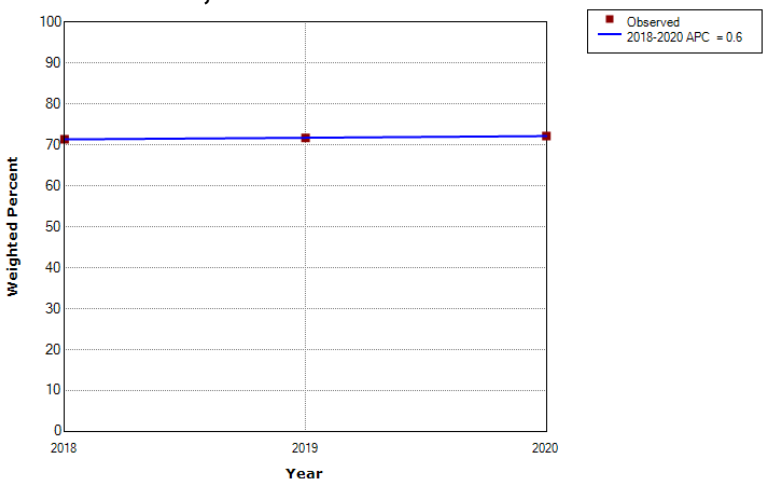
ESM: Percent of women program participants (18-44 years) with a preventive medical visit in the past year

Annual routine medical checkups are important for preventive care. The American College of Obstetricians and Gynecologists recommends that well-women visits specifically include "screening, evaluation and counseling, and immunizations based on age and risk factors."[1] In 2020, an estimated 72.2% of Kansas women aged 18-44 years reported having a routine medical checkup within the past year (95% confidence interval [CI]: 69.4%-74.8%). This was not significantly different from the U.S. estimate of 71.2% (95% CI: 70.4%-72.0%).

Utilization of a routine medical checkup within the past year varied by household income and health insurance status. A significantly higher percentage of women in households with an income of $75,000 or more reported having a routine checkup within the past year (77.6%; 95% CI: 73.0%-81.7%), compared to women in households earning $25,000 to $49,999 (67.5%; 95% CI: 61.1%-73.2%). A significantly lower percentage of women without health insurance coverage (45.1%; 95% CI: 37.0%-53.5%) reported having had a routine checkup within the past year compared to those with health insurance coverage (76.6%; 95% CI: 73.8%-79.2%).

The estimated percentage of Kansas women aged 18-44 years who reported having a routine medical checkup in the past year did not change significantly from 2018 to 2020.

Weighted Percent of Kansas Women, Ages 18-44, Reporting a Routine Medical Checkup within the Past Year, 2018-2020



The Annual Percent Change (APC) was not found to be significantly different from zero at the alpha = 0.05 level.
Source: Centers for Disease Control and Prevention (CDC), Behavioral Risk Factor Surveillance System (BRFSS), 2018-2020

Data note: The routine checkup items changed in 2018 and is not comparable to previous survey years. The definition of a routine checkup as a general physical exam, not an exam for a specific injury, illness, or condition, is no longer part of the standard question and only provided if a respondent asks for clarification: "About how long has it been since you last visited a doctor for a routine checkup?"

Objective: Increase the proportion of women program participants receiving a high-quality, comprehensive preventive medical visit.

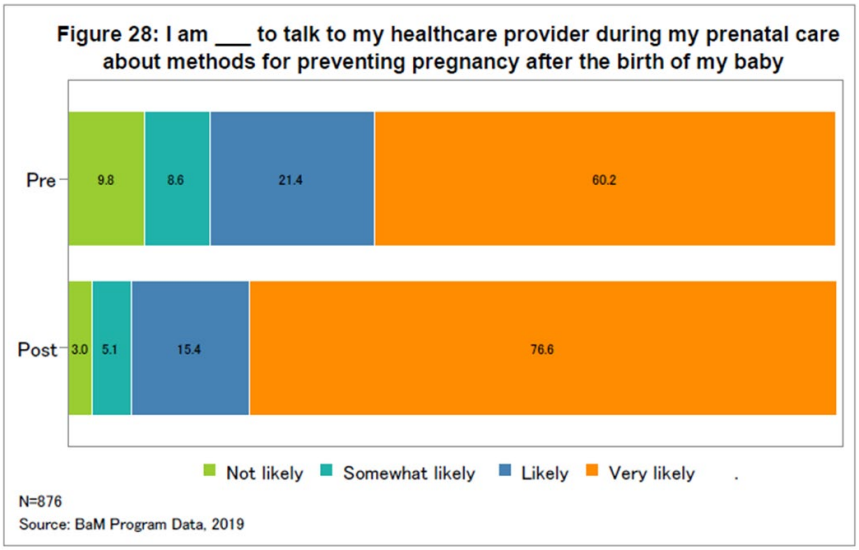
Title V staff continue to support the promotion of women receiving a well-woman visit annually, by messaging the importance of local MCH agencies partnering with other community agencies to provide on-site assistance for accessing health care coverage in the preconception and interconception periods. Local grantees either offer direct well-woman preventive care or enabling services by providing resources and referrals for annual well-woman visits. The tag line "Every Woman, Every Time" ensures that all women are assessed for a well-woman visit and educated on the importance of comprehensive annual preventative care at every visit. Primary strategies to increase the number of women receiving an annual well-woman visit include:

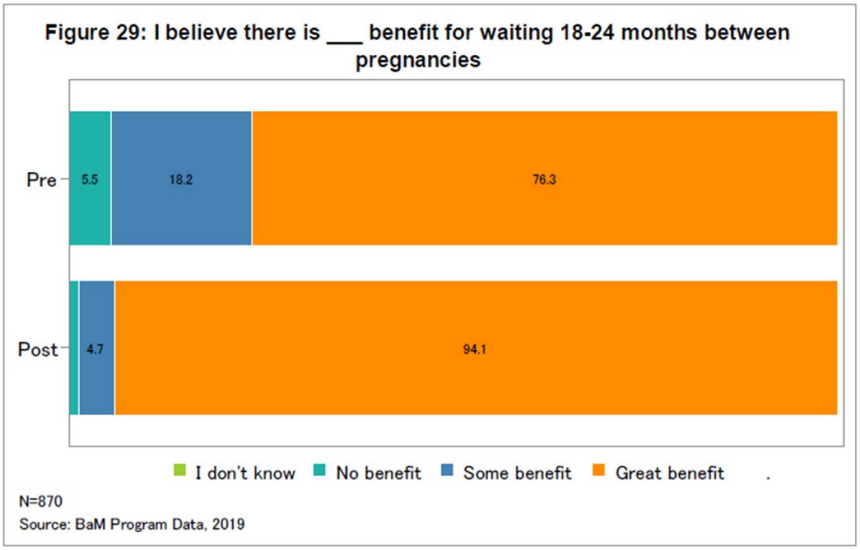
- Providing resources and tools to support local health agencies on educating women about the importance of a high quality, comprehensive annual preventive medical/well-woman visit, assessing for insurance coverage, and assisting women to obtain insurance if needed;
- Providing on-site assistance for accessing health care coverage through certified application counselors or Medicaid eligibility workers to ensure coverage before, during and after pregnancy;
- Utilizing peer and social networks for women, including peer or group education models, to promote and support access to preventive care;
- Providing technical assistance to support local health agencies in developing policies and protocols that incorporate women's goal setting and health screenings to assess for basic needs and health status; and
- Promoting and supporting Medicaid policy change to expand pregnancy coverage through 12 months postpartum and the inclusion of screening for Perinatal Mood and Anxiety Disorders (PMADs) screening as a covered service.

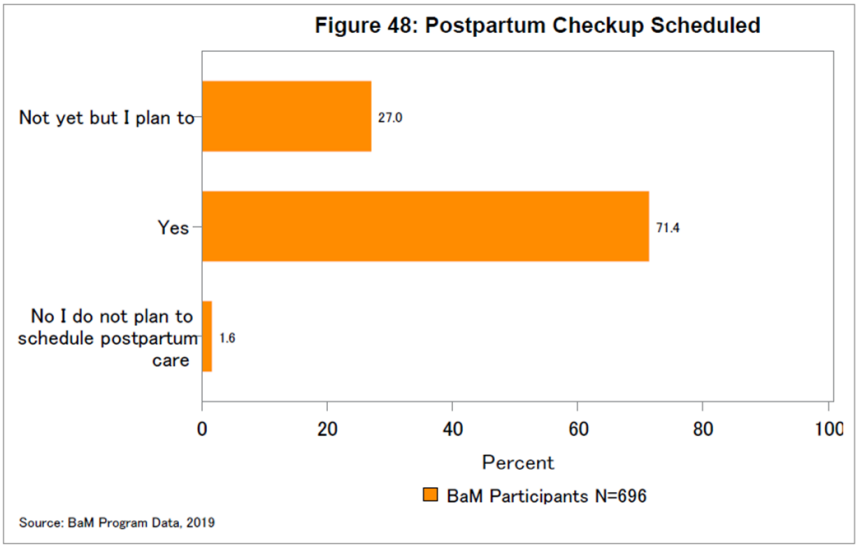
This work is in alignment and collaboration with the Title X Family Planning program and other state partners. The importance of women's health and the annual visit was highlighted at trainings and other events, and associated resources were distributed at the annual Governor's Public Health

Conference, MCH Home Visiting Regional training, and other appropriate venues as well as online through the Kanas MCH website and social media.

Kansas Perinatal Community Collaboratives (KPCC)/Becoming a Mom® (BaM): It has been a priority for perinatal community collaboratives utilizing the March of Dimes (MOD) Becoming a Mom® (BaM) prenatal education curriculum to focus on women's health in the inter-conception period, including but not limited to addressing the importance of well visits. Activities include the integration of personal health plans and the development of a reproductive life plan (RLP) for each woman completing the 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; planning for the prevention of an unplanned pregnancy; healthy diet and exercise plan; planning for daily consumption of at least 400 mcg of folic acid; updating and maintaining vaccinations; practicing stress management techniques; and managing chronic health conditions. July 2021 updates included incorporating a quick walk through of the "Show Your Love" website, with a specific focus on the *My Postpartum Plan* and *Knowledge is Powerful* tabs on the website. Program evaluation data shows improvements in knowledge and planned behavior related to education received. The below figures are examples of data that demonstrates these improvements.







The data and trends cited at the beginning of this section reveal disparities Title V is working to address. The education sessions and associated activities are aimed at improving rates of well-woman visits among various populations.

Well-Woman Visit Integration Toolkits: In December of 2020, KDHE published the Well-Woman Visit Integration Toolkits for Providers and Communities. KDHE developed these resources to help ensure every woman in Kansas has access to, and receives, comprehensive, integrated care every year. There are three main areas covered in each toolkit: recommended components of a well woman visit; barriers faced by women that prevent them from receiving annual preventive care and recommendations to address these barriers; and resources for communities and providers.

The toolkit's success relies on partnerships with allied professionals and community agencies. The Community Provider Toolkit focuses on educating partner programs about the importance of the well-woman visit. Title V provides webinars with key programs, specifically targeting MCH-serving programs (e.g., Title X, WIC, PMI, TPTCM, MIECHV, KPCC). In addition, the Well-Woman Toolkits and the Reproductive Life Plan are components of the Kansas Perinatal Quality Collaborative (KPQC) Fourth Trimester Initiative. Participating FTI birthing facilities are required to ask patients to schedule their postpartum follow-up visit as well as their annual exam prior to discharge in an effort to ensure all new mothers receive this important preventive care.

MCH-led promotional efforts around awareness months and weeks (e.g., National Women's Health Week, Minority Health Month, Black Maternal Health Week) have incorporated messaging related to the importance of the well-woman visit. Action Alerts & Infographics and corresponding social media kits were developed and shared with all Title V and Title X partners as well as other key partners such as the Kansas Maternal and Child Health and Family Advisory Councils.

In an effort to better serve all Kansas women and connect with communities across the state around preventive care, the KMCHC held a listening session during the April 2021 meeting on the state of preventive and maternal health services for Hispanic/Latina women in Kansas. A panel of presenters that are a part of, and serve, Hispanic women across the state shared insights and recommendations related to what both KDHE and local partners can be doing to better engage and serve this population. As a result of this session, the BFH determined that all public-facing documents with patients as the intended audience must be available in English and Spanish and that program staff will be intentional when seeking translation services to ensure the dialect accurately reflects the Spanish-speaking populations in various communities across the state.

Behavioral Health Integration: In support of best practice recommendations, Title V strives to assure women are screened for anxiety, depression, and substance use annually, along with the well-woman visit. Title V added behavioral health screening forms to our shared data management system, DAISEY, to increase availability of evidence-based screenings to local MCH agencies. Title V published behavioral health screening tools guidance that includes framework for administering behavioral health screenings (e.g., selecting a validated screening tool for the population, preparing your agency, establishing and formalizing a local system of care), support resources, an a 1-page overview of each behavioral health screening tool available in DAISEY:

- CRAFFT – Substance Use, Ages 11-21
- Generalized Anxiety Disorder (GAD-7) - Anxiety, Ages 12+
- Patient Health Questionnaire (PHQ-9) - Depression, Ages 11+
- PHQ Modified for Adolescents (PHQ-A) - Depression, Ages 11-17
- Pediatric Symptom Checklist (PSC-17) - General Mental Health Screening, Ages 4-16

Title V staff added three questions to the DAISEY Services Form: *Was an <anxiety / depression / substance use> screening administered?* Question responses, as well as screening results and plan of action form responses, will be reviewed and used to identify any training or technical assistance needs. See the Cross-Cutting Report for more information about these screening tools and subsequent guidance published for local programs.
In addition to the behavioral health screening tools and guidance, Title V worked to review social needs screening tools and identify a validated screen that is comprehensive while not being overwhelming for clients or providers. The tool identified is the AAFP Social Needs Screening Tool and it will be incorporated into DAISEY, along with corresponding guidance, in the summer of 2022.

Medicaid Policy Improvements: The Medicaid Maternal Depression Screening (MDS) policy became effective January 1, 2021 to reimburse for up to three screenings during the prenatal period under the mother's Medicaid ID and for up to five screenings during the 12-month postpartum period under the child's Medicaid ID. The policy also allows for reimbursement to occur when non-licensed professionals, like home visitors and community health workers, administer screenings under supervision of a licensed professional. MCH developed MDS Medicaid Policy Guidance to aid in these efforts. The guidance was added to the Perinatal Mental Health Toolkit, which is available to all Kansas perinatal providers on the KDHE Integration Toolkits website. KS Title V also facilitated a virtual Q&A session for local MCH and Infant, Toddler Service programs related to the MDS policy. The session focused on how to bill for MDS, documentation requirements, and available resources to assist with screening administration, care coordination practices, and billing questions.

Approval of this policy further supports the BFH's guidance to local health agencies to follow American Academy of Pediatrics (AAP)/Bright Futures Guidelines, which includes MDS during well-child visits. Through the BFH's Kansas Connecting Communities (KCC) initiative, BFH contracted with the AAP-KS Chapter to develop guidance for pediatric primary care physicians. The Clinical Guidelines for Implementing Universal Postpartum Depression Screening in Well-Child Checks is also published in the Perinatal Mental Health Integration Toolkit and is promoted for use by BFH and AAP-KS Chapter. This partnership and resource development likely contributed to the initial success of the MDS policy and reimbursement utilization by pediatric physicians administering screens as part of the well-infant/child health benefit. Preliminary Medicaid claims data suggests that in the first six-months of MDS becoming a reimbursable service:

- Over 3,500 women were screening for perinatal depression
- On average, each woman was screened twice, which follows screening frequency recommendations
- Most women (64%) were screened under the infant's Medicaid ID as part of a comprehensive infant/child health benefit (caregiver risk assessment)

- Most screenings (84%) were administered by physicians

MCH continues to support implementation, awareness, and utilization of MDS as a billable service.

Integration Toolkits Website Redesign: In an effort to make Title V resources more accessible to partners, Title V consultants have been working closely with KDHE communications staff to redesign and expand the content and format of the Integration Toolkits website. Resources will be searchable by domain and topic as well as type of resource e.g. toolkits, awareness materials, trainings, etc. The redesign's anticipated completion date is July 2022.

Local MCH Agencies (including affiliate programs PMI/TPTCM): In addition to the Title V proposed strategies outlined previously, local MCH grantee agencies have proposed community-specific approaches to promoting well-woman visits. Some examples include:

- *Community Health Center of Southeast Kansas*: Staff work with all MCO incentive programs to maximize the services available, while also working with local foundations to offer incentives for women to access preventive care. The well-woman exam is incorporated into each participant's individual goals, but available at no "out of pocket" cost and includes transportation to the appointment.
- *Pawnee County*: Education was provided on the importance of regular well woman exams, types of birth control available, STDs as well as mental health, nutrition, healthy relationships, Alcohol, Tobacco and Other Drugs (ATOD).
- *Wyandotte County*: Provides comprehensive care during annual well-woman exams. All staff (nurse practitioner, registered nurse, licensed social worker, public heath educator) are provided detailed training on all components of the American College of Obstetricians and Gynecologist (ACOG) annual well-woman examination guidelines. In addition, staff are trained on implementing the evidence-based Smoking Cessation and Reduction in Pregnancy Treatment Program (SCRIPT). The SCRIPT process has been implemented into the Sexually Transmitted Infection clinic and into all prenatal care and well-woman exams.
- *Delivering Change*: TPTCM staff regularly educate clients about the importance of following up their post-delivery visits around their 34-37 week appointment. Maternal education is provided at this time regarding the importance of waiting at least 18 months between pregnancies and staff facilitate discussion around making a reproductive life plan prior to delivery. Case managers also meet with clients before discharge from the hospital to go over contraceptive methods, including Long Acting Reversible Contraception (LARC), and re-enforce the importance of birth spacing.

Objective: Increase the proportion of women receiving pregnancy intention screening as part of preconception and interconception services.

Local MCH Agencies (including affiliated programs PMI/TPTCM): MCH staff and case managers assured clients have access to holistic services and supports through coordinated and comprehensive care, including preconception and interconception care. Local program staff utilize external partnerships and internal agency programs to help clients access any service that promotes healthy, full-term pregnancies. One of the common goals among PMI/TPTCM grantees is to help clients increase self-sufficiency and reduce negative outcomes. Participants receive assistance to set personal and professional goals according to the eight life domains: empowerment, key relationships, health, daily living, financial, parenting, education/training, and employment. All PMI/TPTCM participants received RLP education, to support family stability through completion of basic education, vocational, and health goals prior to subsequent pregnancies.

- *Barton County*: Provided annual training on OKQ to their staff and refer TPTCM clients to contraception services provided by family planning programs, OB-GYNs, or other health care

providers. OKQ was implemented and discussed with each intake and reviewed semi-annually for each TPTCM participant.

- *Wyandotte County*: Case managers utilize OKQ to track pregnancy intent of all TPTCM enrolled clients. Each client completes a birth plan. Medically accurate education is used by providing and counseling clients with the contraception handout from Reproductive Access. A contraception kit is used as a hands-on tool to demonstrate each method to clients.

Reproductive Life Plan (RLP) Workbook: Officially released in December 2020, the RLP Workbook was developed for use across agencies and sectors of the health care system in our state in both clinical and non-clinical settings. The workbook was designed with the intention of using the tool in a variety of settings where providers have varying degrees of opportunity to work through the workbook with a woman. For example, a case management or home visitation service provider can be revisited over the course of several visits for completion, reflection, and progress monitoring, whereas only targeted sections of the workbook might be completed by a provider in a medical or Title X clinic. Use of the workbook can be customized by each type of service provider but does provide standardized tools and a consistent approach for encouraging women of reproductive age to set life and health goals during a well-woman visit on an annual basis.

The workbook has been tested in a variety of settings including physician offices, safety net clinics, home visiting with parent educators, health department clinics, peer to peer conversations, and a barber shop. The responses were overwhelmingly positive, with an appreciation of the contraceptive devices and effective rates, space to plan/think/take notes, and the reflections on health. The workbook is available in English and Spanish and as both a printable document and a fillable PDF form. The workbook, along with the Well-Woman Visit Toolkit and Preconception Guide (*Prenatal Syphilis Screening, Staging, Treatment, and Monitoring for Congenital Syphilis*) are key components for training related to the well-woman visit. Materials were integrated into promotional efforts for National Women's Health Month, Black Maternal Health Week, the KPQC Fourth Trimester Initiative (FTI) as well as applicable webinars and trainings for MCH and Title X providers.

Long Acting Reversible Contraceptives (LARC): Title V continues collaboration with Title X and other state partners to increase access to LARCs for women, including continued implementation of the LARC Integration Toolkit, described in the Women/Maternal Report narrative. Upcoming plans include:

- *LARC Preceptor Network*: A peer to peer learning model to allow trained physicians to serve as preceptors for newly trained providers that need experience.
- *Lunch and Learn Webinars:* Title V continued the LARC "lunch and learn" online events where organizations can call in for a short didactic session about a specific LARC topic (e.g., LARC myths, educating about LARCs, Intimate Partner Violence Considerations, LARC Service Delivery) followed by a Q&A session where participants can discuss LARC cases and get expert and peer advice. In May of 2021 the Lunch and Learn hosted Angelita Olowu, BSN, RN, SANE-A, SANE-P with the International Association of Forensic Nurses to discuss trauma-informed care and the provision of LARC services.

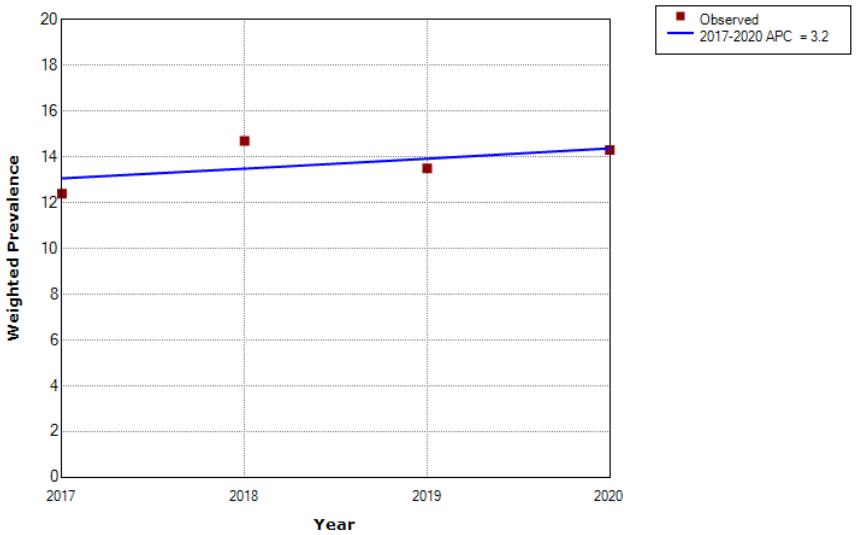
SPM 1: Postpartum Depression (Percent of women who have recently given birth who reported experiencing postpartum depression following a live birth)

ESM: Percent of MCH program participants screened for depression and anxiety during pregnancy and/or the postpartum period using the Edinburgh Perinatal/Postnatal Depression Scale (EPDS)

ESM: Percent of pregnant/postpartum MCH program participants who received a referral in response to a positive screen for depression or anxiety through the Edinburgh Perinatal/Postnatal Depression Scale (EPDS)

According to the Kansas Pregnancy Risk Assessment Monitoring System (PRAMS), among Kansas residents with a recent live birth in 2020, about one in seven (14.3%) were indicated as having postpartum depressive symptoms (95% confidence interval [CI]: 11.9%-17.0%). From 2017 to 2020, no statistically significant change was observed in the prevalence of postpartum depressive symptoms, despite an increasing trend.

Prevalence of Self-Reported Postpartum Depressive Symptoms Among Kansas Residents with a Recent Live Birth, 2017-2020



The Annual Percent Change (APC) was not found to be significantly different from zero at the alpha = 0.05 level.
Source: Kansas Department of Health and Environment, Kansas Pregnancy Risk Assessment Monitoring System (PRAMS), 2017-2020

Among those who gave birth in 2019-2020 (two years combined), some subpopulations were more commonly indicated as having postpartum depressive symptoms, including:

- Those who were under 25 years old (20.6%), compared to those who were 25-34 years old (12.0%) or 35 years or older (9.2%)
- Those whose highest level of education was a high school diploma/GED (21.6%), compared to those with at least some college education (10.3%)
- Those who received WIC food during pregnancy (19.4%), compared to those who did not receive WIC food (12.1%)
- Those whose deliveries were indicated on the birth certificate as being paid for by Medicaid (20.4%), compared to those with non-Medicaid payment sources for the delivery (11.2%)

Prevalence of Self-Reported Postpartum Depressive Symptoms, by Selected Characteristics, Among Kansas Residents with a Recent Live Birth, 2019-2020

Characteristic	Unweighted Numerator	Weighted Numerator (Estimated Population Affected, 2019-2020)	Weighted Prevalence	95% Confidence Interval
Age				
<25 years	118	3541	20.6	16.5-25.6
25-34 years	185	4654	12.0	10.0-14.4
35+ years	41	833	9.2	5.9-14.0
Race/Ethnicity*				
Non-Hispanic White	229	6240	13.2	11.2-15.5
Non-Hispanic Black	45	844	18.7	12.2-27.6
Hispanic	45	1300	13.2	8.7-19.4
Education Level				
Less than HS/GED	38	1019	15.4	10.0-22.9
High School Diploma/GED	128	3860	21.6	17.4-26.5
At least some college education	177	4145	10.3	8.5-12.4
Payment Source for Delivery†				
Medicaid	148	3946	20.4	16.5-24.8
Non-Medicaid	195	5078	11.2	9.4-13.4
WIC Status During Pregnancy				
WIC Recipient	128	3156	19.4	15.5-24.1
Not a WIC Recipient	215	5868	12.1	10.2-14.3
Urban/Rural Residence (NCHS 2013 Classifications)				
Urban	227	5567	12.7	10.6-15.0
Rural	117	3461	16.4	13.1-20.3

* Note on race/ethnicity: To yield more reliable estimates, 2019 and 2020 data have been combined in this table. However, due to issues with mapping of ethnicity fields from the Kansas birth certificate for the PRAMS weighted datasets, not all persons of Hispanic ethnicity were classified as Hispanic in 2017-2019 data. This issue has been fixed beginning with 2020 data. Although the effect of this issue on weighted estimates is believed to have been minor, caution should be used when interpreting race/ethnicity estimates when pre-2020 data are compared/combined with 2020 data.

† As indicated on the infant's birth certificate.

Source: Kansas Department of Health and Environment, Kansas Pregnancy Risk Assessment Monitoring System (PRAMS), 2019-2020

Objective: Increase the proportion of women receiving education or screening about perinatal mood and anxiety disorders (PMADs) during pregnancy and the postpartum period.

Kansas Perinatal Community Collaboratives (KPCC)/Becoming a Mom® (BaM): Perinatal mood and anxiety disorder (PMADs) education and screening is woven into the Becoming a Mom prenatal education series. Participants are screened twice during the education series utilizing the Edinburgh Postnatal Depression Scale (EPDS). Those with a positive score receive follow up by staff and are referred to behavioral health services as indicated.

Based on findings from the Kansas Maternal Mortality Review Committee, the *Maternal Warning Signs Initiative*, launched in July 2021, was created to raise awareness and educate providers, perinatal persons and their support systems, on the Maternal Warning Signs and the need to take appropriate action on these warning signs. The Initiative includes an 18-page Patient Education Guide, utilizing national resources such as the CDC's Hear Her campaign and the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) POST-BIRTH Warning Signs initiative, as well state adapted resources in partnership with organizations such as the Eunice Kennedy Shriver National Institute of Child Health and Human Development. These resources all focus on the Maternal Warning Signs, with targeted messaging on the warning signs of perinatal mood and anxiety disorders.

Local MCH Agencies: Many of the local MCH agencies continue to provide PMAD screenings during visits with pregnant and/or postpartum women using the EPDS. Case managers from the PMI and TPTCM programs screen clients using the EPDS to help identify woman experiencing or at-risk of experiencing PMADs. Several MCH agencies are taking advantage of technical assistance to create innovative ways to screen more women by implementing screenings during infant immunization appointments. Some additional examples among local MCH agencies are as follows:

- *Coffey County*: Provides the EPDS on all 2, 4, 6, & 12-month immunization appointments and make referrals as needed. They continue meeting with the Mental Health Collaborative Resource Team to improve access to care. MCH staff meet with local primary care providers to discuss postnatal depression and the screening tool.
- *Delivering Change:* Screens all clients, at a minimum, twice during the antepartum period and twice during the postpartum period utilizing the EPDS.
- *Dickinson County:* prenatal education clients are screened for PMADs using the EPDS during sessions three and six as well as postpartum. All clients with positive screens are referred to a community mental health center (CMHC) and/or their primary care physician for further evaluation and care.
- *Hamilton County:* Utilizes the MCH Home Visitor who uses the EPDS at every home/clinic visit for both prenatal and postpartum women. The home visitor provides educational materials that address substance use during pregnancy and within the household. MCH staff provide clients with educational materials that address nutrition, good health hygiene, dental care, sleep practices, and having a medical home.
- *Nemaha County:* Has a PMAD Screening Policy that assures the MCH nurse universally screens every pregnant and postpartum woman (through one-year post-delivery) served using the EPDS. Repeat screening is administered according to the policy, as the client remains engaged in MCH Services, WIC, and/or the Breastfeeding Clinic. The EPDS is recorded in DAISEY and documents referrals on all positive screens. A referral is made to the client's primary health care provider or CMHC. The MCH nurse follows up by phone call to the client and if needed, the health care provider. MCH staff work with providers and agencies across the community to ensure an adequate system of care is in place. Staff also provide educational resources on PMAD and information on available mental health services to every pregnant and postpartum woman served by the agency.
- *Wichita Children's Home:* Provides residential maternity care to pregnant and parenting teens to give them and their babies a healthy start and screen PMI/TPTCM clients for mental health and substance use. Program staff are trained in trauma informed care to provide trauma sensitive direct care services. A biopsychosocial assessment is completed for each client and referrals are made according to identified needs.

Kansas Connecting Communities (KCC): Managed by the Title V Behavioral Health Consultant as funded by the HRSA *Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program Cooperative Agreement* (awarded in October 2018), KCC strives to increase health care providers' capacity to screen, assess, treat, and refer pregnant and postpartum women for depression, anxiety, and substance use disorders.

- *KCC/KPCC Integration:* To bring awareness and utilization of KCC capacity-building trainings, a Perinatal Behavioral Health Survey was developed with goals to pilot with KPCCs, PMI, TPTCM, and MCH ATL grantees. The survey was designed to support the KCC team in tailoring resources to meet program needs. The survey will be conducted across these programs in a phased approach, beginning with the KPCC sites in May 2021 to support the implementation of a KCC/KPCC Fall 2021 training plan focusing on implementing perinatal substance use screening and interventions.

More information about KCC is included in the Cross-Cutting Report.

Maternal Mental Health Treatment Pilot Project: To further increase the identification of postpartum women experiencing perinatal mood and anxiety disorders (PMADs) and improve access to mental health treatment (counseling/therapy), Title V partnered with Russell Child Development Center (RCDC) on a *Maternal Mental Health Treatment Pilot Project*. RCDC is a Part C, Infant Toddler Services program, that provides early childhood services in 19 rural/frontier counties in Southwest Kansas. All 19 counties are designated Mental Health Provider Shortage Areas, and timely access to quality perinatal mental health treatment is limited.

The aim of the pilot is to increase the availability, accessibility, and affordability of evidence-based maternal mental health treatment services by:

- Increasing timely detection, assessment, and treatment of PMADs in postpartum women using evidence-based practices;
- Increasing RCDC staff capacity to provide maternal mental health specialty treatment services to caregivers of children participating in RCDC services; and
- Supporting infrastructure development and create a replicable and sustainable model for treating maternal mental health conditions that can be replicated through early childhood systems.

RCDC staff participated in a Maternal Mental Health 101/Screening Implementation Training offered by Kansas Connecting Communities. Staff administer the Edinburgh Postnatal Depression Scale (EPDS) with pregnant and postpartum mothers and submit referrals to the *Finding the Light* program, when indicated. The program lead is a licensed master's social worker (LMSW) who is actively pursuing her clinical license following the Kansas Behavioral Sciences Regulatory Board guidelines, which includes clinical supervision and continuing education requirements. The LMSW reviews the screening and referral information, meets with the mother and completes a psychiatric assessment, when indicated. Based on findings and the mother's interest/willingness to engage in treatment or support services, the LMSW coordinates care. Maternal mental health therapy services are made available in-person and by telehealth and in collaboration the individuals' healthcare providers to coordinate comprehensive care for the caregiver and the family.

The pilot allows infants and toddlers (0-3) and their caregivers to receive therapeutic services from one organization. While reducing barriers in accessing care, the pilot also increases local capacity by expanding the mental health professional network and subject-matter expertise in a mental health professional shortage area. Title V provides instruction and technical assistance to RCDC, including coordination with Kansas Medicaid, to ensure services will be sustained beyond the pilot project period and can be replicated by other early child development centers.

Who Qualifies for Finding the Light Perinatal Support?

- Pregnant Mothers
- New parents with a baby 12 months of age or younger
- Parent(s) who experienced a stillbirth or miscarriage
- Parent(s) who lost a child

Finding the Light Perinatal Support Can Help You:

- Develop a strong bond with your baby
- Manage fears, racing thoughts, and worry
- Develop coping and self-care strategies
- Process relationship changes
- Develop a stable self-identity
- Process trauma related to birth, new parental experience, loss, disability, etc.
- Provide a safe and stable environment for you and baby to grow together

RUSSELL CHILD DEVELOPMENT CENTER

FINDING THE LIGHT PERINATAL SUPPORT
A PROGRAM OF RCDC

Supported by:

Kansas Department of Health and Environment

KANSAS MATERNAL & CHILD HEALTH

CONTACT US

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F: 620-275-0364
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www.rcdc4kids.org

English Version

How are you feeling now?

Pregnancy and the birth of a new baby can bring many complex emotions. It can trigger excitement and joy, but also feelings you may not expect, such as sadness and worry. These feelings may lead to depression and anxiety.

Some common signs of perinatal mental health challenges:

- Depressed mood or mood swings
- Excessive crying
- Difficulty bonding with the baby
- Overwhelming fatigue or energy loss
- Shortness of breath
- Intense fear
- Constant worry that can't be eased
- Racing thoughts
- Hopelessness

If you suspect that you are dealing with perinatal depression or anxiety, timely treatment is important for your health and the healthy development of your baby.

What is depression?

You may feel sad, empty, irritable, angry, guilty, and many other emotions—or you may feel numb and like you are "going through the motions—all of these feelings are valid and could be signs of depression.

What is anxiety?

You may feel nervous, worried, and/or scared. The entire conception, pregnancy and birthing process can trigger anxiety, which can occur at any stage and become worse over time.

How common are maternal depression and anxiety?

About 1 in 7 women experiences postpartum depression after having a baby. Anxiety during and after pregnancy is as common as depression and both may occur at the same time.

To learn more about no-cost **Finding the Light Perinatal Support** please visit www.rcdc4kids.org or call 620-275-0291.

Finding the Light Perinatal Support includes:

- **Mental health screening**
- **Short term, solution-focused model**
- **6-8 virtual or in-person therapy sessions**
- **A licensed mental health professional with training in perinatal mental health**
- **Referral to other agencies or services when indicated**

Finding the Light Perinatal Support is funded through the Kansas Department of Health and Environment.

This publication is supported by the Kansas Department of Health and Environment with funding through the Health Resources and Services Administration (HRSA) of the HHS under grant number #B04MC33839 and Title V Maternal and Child Health Services.

Peer & Social Networks: Title V staff support pregnant and new mothers through the KPCC model, which allows mothers to connect with one another during this important time and share lived experiences in an authentic and supportive environment. Plans to extend the program past birth are underway, which provides an opportunity for mothers to share birth stories as well as postpartum struggles – reinforcing a network that can reduce isolation and promote healing and resilience. For women not participating in BaM, Title V staff vet and promote secure and safe peer support options through social media, training and marketing including those offered through Postpartum Support International (PSI).

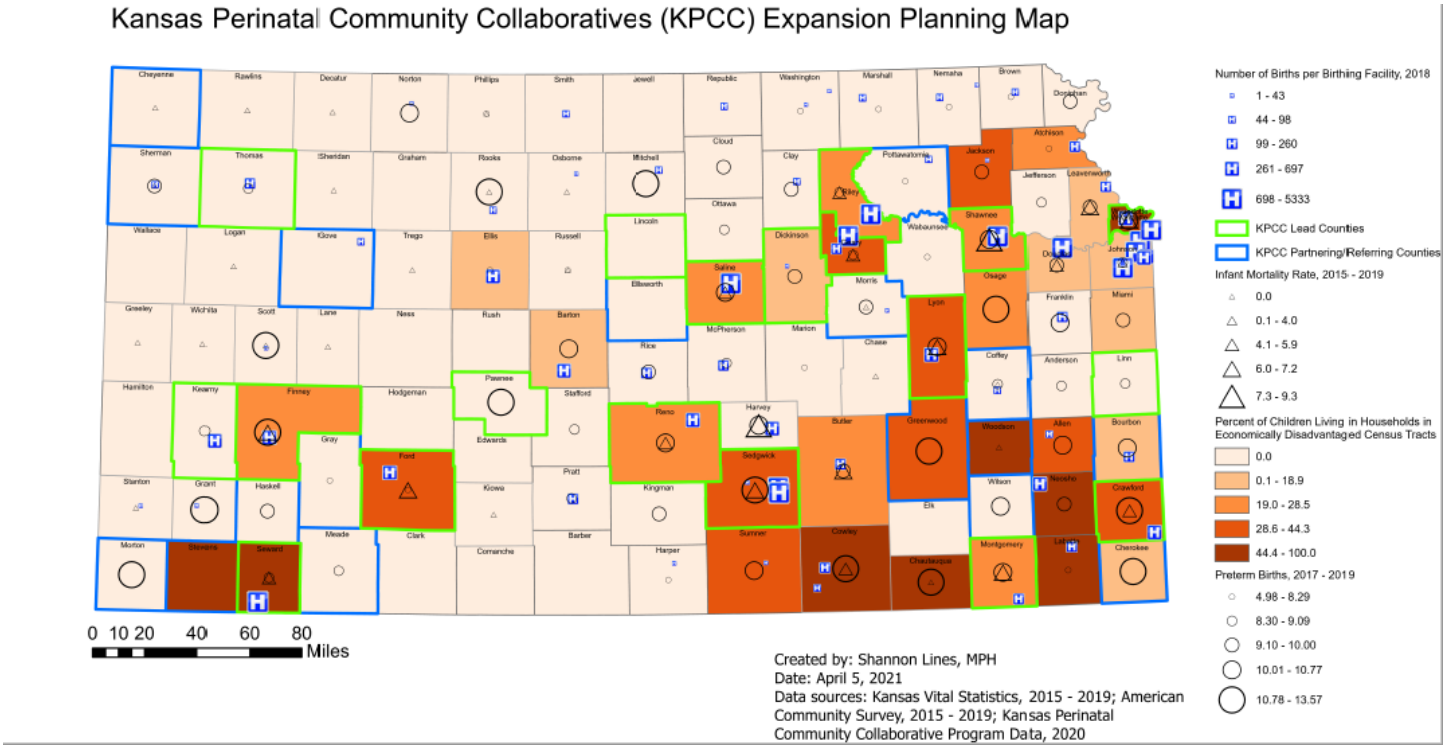
In partnership with Wichita State University's Community Engagement Institute (CEI), health care practitioners/organizations and interested groups can receive support in the development of peer support groups within their community. CEI manages the Kansas Support Groups website. Individuals can search for support groups by type of group and/or location of group meetings. Support groups can register on the site, so individuals can find and participate in their groups. CEI joined the Southeast Kansas IRIS Community; providers can refer patients to CEI who can help identify support groups in their area, as well as help establish groups, if that is the request. CEI also developed a *Perinatal Support Group Guidebook*, a resource for local communities wanting to start or revamp a perinatal support group. More information about the Guidebook is included in the Cross-Cutting Report.

Objective: Increase the proportion of high-risk pregnant women receiving prenatal education and support services through perinatal community collaboratives.

Kansas Perinatal Community Collaboratives (KPCC)/Becoming a Mom® (BaM): With proven success, Kansas MCH remains committed to supporting the expansion and sustainability of the KPCC initiative, providing training and technical assistance on community collaborative development and MCH program integration targeted at reaching a greater disparity population, and integrating additional services and support mechanisms for populations at greatest risk. View a map of existing sites and implementation progress on the KPCC website. See our FY2023 Plan Narrative for a description of our strategic approach to continued expansion across the state.

Data from the 2019 Becoming a Mom Aggregate State Report highlights disparities (see BaM Infographic) that Title V is working to address. According to the Report, mothers receiving education through the Becoming a Mom® prenatal education program were *more likely* than other mothers giving birth in the state to be racial/ethnic minorities; younger; lower education level; enrolled in WIC; and covered by non-private insurance. The education sessions and associated activities are aimed at improving pregnancy health and infant health outcomes for disparity populations.

Since inception in 2010, KPCCs have been a driving force behind improving birth outcomes in Kansas. In two of the longest running sites, infant mortality has decreased from pre-implementation to post-implementation. The Geary County infant mortality rate has decreased significantly from 11.9 infant deaths per 1,000 live births in 2005-2009, to 5.1 in 2016-2020. The Saline County infant mortality rate has decreased from 9.0 infant deaths per 1,000 live births in 2005-2009, to 6.4 in 2016-2020.



KPCC/BaM Website: Resources for regional and statewide implementation of KPCCs have been under development over the past several years to ensure both growth and sustainability of the initiative. The KPCC website serves as an access point to introductory information about the initiative. Updates to the site were made during this reporting period, however the full website redesign and expansion is still under development. The completed updates to the website allows for interested communities to explore the initiative, use technical assistance resources, and engage in conversations with community partners on their own timeline. By publishing materials and creating this centralized repository, Title V intends to better meet the needs of local communities interested in enhancing perinatal services while reducing burden on Title V staff, thus improving program expansion and sustainability activities long-term. KPCC and BaM infographics were also developed to aid communication and recruitment for new communities while showcasing the impact of the KPCC model and BaM programming in existing communities.

New training and resources were also added to the existing KPCC partner-only website. Local program coordinators and group facilitators can now access the new integration toolkits and initiatives that were implemented during this reporting period (e.g., Maternal Warning Signs Toolkit and Fourth Trimester Initiative). Additionally, the COVID-19 pandemic has heightened the need for a virtual prenatal education option. Resources and guidance documents for virtual implementation, including online data collection and guidance for virtual screening for PMADs, were developed and disseminated. This infrastructure component will continue to be improved and supported.

Other Women/Maternal Activities

Count the Kicks® (CTK) Stillbirth Prevention Initiative:. The Kansas stillbirth rate increased from 4.4 per 1,000 live births and stillbirths in 2007 to 5.4 per 1,000 live births and stillbirths in 2018. Vital Statistics reports that 196 stillbirths occurred in 2018 which was up from 184 stillbirths in 2017. In 2018, Title V launched a partnership with a nonprofit lead for an intervention known as Count the Kicks (CTK). CTK is a campaign to prevent stillbirth through provider and patient education that

emphasizes the critical importance of monitoring fetal movements during the 3rd trimester of pregnancy. Thanks to this investment from Title V, Kansas maternal providers have free, full access to videos and educational materials (including posters, brochures, magnets, and appointment cards in English and Spanish) for use in their practices. Mothers everywhere can download the free app, which is available in the Google Play and iTunes online stores. The app, available in English and Spanish, allows expectant mothers to monitor their baby's movement, record the history, set a daily reminder, and count for single babies and twins. Additionally, a KS-specific version of the app with four follow-up questions that connect mothers directly with resources in Kansas based on expressed needs and concerns, was developed.

From the time of launch in August 2018 to October 2021, over 385 orders for free materials were placed by providers from all corners of the state, equating to 115,460 pieces of education being distributed. Over 6,700 Kansans have visited the CTK website seeking more information about kick counting, and more than 2,400 expectant parents have downloaded the free app to track their baby's movements.

During FY21, professional development opportunities regarding stillbirth prevention utilizing CTK were offered to the MCH workforce. More than 50 health professionals attended "Using Technology to Kick Off a Healthy Birth", a joint presentation given by Title V staff and the CTK Program Manager at the Governor's Public Health Conference in March. In total, over 150 healthcare professionals and maternal health workers were trained and over 1,000 individuals were mailed educational information about the KDHE/CTK partnership.

In 2020, there were 167 stillbirths reported for Kansas residents, a decrease of 14.8% from 2018. While it is impossible to tell if this decrease is related to the CTKs initiative we continue to track stillbirth data for impact. The introduction of CTK has the potential to save 60 babies every year if the stillbirth rate decreases by 26%, which is the result of the campaign in neighboring Iowa.

Black Maternal Health Statewide Virtual Focus Groups: Title V has awarded a contract to Wichita State University to collect qualitative data from Black mothers across the state to better identify barriers to care and gaps in services. The goal of this research is to better understand the following from Black mothers and families in Kansas:

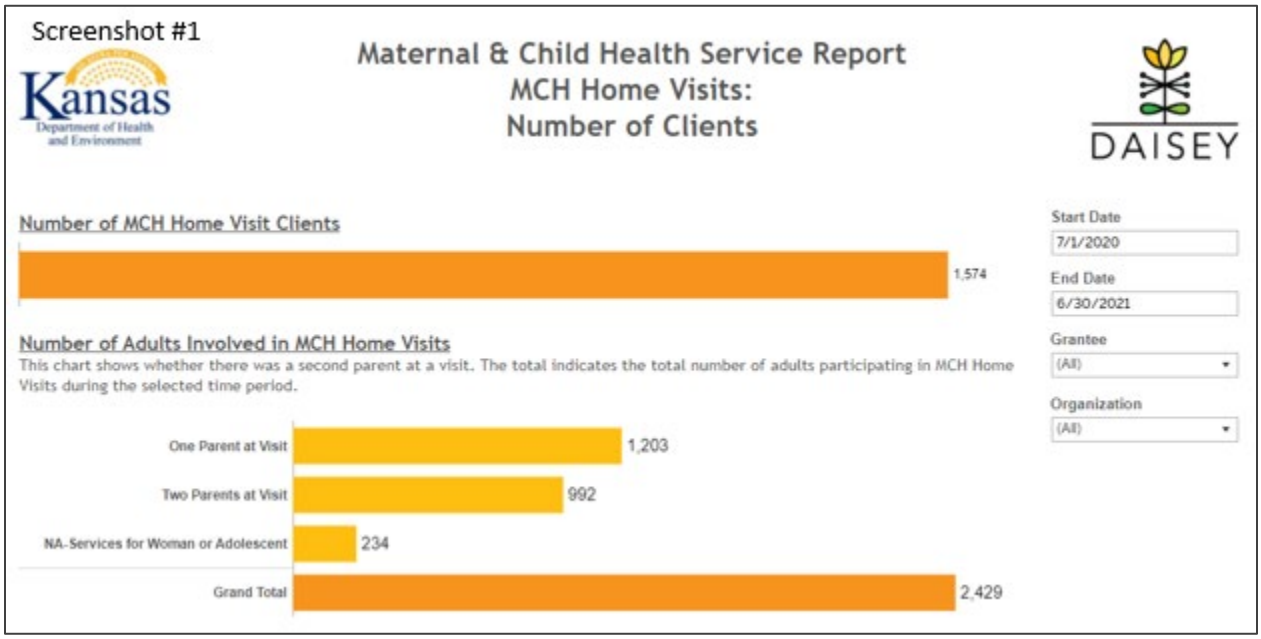
- Views on importance of overall health and the functionality of the current health care system
- Health priorities and biggest needs
- Availability of health care services for them and their children
- Services and supports they feel were lacking during the perinatal period III and neonatal periods related to physical health, emotional wellbeing, and mental health
- Barriers faced when seeking whole health services, including prenatal and postpartum care
- Tools they find helpful, or would find helpful, when navigating the health care system

The final report which will include this data as well as a literature review and recommendations will be available in Spring of 2022.

MCH Universal Home Visiting: The MCH Universal Home Visiting program includes protocol and utilization of standard tools for smoking/tobacco, alcohol, substance abuse, and mental health, including perinatal depression. MCH Home Visitors make every effort to ensure that prenatal and postpartum mothers and their infants receive screening assessments with persons that are trained and qualified to conduct them.

Based on data collected in DAISEY, MCH local agencies offering home visiting services provided a total of 3,040 visits, reaching 1,574 women (16% inter-conception; 36% pregnant; 48% postpartum)

during SFY21. Women are encouraged to have their partner/family attend the visit (see screenshot #1). MCH Home Visitors provided verbal and written education to the prenatal and postpartum mother. For SFY21, parents were educated on a variety of topics including breastfeeding, safe sleep, infant care, immunizations, etc. (see screenshot #2). There were 171 women who received a home visit that reported they smoked (9%) and 248 reported someone else in the household smokes (13%). A total of 75% of women reported they initiated prenatal care in the 1st trimester (see screenshot #3). Of the total women served in SFY21, 874 women-initiated breastfeeding (66%). NOTE: This data reflects information collected from local MCH agencies related to the individuals served and services provided. Results may not be comparable to state data or rates. We regularly monitor data for local MCH agencies in relation to state/local goals and data.



MIECHV & MCH Universal Home Visiting Partnership: The MIECHV local programs continued to provide educational information, referrals, and support addressing multiple areas affecting maternal health including prenatal and postpartum care. Screenings of 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. All KS MIECHV and MCH Home Visitors were invited to attend the Governor's Conference on Abuse and Neglect and the Governor's Public Health Conference.

References

1. *ACOG Committee Opinion No. 755: Well-Woman Visit. Obstet Gynecol. 2018;132(4):e181-e186. doi:10.1097/AOG.0000000000002897*

2023 WOMEN / MATERNAL HEALTH APPLICATION PLANS

PRIORITY 1: Women have access to and utilize integrated, holistic, patient-centered care before, during, and after pregnancy

NPM 1: Well-woman visit (Percent of women, ages 18-44, with a past year preventive visit)

SPM 1: Postpartum Depression (Percent of women who have recently given birth who reported experiencing postpartum depression following a live birth)

Local MCH Reach: Based on SFY2023 MCH Aid-to-Local applications received:

- 41 of 55 grantees (75%) plan to provide services to the Woman & Maternal population
- 23 of 41 grantees serving Woman & Maternal population (56%) plan to provide well-woman services
- 32 of 41 grantees serving Woman & Maternal population (78%) plan to provide post-partum depression services
- 39 of 41 grantees serving Woman & Maternal population (78%) plan to provide prenatal education and support services
- 30 of 41 grantees serving Woman & Maternal population (73%) plan to provide pregnancy intention screening services

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NPM 1: Well-woman visit (Percent of women, ages 18-44, with a past year preventive visit)

Objective: Increase the proportion of women program participants receiving a high-quality, comprehensive preventive medical visit.

Kansas Title V remains committed to the continued development and expansion of the Kansas Perinatal Community Collaboratives (KPCC) model, implementing the Becoming a Mom® (BaM) curriculum. This commitment extends to the development and implementation of additional integration components that allow for the strengthening of particular priority areas, such as the: Well-Woman Visit Integration Toolkit; Reproductive Life Plan (RLP) Workbook; One Key Question® approach; Fourth Trimester Initiative (FTI); and LARC resources. These resources will be expanded to include comprehensive screening guidance and tools as well as implementation technical assistance. This will continue to be the primary work for women of reproductive age throughout FY25.

Well-Woman Visit Toolkits: Published in December of 2020, the KDHE Well-Woman Visit Integration Toolkits for Providers and Communities are intended to help ensure every woman in Kansas has access to, and receives, comprehensive, integrated care every year. There are three main areas covered in each toolkit: recommended components of a well-woman visit; barriers faced by women that prevent them from receiving annual preventive care and recommendations to address these barriers; and resources for communities and providers.

- *Violence prevention*: MCH ATL programs, as well as Title X providers, will have access to resources and trainings created by the Kansas Coalition Against Sexual and Domestic Violence (KCSDV) on the CUES: Evidence Based Intervention (universal education regarding intimate partner violence). KCSDV will be facilitating a workshop at the Governor's Public Health Conference to discuss how to implement CUES in an MCH setting.
- *Social Determinants of Health (SDOH) Screening*: In July of 2022, the American Academy of Family Physicians' EveryONE SDOH screener will be available to all local program through DAISEY. In addition to the screening tool, providers will have access to guidance that assists with how to deliver the screen as well as next steps should a client indicate there is a need or concern during the screening process.
- *Partnerships*: The toolkit's success will rely on partnerships with allied professionals and community agencies. The Community Provider Toolkit focuses on educating partner programs about the importance of the well-woman visit. Title V will provide webinars with key programs, specifically targeting MCH-serving programs (e.g., Title X, WIC, PMI, TPTCM, MIECHV,

KPCC). In addition, the Well-Woman Toolkits and the Reproductive Life Plan will be a key component of the Kansas Perinatal Quality Collaborative (KPQC) Fourth Trimester Initiative.

MCH-led promotional efforts around awareness months and weeks (e.g., National Women's Health Week, Minority Health Month, Black Maternal Health Week) will incorporate messaging related to the importance of the well-woman visit. Promotional materials and social media kits developed will be shared with all Title V and Title X partners as well as other key partners such as the Kansas Maternal and Child Health and Family Advisory Councils.

Behavioral Health Integration: Three behavioral health pre-screeners will be added to the DAISEY MCH Service Form in July 2022 to further support universal screening and early identification practices. Local programs will administer the pre-screens at every MCH visit. Guidance and workflows will be developed to address appropriate next steps based on responses to pre-screen questions. The three pre-screeners are:

- Generalized Anxiety Disorder-2 (GAD-2) - Anxiety
- Patient Health Questionnaire-2 (PHQ-2) - Depression
- NIDA Quick Screen – Substance Use (alcohol, tobacco, prescription drugs for non-medical reasons and illegal drugs)

NIDA Quick Screen questions were added to the BaM Initial Survey January 1, 2022. BaM Risk Report enhancements should be completed by the beginning of FY2023 that will pull positive response options to any of these pre-screen questions into the Risk Report, identifying for staff any "positive" screen or "at risk" participant, warranting follow-up with completion of the full ASSIST screen on a one-on-one basis with the participant outside of the group setting, as well as completion of an associated Plan of Action. Guidance was provided during a January TA Webinar; however, additional TA will be provided once the reports become available and data obtained and reviewed from at least a 6-month period.

Medicaid Policy Improvements: The Medicaid Maternal Depression Screening (MDS) policy became effective January 1, 2021 to reimburse for up to three screenings during the prenatal period under the mother's Medicaid ID and for up to five screenings during the 12-month postpartum period under the child's Medicaid ID. The policy also allows for reimbursement to occur when non-licensed professionals, like home visitors and community health workers, administer screenings under supervision of a licensed professional. MCH developed MDS Medicaid Policy Guidance to aid in these efforts. The guidance was added to the Perinatal Mental Health Integration Toolkit, which is available to all dKansas perinatal providers on the KDHE Integration Toolkits website.

Approval of the MDS policy further supports the BFH's guidance to local health agencies to follow American Academy of Pediatrics (AAP)/Bright Futures Guidelines, which includes MDS during well-child visits. Through the BFH's Kansas Connecting Communities (KCC) initiative, BFH contracted with the AAP-KS Chapter to develop guidance for pediatric primary care physicians. The Clinical Guidelines for Implementing Universal Postpartum Depression Screening in Well-Child Checks is also published in the Perinatal Mental Health Integration Toolkit and is promoted for use by BFH and AAP-KS Chapter. MCH will continue to support implementation, awareness, and utilization of MDS as a billable service.

Further, the BFH Behavioral Health Consultant served as the KDHE Secretary's designee representing the Division of Public Health and Kansas MCH on the 2021 Special Legislative Committee on Kansas Mental Health Modernization and Reform. Among many issues, the Committee was tasked with reviewing status and system enhancement opportunities for improving maternal mental health. This contributed to a request for the Kansas Connecting Communities (KCC) grant team to present about perinatal behavioral health challenges in Kansas and program

overview/impact. The Committee drafted a new recommendation (Special Populations Recommendation 6.6): Request Robert G. (Bob) Bethell Home and Community Based Services and KanCare (Kansas Medicaid) Oversight Committee review of extending the Medicaid postpartum coverage period to 12-months postpartum. This supports access to behavioral health treatment and other preventive care, thus improving health outcomes for both the mother and child. The KCC grant team was then invited to present to the Bob Bethell Committee, who also received testimony about Medicaid eligibility extension for postpartum individuals. The Bob Bethell Committee then made the following recommendation on December 14, 2021, "Recommend expanding postpartum coverage to 12-months for new mothers enrolled in KanCare and direct KDHE to provide data on the number of women who have used the first 2 months of postpartum services and could benefit from 12 months. Without objection, the recommendation was approved." The BFH and Title V will continue closely monitoring status of recommendation during the 2022 Kansas Legislative session.

Integration Toolkits Website Redesign: In an effort to make Title V resources more accessible to partners, Title V consultants will continue to work closely with KDHE communications staff to redesign and expand the content and format of the Integration Toolkits website. .

Local MCH Agencies: In addition to the Title V proposed strategies outlined previously, local MCH grantee agencies have proposed community-specific approaches to promoting well-woman visits. Some examples include:

- Crawford County Health Department will increase the number of well women visits by mailing appointment reminders to current patients and calling a day or two before the scheduled appointment. An educational flyer will also be distributed to women visiting for WIC and immunization appointments to promote referral between programs.
- Sedgwick County Health Department will increase the percentage of Healthy Babies clients who received a well woman visiting in the last year from 91%-95%. If clients are uninsured or underinsured they are referred to the Family Planning program within Sedgwick County Health Department or a local FQHC. If they are insured, they are encouraged to see their primary care provider.
- Unified Government of Wyandotte County and Kansas City, KS will increase the number of women receiving comprehensive and preventative screenings may be achieved by a change in practice and semantics. That is, single-issue visitors to the health department, i.e., for HIV testing, may be more receptive to a coupled Pap smear and STI test battery by an on-site provider for 'peace-of-mind', and in that receptive state be willing to engage in a comprehensive exam along with health discussions and questions. The net result would be a Well Woman visit without the label and associated anxiety. The specialist approach to healthcare, which involves time-consuming, serial one-on-one interactions with providers, evokes anticipation about the length of time needed, and lessens the probability of follow up visits. However, a holistic, simultaneous, team-based process, where expertise in several domain simultaneously conduct assessment and interventions during all health department visits, is more efficient, and demonstrates a desirable level of concern and care. Thus, the UGPHD will utilize the Well Women visit as an excellent opportunity to counsel patients about maintaining a healthy lifestyle and minimizing health risks. MCH service providers will work as a multidisciplinary team to provide an integrated approach to address all the components of a well women visit. The MCH service team will complete a comprehensive assessment, brief intervention including health education and risk reduction counseling, and initiate and facilitate a client's entry into an appropriate system for care or provide links to other resources as indicated. As an example, a key component of a well-women visit for the reproductive aged woman is the development of her Reproductive Life Plan to ensure that medical testing and treatments provided are aligned with her current and future goals.

Objective: Increase the proportion of women receiving pregnancy intention screening as part of preconception and interconception services.

According to the 2020 Title V MCH Needs Assessment community survey, approximately 44% of women said that reproductive health and family planning access was a concern. Title V will continue, and expand, work related to pregnancy intention through the following strategies:

- Increase consumer/family and provider awareness about the importance of preconception and interconception care, counseling/planning, and pregnancy intention screening by utilizing social media, infographics, data briefs, and partner networks. One such example of this will be to update and disseminate the Preconception Health Action Alert, that includes social media messages, in February 2023, and on an ongoing annual basis. This action alert was initially developed in December 2021 for a first-time dissemination in February 2022.
- Provide resources and education specific to preconception and interconception care to providers in support of quality services and comprehensive visits during these critical periods.
- Increase the number of local health agencies utilizing evidence-based pregnancy interventions including One Key Question, support implementation into practice through virtual skills building sessions and increase provider capacity to implement pregnancy intention screening into their practice.

Local MCH Agencies: Case managers from the Pregnancy Maintenance Initiative (PMI) and the Teen Pregnancy Targeted Case Management (TPTCM) will assure clients have access to holistic services and supports through coordinated and comprehensive care, including preconception and interconception care. They will utilize external partnerships and internal agency programs to help clients access any service that promotes healthy, full-term pregnancies. In addition, one of the common goals among all SFY22 grantees is to help clients increase self-sufficiency and reduce negative outcomes. Participants will receive assistance to set personal and professional goals according to the eight life domains: empowerment, key relationships, health, daily living, financial, parenting, education/training, and employment. All PMI/TPTCM participants will receive RLP education, to support family stability through completion of basic education, vocational, and health goals prior to subsequent pregnancies.

- *Cloud County Health Department* will firm up their data collection methods to show an increase in the number of One Key Question screenings completed among MCH home visiting clients.
- *Crawford County Health Department's* MCH program will begin using One Key Question and establish a baseline measure this year.
- *Wichita Children's Home:* The TPTCM case manager will work with clients to promote the importance of completing their basic education or vocational goals and will work to help clients understand the benefits of delaying subsequent pregnancies. The TPTCM case manager will utilize OKQ® during the second case manager session with clients to facilitate conversations. It will be discussed throughout the program for any changes that may be deemed necessary. The TPTCM case manager will refer clients to family planning services in the community, if not already established with one.
- *KU School of Medicine:* PMI and TPTCM program participants who attended at least three visits will receive education on a reproductive life plan. The agency staff will work with participants to develop a reproductive life plan. Staff will encourage participants to think about their basic education or vocational goals in determining how long to delay subsequent childbearing and utilize the Partners for a Healthy Baby Personalize Reproductive Life Plan form to help participants understand the benefits of delaying subsequent pregnancies. Staff have been trained in the One Key Question and will utilize the One Key Question form to facilitate conversations. Introduction to reproductive life planning often takes place during the second or third visit; however, participants may update or create the plan at any point during their participation in the program as goals, such as vocational and educational plans may shift,

thus impacting the Reproductive Life Plan. Referral to Family Planning services will be made for participants who do not have access to family planning services which may be needed to meet their reproductive goals.

Reproductive Life Plan (RLP) Workbook: Officially released in December 2020, the RLP Workbook was developed for use across agencies and sectors of the health care system in our state in both clinical and non-clinical settings. The workbook was designed with the intention of using the tool in a variety of settings where providers have varying degrees of opportunity to work through the workbook with a woman. For example, with a case management or home visitation service provider it can be revisited over the course of several visits for completion, reflection, and progress monitoring, whereas only targeted sections of the workbook might be completed by a provider in a medical or Title X clinic. Use of the workbook can be customized by each type of service provider but does provide standardized tools and a consistent approach for encouraging women of reproductive age to set life and health goals during a well-woman visit on an annual basis.

The workbook has been tested in a variety of settings including physician offices, safety net clinics, home visiting with parent educators, health department clinics, peer to peer conversations, and a barber shop. The responses were overwhelmingly positive, with an appreciation of the contraceptive devices and effective rates, space to plan/think/take notes, and the reflections on health. The workbook is available in English and Spanish and as both a printable document and a fillable PDF form. In the coming year, the workbook, along with the Well-Woman Visit Toolkit, Preconception Guide (*Prenatal Syphilis Screening, Staging, Treatment, and Monitoring for Congenital Syphilis*) will be key components for training related to the well-woman visit. Materials will be integrated into promotional efforts for National Women's Health Month, Black Maternal Health Week, the KPQC Fourth Trimester Initiative (FTI), BaM Session 6 curriculum, as well as applicable webinars and trainings for MCH and Title X providers.

SPM 1: Postpartum Depression (Percent of women who have recently given birth who reported experiencing postpartum depression following a live birth)

Objective: Increase the proportion of women receiving education or screening about perinatal mood and anxiety disorders (PMADs) during pregnancy and the postpartum period.

Title V will continue, and expand, work related to PMAD education and screening through the following strategies:

- Integrate evidence-based mental health interventions into community-based services.
- Increase consumer and provider awareness about the importance of screening pregnant/postpartum women and new fathers for PMADs.
- Increase the number of local health agencies screening pregnant/postpartum women and fathers for postpartum/paternal PMADs.
- Partner with Medicaid and pediatric providers to implement parental depression screening during the child well visit to assess the needs for the family to support child social-emotional development, healthy family functioning, and ensure referral and early intervention.

Local MCH Agencies: Many of the local MCH agencies will continue to provide PMAD screenings during visits with pregnant and/or postpartum women using the EPDS. Case managers from the Pregnancy Maintenance Initiative (PMI) and the Teen Pregnancy Targeted Case Management (TPTCM) programs will screen clients using the EPDS to help identify woman experiencing or at-risk of experiencing PMADs. Several MCH agencies are taking advantage of technical assistance to

create innovative ways to screen more women by implementing screenings during infant immunization appointments. Some additional examples among local MCH agencies are as follows:

- *Barton County* will increase the percentage of women with a high EPDS who receive a referral for intervention that is documented in DAISEY. To reach their goal, Barton County Health Department will continue to screen all women who present at our MCH/WIC office prenatally through 1 yr postpartum and at home visitation appts. They will notify medical/mental health providers of concerning scores and refer as indicated. Staff will be more intentional about documenting referrals in DAISEY. Staff will be reminded and trained to enter referrals using the DAISEY KDHE referral form. In addition, they will recruit and onboard additional mental health providers to the IRIS referral system. Ongoing community education will destigmatize mental health through educating the public about PMADS using social media, literature at health fairs, digital sign, community baby shower etc. Literature is available in Spanish as well as English.
- *Cloud County* will increase the percent of women screen for PMADs during home visits from 30% to 65%. Staff will be educated on the Maternal Warning Signs materials that they will then utilize during client visits. Clients will receive education on Maternal Warning Signs and be screened utilizing the Edinburgh Postnatal Depression Scale, Clients scoring higher than a 12, in the risk range, will be referred to Pawnee Mental health, a local mental well-being facility.
- *Catholic Charities of Northern Kansas:* PMI participants will complete the EPDS during their visit with their PMI case manager. Program participants with an EPDS score of 10 or higher will receive a referral to a behavioral health provider. The case manager will maintain referral partnerships with local OBGYN offices, prenatal /postnatal depression and mental health support groups, local community mental health centers, and mental health providers.
- *Lawrence-Douglas County:* will continue using the Edinburgh depression screen during the third trimester of pregnancy, six weeks postpartum, and again six months postpartum to screen for maternal depression. When the screen yields a score of concern, a referral will be made, and the screen will be conducted again with the mother two weeks later. The PHQ-9 screen will be completed with the mother one year postpartum. When depression screens yield a score of concern or when mothers report struggling with perinatal anxiety or depression, a referral will be made.

Kansas Connecting Communities (KCC): Managed by the Title V Behavioral Health Consultant as funded by the HRSA *Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program Cooperative Agreement* (awarded in October 2018), KCC strives to increase health care providers' capacity to screen, assess, treat, and refer pregnant and postpartum women for depression, anxiety, and substance use disorders. KCC will continue to increase statewide access to screening, assessment, and treatment for maternal depression, anxiety, and substance use disorders. Grant activities were focused in the SE KS region for the first 2 years of the award (10/2018 – 09/2020), however KCC has since expanded efforts and is promoting all resources and capacity building opportunities statewide.

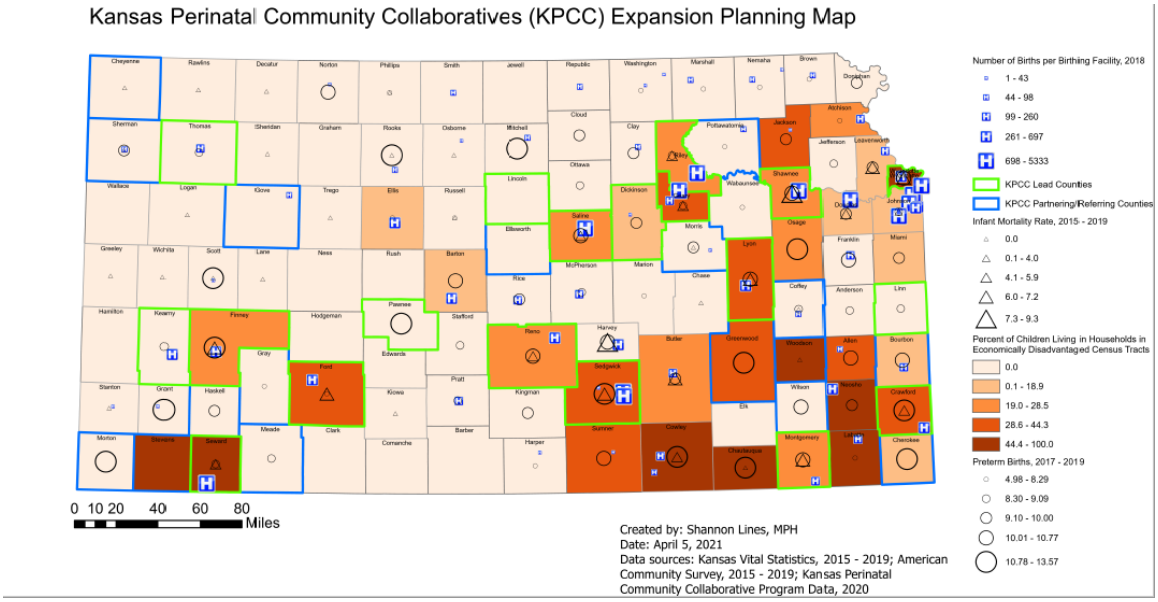
To bring awareness and utilization of KCC capacity-building trainings, a Perinatal Behavioral Health Survey was developed with goals to pilot with KPCCs, PMI, TPTCM, and MCH ATL grantees. The survey was designed to support the KCC team in tailoring resources to meet program needs. Survey administration will be conducted across these programs in a phased approach, which began with the KPCC sites in May 2021, to support the implementation of a KCC/KPCC training plan focusing on enhancing perinatal mood and anxiety disorder screenings and interventions and implementing perinatal substance use screening and interventions. This opportunity will be tailored and replicated for other MCH programs during FFY2023.

For MCH programs, this is a continuation of the 2020-2021 Perinatal Behavioral Health Community Collaborative. By aligning with KCC, there is an increase in trainer capacity to assist more local programs. The components that were developed as a guide to Perinatal Behavioral Health Community Collaborative participants will be incorporated into KCC's training plans and will serve as guidance for local agencies to enhance their programs. These components include establishing an agency screening policy, executing a MOA/MOU with a mental health or substance use treatment professional/organization to increase access to timely care, and starting a support group.

Maternal Mental Health Treatment Pilot Project: RCDC employs a licensed master's social worker (LMSW) who accepts referrals for treatment from RCDC staff who administer PMAD screenings. Maternal mental health therapy services are made available in-person and by telehealth and in collaboration the individuals' healthcare providers to coordinate comprehensive care for the caregiver and the family. The pilot will allow infants and toddlers (0-3) and their caregivers to receive therapeutic services from one organization. While reducing barriers in accessing care, the pilot also increases local capacity by expanding the mental health professional network and subject-matter expertise in a mental health professional shortage area. Title V will continue providing instruction and technical assistance to RCDC, including coordination with Kansas Medicaid, to ensure services will be sustained beyond the pilot project period and can be replicated by other early child development centers.

Objective: Increase the proportion of high-risk pregnant women receiving prenatal education and support services through perinatal community collaboratives.

KDHE's Title V commitment to this model is greater than just increasing the number of KPCCs across the state, or programs who implement the BaM program. Rather it is our desire to strengthen the model, targeting and reaching a greater disparity population, and integrating additional services and support mechanisms for populations at greatest risk. Plans are in early stages but will focus on targeted outreach and potential funding opportunities for sites who develop specific marketing and implementation plans that will engage these high-risk populations to a greater degree than have historically been reached. Additionally, these mini-grant pilot projects will provide opportunity for program development around social determinants of health and chronic disease risk reduction among BaM participants. Read more about this under the Cross Cutting – Workforce Development section. The below "Expansion Planning Map" identifies hot spots in the state related to economic risk factors and rates of preterm birth and infant mortality, while also identifying existing KPCC and birth facilities, assisting in planning for targeted outreach and recruitment based on areas of greatest need, while pulling from existing resources.



An additional session is being developed for the existing BaM prenatal education series with a focus on the postpartum

period, creating an additional touch-point opportunity following the birth of the baby. This will provide an environment of support for these new families, while giving a booster dose of education on several postpartum and infant care topics as well as infant development, creating an opportunity for very real conversations with parents that hopefully will begin to identify and address the real barriers to healthy maternal and infant care behaviors (e.g., safe sleep practices, breastfeeding, postpartum/interconception self-care activities). The design of this session will be interaction and conversation based instead of the traditional format where the instructor and participants are closely following curriculum handouts. The design is also intended to engage support persons in the conversation to a greater degree, as well as more fully engage community partners in providing content and program/service engagement opportunities.

KPCC/BaM Website: Resources for regional and statewide implementation of KPCCs have been under development over the past several years to ensure both growth and sustainability of the initiative. The Perinatal Community Collaborative website, which is an access point to introductory information about the initiative, has been completed, however a website redesign and expansion is under development with a completion target date for early FFY2023. This will allow interested communities to explore the initiative and engage in conversations with community partners on their own timeline, utilizing TA resources provided online. This approach is hoped to better meet the needs of local communities who are interested in enhancing perinatal services, while reducing burden on Title V staff, which will improve expansion and sustainability efforts long term. These enhancements will include the incorporation of infrastructure support components, such as links to the March of Dimes 5P's approach; KDHE's MCH Integration Toolkits; resources on health equity; and much more.

Revisions are also being made to the existing KPCC partner-only website to provide additional trainings and implementation resources for program coordinators and group facilitators, especially once they are ready to begin implementation. Additional training webinars will be developed as new integration toolkits are made available and new initiatives are implemented, such as the Maternal Warning Signs and Fourth Trimester Initiative (FTI). Promotional material templates have been expanded to include materials for provider outreach, as well as additional "getting started" resources, while other materials are periodically being developed and shared by existing sites. All efforts are aimed at decreasing burden on new sites embarking upon implementation and existing sites facing staff turnover.

Conversations continue with clinical service providers in rural southwest Kansas to identify local issues and needs for the region around KPCC/BaM implementation. 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 in the region, requiring pregnant women to travel for services, including BaM prenatal education. The COVID-19 pandemic heightened the need for a virtual prenatal education option across all sites, as well as increased the strain on programs to stay afloat amidst increased staffing demands and shortages. Resources and guidance documents for virtual implementation, including online data collection and screening for PMAD, were developed and disseminated. This infrastructure component will continue to be improved and supported, including potential KDHE partnership with a local program site to offer virtual Spanish sessions on a broader basis for access across the region, as well as potentially across the state.

KPCC and BaM infographics were developed to aid communication and recruitment for new communities and to showcase the impact of the KPCC model and BaM programming in existing communities. A listening session was hosted in the fall of 2020 to determine technical assistance needs of local programs and their community partners as they strived to meet the needs of their MCH population during the quickly and ever challenging conditions of the pandemic. Continued conversations with local stakeholders are planned for FY23, as well as an in-person retreat for KPCC leads and key community partners. Many of our local program sites have experienced vast turnover

of staff during the pandemic. With new staff in many programs, as well as existing staff struggling to meet the increasing demands of service provision during the ongoing pandemic, many have voiced a desire for an in-person opportunity for dialogue and idea exchange with others, which we will strive to facilitate in FY23. Local MCH Agencies: 19 local agencies will implement BaM.

Delivering Change: will ensure Perinatal Quality Initiatives are being incorporated into the education each MCH client receives. They'll continue to integrate KPQC Toolkits, like the Maternal Warning Signs, Signs and Symptoms of Preterm Labor, Count the Kicks and Hear Her campaign into ongoing services. During visits with prenatal women, Navigators will educate on Count The Kicks, for mothers to be aware of daily fetal kicks and movement, encouraging women to download the Count the Kicks App. Additionally, education surrounding Preterm Labor and the signs and symptoms to be aware of will be discussed during early pregnancy. Navigators will distribute Preterm Labor magnets provided by KDHE to clients and encourage them to call into their provider if they are experiencing any of the signs or symptoms listed. These topics are embedded in Becoming A Mom Prenatal Education Classes, offered by Delivering Change. Delivering Change is also a collaborating partner of Geary Community Hospital, who is currently an enrolled Fourth Trimester Initiative Facility. Through this collaboration, all mothers will receive education and support surrounding Perinatal Quality Initiatives prior to discharge. As a part of the 4th Trimester Initiative, Delivering Change will develop a procedure for uniform delivery of Perinatal Mood and Anxiety Disorder Screenings across Delivering Change, Geary Community Hospital and Flint Hills OB/GYN. Through this uniform procedure, the same screening tool will be used at prescribed times, so that a woman's score can be tracked over time and recognition of changes in a woman's mental health may be identified early.

Baby Talk: will increase the number of Baby Talk participants who are knowledgeable about postpartum symptoms that may result in morbidity and mortality and know the appropriate course of action to address the symptoms. They will focus on trouble breathing, chest pain or fast-beating heart, seizures and thoughts of hurting self or baby for FY23. Maternal mortality prevention will be discussed in Session 6- Healthy after pregnancy. The curriculum will focus on understanding the difference between "concerning" warning signs for which they should notify their physician and "urgent" warning signs that warrant a call to 911. Participants will receive several handouts on these topics in their binders which were developed by the March of Dimes (What Are Warning Signs to Look for After Giving birth), AWHONN (Save Your Life: Get Care for These Post-Birth Warning Signs), CDC (Listening and Acting Quickly, You Know Your Body Best), and KDHE (Urgent Maternal Warning Signs, Action Plan for Depression and Anxiety Around Pregnancy).

Other Women/Maternal Activities

Count the Kicks® (CTK) Stillbirth Prevention Initiative: Title V will continue the formal partnership with Healthy Birth Day to continue the CTK campaign to prevent stillbirth through provider and patient education around monitoring fetal movements during the 3rd trimester of pregnancy. This will continue to be provided across the state at no cost to providers, who will have full access to videos and educational materials (including posters, brochures, and appointment cards in English and Spanish). Kansas plans to build on the momentum of the CTK campaign through social media and sharing data and information with the MCH network. The following are examples of planned initiatives:

- *Stillbirth Awareness Month*: Encourage local MCH agencies to spread awareness in their communities and encourage moms to count kicks. (October 2022)
- *Kansas CTK Mobile App*: A KS-specific version of the app with four follow-up questions that connect mothers directly with resources in Kansas based on expressed needs and concerns was developed and launched in 2022. Data from this app will be collected and evaluated throughout FY23, and adjustments will be made as deemed necessary in the following contract.

- *CTK Toolkit:* including low literacy materials and kick counting wrist bands distributed to MCH, home visiting (including MICEHV), and TPTCM/PMI programs across the state. Utilization of these materials will be monitored throughout the year for discussion and inclusion of material/resource needs in the upcoming contract year.

Black Maternal Health Statewide Interviews: Title V has awarded a contract to Wichita State University to solicit feedback from Black mothers about their pregnancy, delivery and postpartum experiences to better identify barriers to care and gaps in services to inform policies and programs. The goal of these interviews is to facilitate conversations and record the perspectives of Non-Hispanic Black mothers in Kansas regarding the following:

- Views on importance of overall health and the functionality of the current health care system
- Health priorities and biggest needs
- Availability of health care services for them and their children
- Services and supports they feel were lacking during the perinatal period III and neonatal periods related to physical health, emotional wellbeing, and mental health
- Barriers faced when seeking whole health services, including prenatal and postpartum care
- Tools they find helpful, or would find helpful, when navigating the health care system

The interviews will began in early summer of 2021 and the final report and subsequent presentation of the findings will be concluded by May 2022. The final report, with recommendations, will be presented during Black Maternal Health Week during an HHS Region 7 webinar series highlighting state work in Region 7 addressing Black maternal health.

Cuff Project: Based off data from the Kansas Maternal Mortality Review Committee (KMMRC) hypertensive conditions in pregnancy and the postpartum period are a significant contributing factor to maternal morbidity and mortality in Kansas. In response, Title V is collaborating with the Maternal Infant Child Early Home Visiting (MICEVH) program to implement a pilot cuff project that will provide eligible pregnant persons access to blood pressure cuffs to be utilized in the home setting at little to no cost. High risk, eligible pregnant (and postpartum) persons identified by their health care provider in existing MICEHV communities will be connected to the home visiting program and will receive a gift card to purchase an automatic blood pressure cuff. Patient and provider materials are currently under development to provide education and guidance around how to accurately measure, and what appropriate blood pressure readings are; along with how to select and size an appropriate blood pressure monitor and cuff. Based on the success of this pilot project,Title V hopes to replicate a similar program across the state utilizing the Universal Home Visiting model, the BaM prenatal education program and KPCC model.

PRIORITY 2: All infants and families have support from strong community systems to optimize infant health and well-being.

Domain: Perinatal & Infant Health

NPM 5: Safe Sleep (Percent of infants placed to sleep; (A) on their backs; (B)on separate sleep surface; and (C) without soft objects and loose bedding)

ESM: Percent of Kansas Perinatal Community Collaboratives (KPCC) participants who placed their infants to sleep (A) on their backs; (B) in a crib/bassinet or portable crib

SPM 2: Breastfeeding (Percent of infants breastfed exclusively through 6 months)

ESM: Percent of WIC non-Hispanic black infants breastfed exclusively through six month

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Local MCH Reach: During SFY2021, 61 of 67 grantees (91%) provided services to the Perinatal/Infant population.

NPM 5: Safe Sleep (Percent of infants placed to sleep; (A) on their backs; (B) on separate sleep surface; and (C) without soft objects and loose bedding)

ESM: Percent of Kansas Perinatal Community Collaboratives (KPCC) participants who placed their infants to sleep (A) on their backs; (B) in a crib/bassinet or portable crib

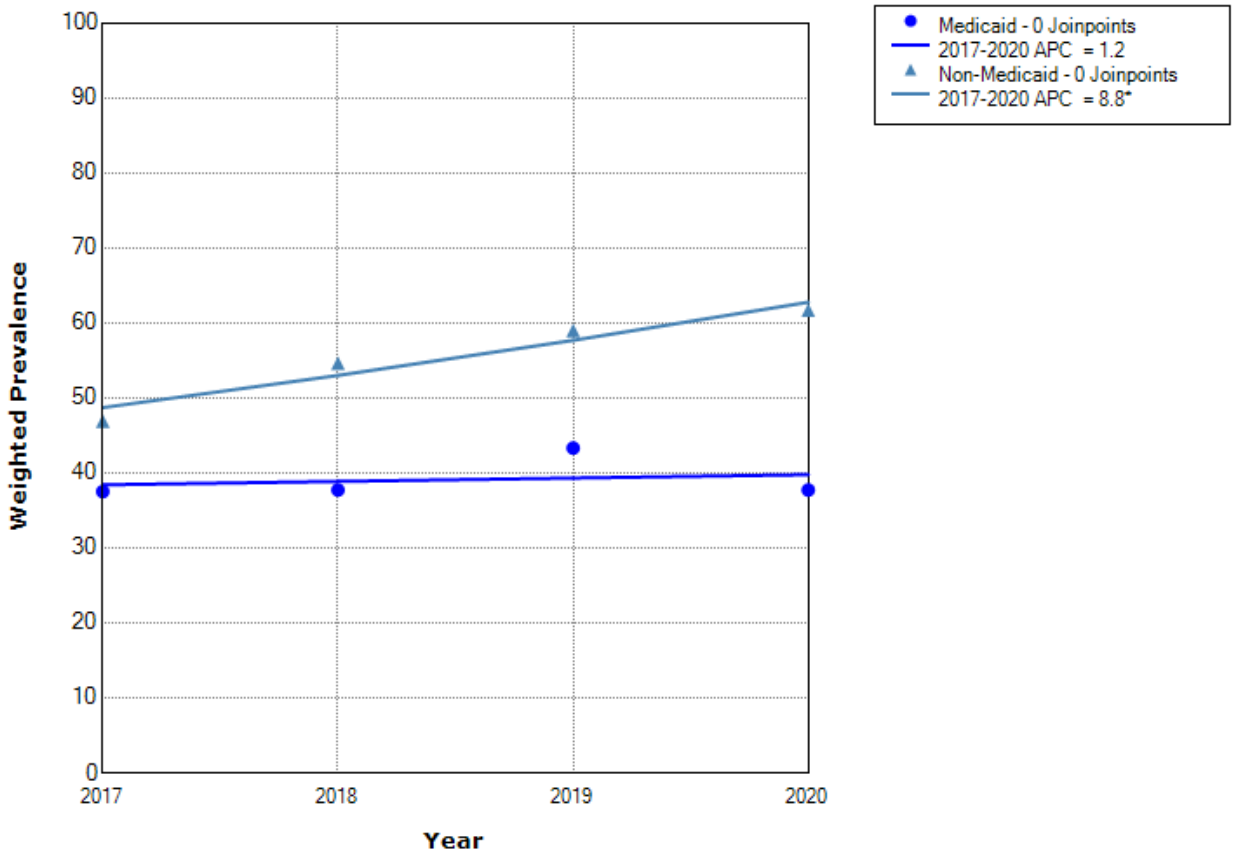
According to data from the Pregnancy Risk Assessment Monitoring System (PRAMS), among Kansas residents with a recent live birth in 2020:

(A) 82.3% reported that their infants were placed to sleep on their backs most often – rather than on their sides, stomachs, or a combination of positions (95% confidence interval [CI]: 79.4%-85.0%). The prevalence did not change significantly from 2017 to 2020.

(B) 46.1% reported that their infants "always" or "often" slept alone, usually in a crib, bassinet, or pack and play, and *not* usually in a standard bed, couch, sofa, armchair, car seat, or swing in the past two weeks (95% CI: 42.4%-49.7%). The prevalence of this indicator also did not experience a statistically significant change from 2017 to 2020, despite an increasing trend. However, for those whose deliveries had a non-Medicaid payment source, the prevalence increased significantly, with an annual percent change of 7.2% (95% CI: 2.4%-12.1%).

(C) 54.8% reported that their infants did not usually sleep with blankets, toys, cushions, pillows, or crib bumper pads in the past two weeks (95% CI: 51.2%-58.5%). The prevalence of this indicator increased significantly from 2017 to 2020, with an annual percent change of 7.2% (95% CI: 0.1%-14.7%). Those with a non-Medicaid payment source for their deliveries, specifically, experienced a significant increase with an annual percent change of 8.8% (95% CI: 1.3%-16.9%). However, no statistically significant change from 2017 to 2020 was observed for those whose deliveries had been indicated as being paid for by Medicaid. This suggests that while overall, improvement is being observed in this indicator, those with Medicaid-covered births may need additional supports to help reduce the percentage of infants sleeping with soft objects or loose bedding.

Weighted Prevalence of Infant Sleeping without Soft Objects or Loose Bedding, by Payment Source for the Delivery, as Reported by Kansas Residents with a Recent Live Birth, 2017-2020



* Indicates that the Annual Percent Change (APC) is significantly different from zero at the alpha = 0.05 level.
Payment source for the delivery was derived from the infant's birth certificate.
Source: Kansas Department of Health and Environment, Kansas Pregnancy Risk Assessment Monitoring System (PRAMS), 2017-2020

Adherence to these three safe sleep recommendations varies by maternal age, race/ethnicity, and socioeconomic status. For instance, according to 2019-2020 data from PRAMS (two years of data combined), Kansans with a recent live birth who were at least 25 years old, of non-Hispanic White race, had at least some college education, or did not receive WIC food during pregnancy, were significantly more likely to report adhering to each of these three safe sleep indicators, compared to those who were younger than 25 years old, of non-Hispanic Black race, had only a high school diploma, or received WIC food during pregnancy, respectively.

Objective: Promote and support safe sleep practices and cross-sector initiatives to reduce the sudden unexplained infant death (SUID) rate.

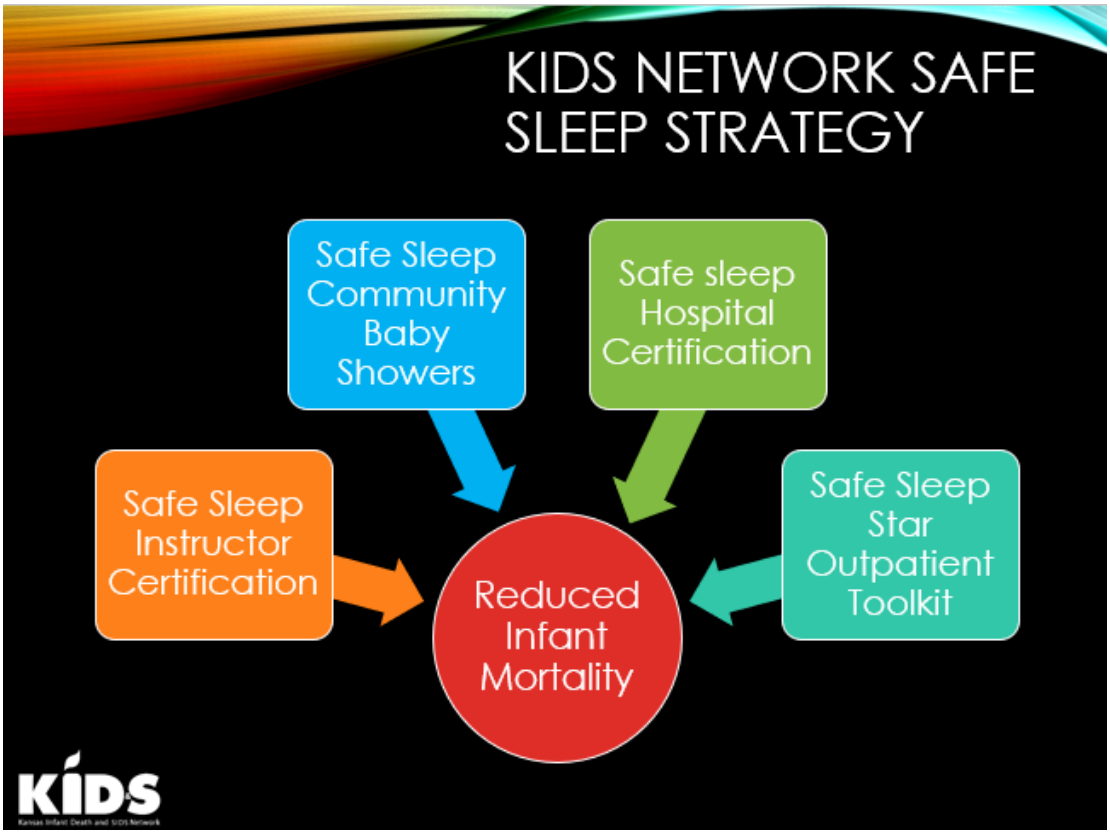
Title V continues to focus on reducing SUID rates through safe sleep education and professional trainings/resources offered to local MCH agencies, home visiting programs, hospitals, childcare facilities, and other providers to support safe sleep practices and accurate, consistent safe sleep messages across all sectors in a community. Consistent and current safe sleep education and messaging is critical as we strive to eradicate unsafe sleep practices.

Kansas Infant Death and SIDS (KIDS) Network Infrastructure: Title V continues its strong partnership with the Kansas Infant Death and SIDS (KIDS) Network. Title V provides organizational infrastructure support for the Executive Director and support staff to execute activities outlined within the contractual agreement. The KIDS Network collaborates with local organizations and coalitions across the state to reduce the number of infant deaths. Safe sleep promotion is the predominant focus of the Network's outreach activities, including Safe Sleep Community Baby Showers (CBS), Cribs for Kids, dissemination of Safe Sleep education materials, and health and childcare provider education/training opportunities. In FY2021, the KIDS Network worked with 20 Kansas counties:

- 45 healthcare professionals were certified by the KIDS Network as Safe Sleep Instructors (SSI)
- 206 Safe Sleep Trainings were conducted (Safe Sleep Parent and Caregiver = 94; Safe Sleep Professional = 112). Trainings were held in-person (n=162, 79%) and virtually (n=44, 21%) to accommodate COVID-19 restrictions. 1,690 professionals and 236 caregivers attended the trainings.

In collaboration with their certified SSIs, the KIDS Network also hosted 85 Safe Sleep CBS and 70 Safe Sleep Crib Clinics in 18 counties, reaching 459 pregnant women. Due to COVID-19 health and safety restrictions, eight (53%) Safe Sleep CBS and 33 (47%) Safe Sleep Crib Clinics were conducted virtually. A total of 14,017 community members were trained on safe sleep and bereavement through presentations at hospitals, universities, online education system (KS Train), conferences, and outreach activities including professional meetings, community events, social media and KIDS Network events (e.g., Susan E. Bredehoft Candle Lighting, Haley's SIDS Scramble, Step Up for KIDS).

(KIDS) Network – Safe Sleep Expansion Initiative: As mentioned above, Title V has maintained a contractual partnership with the KIDS Network of Kansas to reduce infant mortality, specifically with focus on continued implementation of a comprehensive statewide safe sleep approach. Components include the Safe Sleep Instructor program and Community Baby Shower model, the Hospital Safe Sleep Certification and the Provider Safe Sleep Star Program (including the Provider Outpatient Toolkit).These initiatives are instrumental in providing shared safe sleep messaging and education across the state.



Safe Sleep Instructor (SSI) Program - Each year, the KIDS Network hosts two SSI Trainings to certify professionals and caregivers as educators on safe sleep best practices. The curriculum was developed based on American Academy of Pediatrics (AAP) guidelines and the ABC's of Safe Sleep, and updated each year based on current research and recommendations. Topics discussed in this training include diagnosis and disparity of sleep-related deaths, including sudden infant death syndrome (SIDS); safe sleep location, environment, position, and messaging strategies; risks of smoking and protective quality of breastfeeding; the importance of mental health and recommended practices related to temperature regulation, pacifiers and tummy time. Following training, SSIs are certified (three levels – Gold, Silver, Bronze) to educate parents/caregivers, childcare providers, health care providers and other members of their communities about safe sleep practices.

KIDS has continued to provide technical assistance to SSIs to ensure consistent messaging and continuity of existing supports throughout the COVID-19 pandemic. SSI 2020 annual trainings were provided in-person to assure continuation of efforts during the pandemic, while adhering to the following COVID-19 safety guidelines: Required mask wearing; assigned seating, with 6 ft. between individual seating locations; hand sanitizer; prepacked lunch and snacks; routine cleaning of training area. Additionally, enrollment was reduced to 50% usual capacity to allow for adequate social distancing.

Community Baby Shower (CBS) model – This model goes beyond the traditional health fair to an education and service access focus. A memorandum of understanding was established by the BFH, KIDS Network, KBC, and the Bureau of Health Promotion/KS Quitline to collaboratively support the CBS model statewide through staffing, education, and the provision of resources and referrals. This is a significant step forward, bringing together key lead agencies to provide consistent safe sleep messaging and comprehensive services to reach more perinatal women. This multi-agency approach also supports cross-sharing of accurate and reliable information related to safe sleep, breastfeeding, and tobacco cessation. In this reporting period, perinatal mental health was integrated into the model. Goals were established for each of these priority areas:

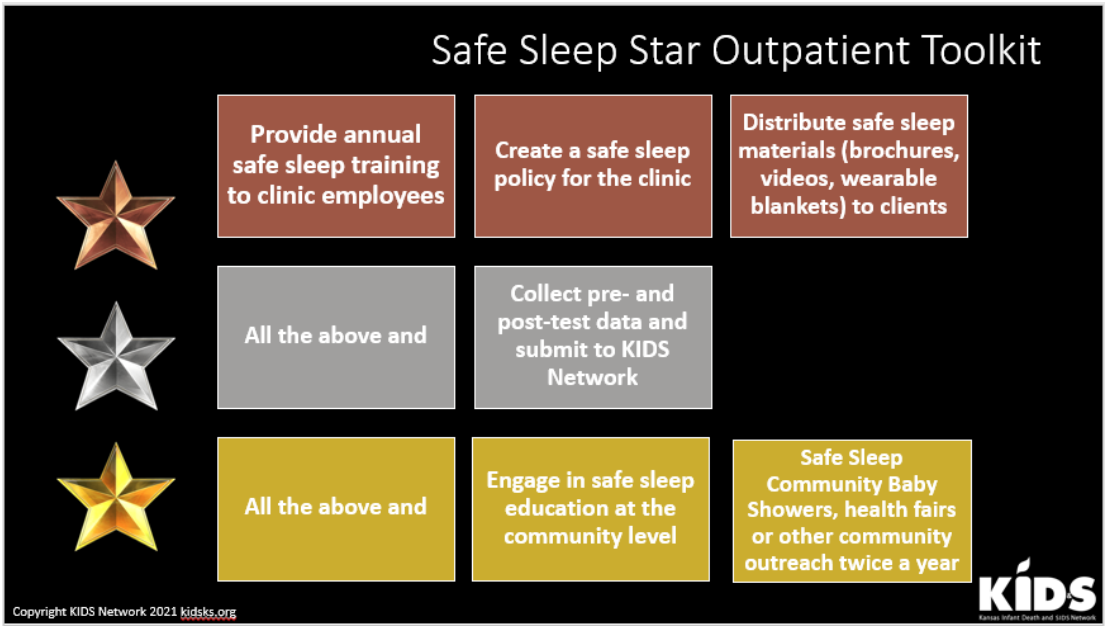
- Safe Sleep: increase education and adherence of safe sleep practices (e.g., back position only, safe location, no unsafe items in bed)
- Tobacco Cessation: identify three or more ways to avoid secondhand smoke; identify at least one local tobacco cessation resource
- Breastfeeding: increase confidence in ability to breastfeed for at least 6-months; identify at least one local resource for breastfeeding support
- Mental Health: increase understanding of perinatal mood and anxiety disorders (PMADs) as a potential complication of pregnancy and the postpartum period; identify strategies for reducing PMAD symptoms; identify at least one external resource for PMAD support

As mentioned above, 459 pregnant women were educated about safe sleep through demonstrations at KIDS Network Safe Sleep CBS/Crib Clinics. Kansas PRAMS data shows improvement of infants being placed to sleep “mostly on the back” from 80.2% in 2017 to 84.0% in 2019, suggesting that the years of safe sleep collaboration/work is resulting in positive change. During the COVID-19 pandemic, many communities began offering local CBS events virtually. KIDS has provided support and technical assistance (TA) to local SSI on adapting this model to virtual format. Review of evaluation results from this format was completed to determine its effectiveness and practicality for continuation beyond the pandemic. Although both event formats demonstrated increased knowledge/intentions to follow safe sleep recommendations, interpretation of results indicate that virtual events may further marginalize groups who are at high risk for poor birth outcomes. Strategies to increase technology access, recruit

priority populations, and ensure disparities are not exacerbated will be critical for the implementation of future virtual events.

Hospital Safe Sleep Certification Program - 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. Due to COVID-19, outpatient clinics in the process of KIDS Network Safe Sleep Star Outpatient Toolkit implementation have been halted until non-mandatory trainings are resumed in the clinical setting. Likewise, hospitals that are in the process of certifying have halted and will be reevaluating the process to proceed as they see manageable, once pandemic related response and staffing issues begin to resolve.

Safe Sleep Star Outpatient Toolkit - The Safe Sleep Star Outpatient Toolkit was launched in FY18 to address infant mortality by providing tools to help outpatient maternal and infant healthcare providers improve safe sleep promotion utilizing evidence-based/informed practices, including the Medical Society of Sedgwick County's Safe Sleep Toolkit targeted to health care providers, child care providers, and caregivers. To maintain the earned stars, practices must continue to report compliance on an annual basis. Practices may upgrade their status at any time a higher level is reached. The certification program identifies three designations:



Limitations associated with the pandemic slowed progress with the certification program. No new clinics became Safe Sleep Star certified during the reporting period; clinics halted the process due to restrictions on visitors being allowed to present non-mandatory trainings. This will be reevaluated once feasible.

Kansas Perinatal Community Collaboratives (KPCC)/Becoming a Mom® (BaM): Training on the SIDS/Safe Sleep integration component is provided to new KPCCs preparing to implement the BaM curriculum. This training is recorded and available on the private website, along with the other integration components for new facilitators to receive comprehensive training on their own timeline and support long-term expansion and sustainability efforts. Recent experiences during the pandemic have validated the need for online training opportunities more than in any previous year. Review and updates to the safe sleep and SIDS curriculum content were made by our KIDS Network partners in June 2021, as done on an annual basis. In addition to curriculum including a SIDS/Safe Sleep focus, program incentives across every site include the pack-n-play crib distribution, which provides a safety-approved crib for expectant mothers with limited resources.

Local MCH Agencies (including affiliate programs PMI & TPTCM): Information is provided to all pregnant and postpartum women regarding the importance of safe sleep practices. Local agency staff continue to educate and encourage pregnant and postpartum women to discuss safe sleep with all their infant care providers (e.g., family members, friends, childcare providers). Local agencies collaborate with community partners and other health care providers to promote safe sleep in their community in a consistent manner. A sampling of local efforts include:

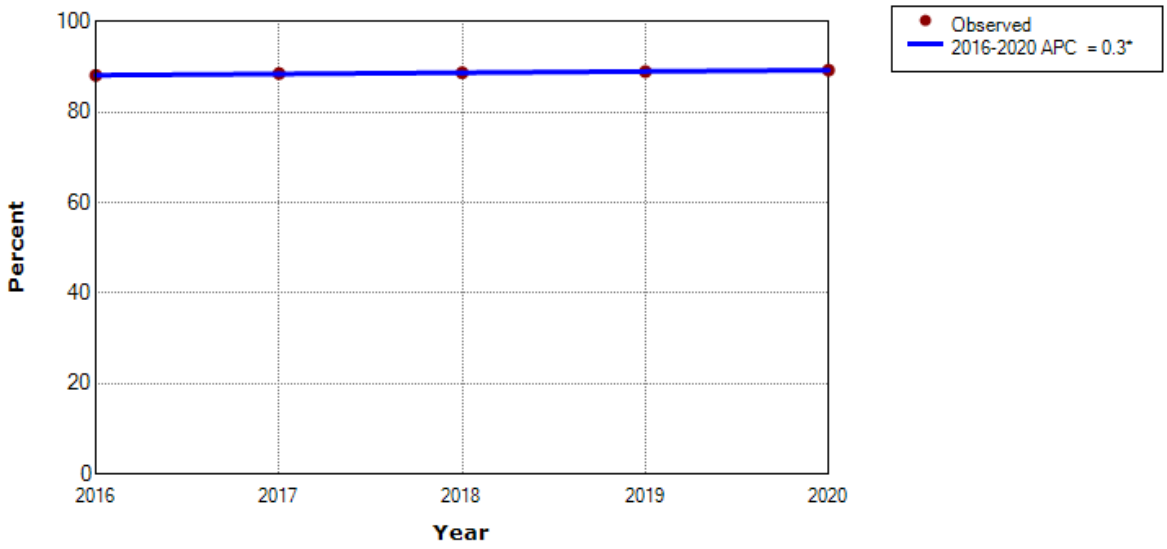
- *Butler County*: In August at Baby Jubilee, three safe sleep trainings were provided to 19 participants. The current Health Department Safe Sleep Trainer has provided three Safe Sleep trainings. From July to September anyone requesting a Safe Sleep training was referred to EMS who has a trainer on staff. The Health Department now has a Safe Sleep trainer on staff and anyone interested in a class is referred to her. Due to COVID-19 there have been few requests but it is anticipated these will increase in the coming months.
- *Riley County:* The MCH HV and nurse identified an unsafe sleep environment during a home visit where twin infants were co-sleeping in the same pack-and-play. The family was saving to purchase an additional pack-and-play to separate the infants. The MCH Nurse was able to purchase and deliver a pack-and-play that afternoon to the family. The family was very thankful for the safe sleep education and additional pack-and-play.
- *University of Kansas School of Medicine*: The Baby Talk curriculum, Session 5-Infant and Newborn Care, discusses the importance of safe sleep practices and highlights what is considered a safe sleep environment as well as why certain options would not be considered a safe sleep environment. The curriculum also highlights the risks of unsafe sleep practices. 95% reported they place their baby ONLY on the back for sleep and 95% reported placing baby to sleep ONLY in a crib, bassinet or portable crib.
- *GraceMed*: All new PMI enrollees were provided the “My Baby” book from which they can learn and document their journey throughout their pregnancy. The book also includes information on prenatal health, parenting skills, SIDS, safe sleep, SUD/tobacco abstinence, mental health and nutrition. In addition, the facility continued participation in the quarterly "community baby shower" events sponsored by Heartland Healthy Neighborhoods, as well as local health fairs, and sponsorship of an informational booth at city of Topeka events (e.g. Winterfest, Downtown Jazz & Food Truck Festival).

SPM 2: Breastfeeding (Percent of infants breastfed exclusively through 6 months)

ESM: Percent of WIC non-Hispanic black infants breastfed exclusively through six months

In 2020, Kansas birth certificate data showed that mothers initiated breastfeeding in 89.3% of resident live births. This was a small increase from the 88.9% reported in 2019 and surpassed the Healthy People 2020 target of an 81.9% breastfeeding initiation rate.[1] The overall breastfeeding initiation rate has been significantly increasing by 0.3% per year (95% Confidence Interval: 0.2%, 0.4%) for the past five-year period (2016-2020).

Figure 1. Trends in breastfeeding initiation among infants born in Kansas, 2016-2020



* Indicates that the Annual Percent Change (APC) is significantly different from zero at the alpha = 0.05 level.
Final Selected Model: 0 Joinpoints.

Source: Birth certificate data (Resident)

Breastfeeding initiation rates varied across racial and ethnic groups (Table 1). In 2018-2020, non-Hispanic Asian mothers had the highest breastfeeding initiation rate (93.9%), followed by non-Hispanic White (90.1%), Hispanic (87.4%), non-Hispanic Other (86.2%), non-Hispanic Black (81.4%), non-Hispanic American Indian or Alaska Native (80.7%), and non-Hispanic Native Hawaiian or Other Pacific Islander (80.6%) mothers. Most notably, for non-Hispanic Black mothers, breastfeeding initiation rate increased significantly from 77.7% in 2015-2017 to 81.4% in 2018-2020. Furthermore, the racial/ethnic gaps in breastfeeding initiation decreased. However, non-Hispanic Black mothers breastfeeding initiation continued to remain the lowest among the three largest race and Hispanic-origin groups.

Table 1. Breastfeeding initiation by maternal race and ethnicity, Kansas, 2018-2020 vs. 2015-2017

Maternal race/ethnicity	Initiated breastfeeding	Resident live births	2018-2020 % (95% CI)	Trend	2015-2017 % (95% CI)
Asian, non-Hispanic	3213	3420	93.9 (93.1-94.7)	↑	93.4 (92.5-94.2)
White, non-Hispanic	65570	72780	90.1 (89.9-90.3)	↑*	89.2 (89.0-89.4)
Hispanic	15662	17926	87.4 (86.9-87.9)	↑	86.7 (86.2-87.2)
Other, non-Hispanic	2904	3370	86.2 (85.0-87.3)	↑	85.5 (84.3-86.7)
Black, non-Hispanic	5884	7229	81.4 (80.5-82.3)	↑*	77.7 (76.7-78.6)
American Indian or Alaska Native, non-Hispanic	369	457	80.7 (77.1-84.4)	↑	79.9 (76.4-83.3)
Native Hawaiian or Other Pacific Islander, non-Hispanic	170	211	80.6 (75.2-85.9)	↑	78.9 (72.8-85.1)
Total	93869	105512	89.0 (88.8-89.2)	↑*	88.0 (87.8-88.2)

*Statistically significant ($p<0.05$)
CI=confidence interval
Note: Missing/unknown breastfeeding status and infants that died shortly after birth were excluded.
Source: Birth certificate data (Resident)

Breastfeeding initiation rates also varied widely based on where in the state a mother resides at the time of the birth (Figures 2 and 3). From 2015-2017 to 2018-2020, the overall percentage of breastfeeding initiation increased significantly in Kansas (88.0% and 89.0%, respectively) (Figure 2 and Figure 3).

Counties with significantly higher breastfeeding initiation rate in 2018-2020 than in 2015-2017:

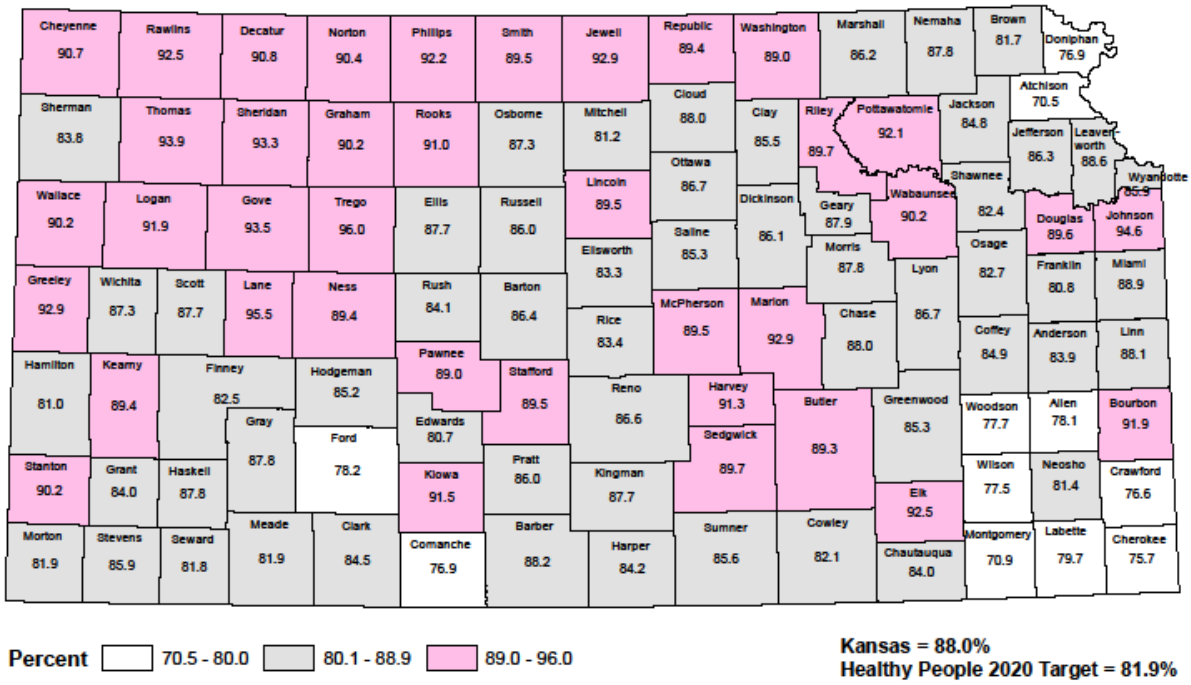
- Anderson
- Atchison
- Ellis
- Finney
- Ford
- Franklin
- Harper
- Johnson
- Kingman
- Leavenworth
- Rice
- Sedgwick
- Shawnee
- Wyandotte

Counties with significantly lower breastfeeding initiation rate in 2018-2020 than in 2015-2017:

- Bourbon
- Labette
- Logan
- Lyon
- Seward
- Thomas

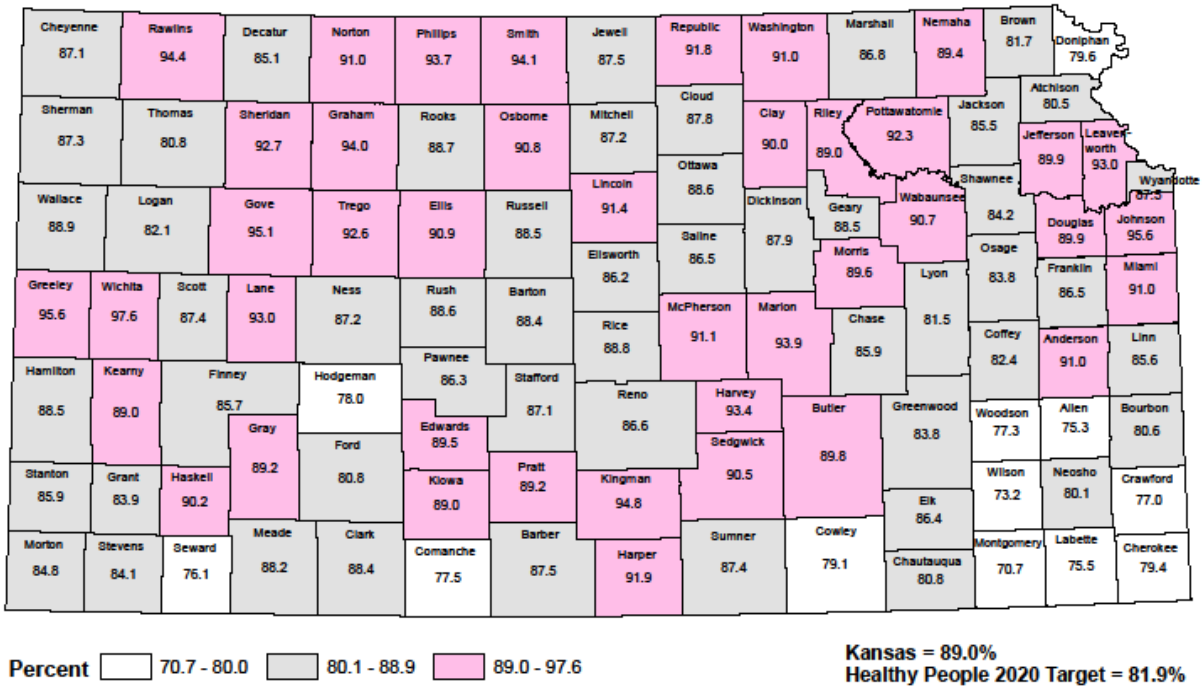
Infants born in the Northeast, Northcentral and Southcentral regions, were most likely to be breastfed. These regions have eight of ten Kansas hospitals that are currently recognized as 'Baby-Friendly Designated Facilities' through the Baby-Friendly Hospital Initiative.[2]

Figure 2. Breastfeeding initiation by county of residence, Kansas, 2015-2017



Note: Missing/unknown breastfeeding status and infants that died shortly after birth were excluded.
Source: Birth certificate data (Resident)

Figure 3. Breastfeeding initiation by county of residence, Kansas, 2018-2020



Note: Missing/unknown breastfeeding status and infants that died shortly after birth were excluded.
Source: Birth certificate data (Resident)

According to the most recent National Immunization Survey (NIS), for infants born in Kansas, in 2018, 87.9% of mothers reported ever breastfeeding, 60.2% reported breastfeeding at six months, and 32.0% reported exclusive breastfeeding at six months.[3] While there has been an improvement in exclusive breastfeeding at six months, more work is needed to meet the Healthy People 2030 goal (42.4%).[4] Breastfeeding is linked to a reduced risk for many illnesses in children and mothers. The U.S. Dietary Guidelines for Americans and the American Academy of Pediatrics recommend exclusive breastfeeding for about 6 months, and then continuing breastfeeding while introducing complementary foods until your child is 12 months old or older. Preventative health through exclusive breastfeeding can save health care dollars through reduction in acute illnesses and chronic disease.[1,3] One of the factors contributing to stopping breastfeeding earlier than 6 months may include lack of accessible breastfeeding support especially for those returning to work or school soon after birth. Breastfeeding support programs including Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Breastfeeding Peer Counselors, lactation consultants, workplace policies, and supportive communities can help address these barriers.

The Centers for Disease Control and Prevention (CDC) invites biennially all hospitals across the country to complete the Maternity Practices in Infant Nutrition and Care Survey (mPINC).[5] The Survey measures maternal care practices and policies that impact newborn feeding, feeding education, staff skills and discharge support.[5] A Total mPINC score indicates its overall level of maternity care practices and policies that support optimal infant feeding.[5] Subscores further categorize maternity care practice subdomains: Immediate Postpartum Care, Rooming-In, Feeding Practices, Feeding Education & Support, Discharge Support, Institutional Management.[5] Responses are scored using an algorithm that denotes the evidence and best practices to promote optimal infant feeding within the maternity care setting.[5] Possible scores range from 0 to100, with higher scores indicating better maternity care practices and policies.[5] The mPINC survey results provide feedback to encourage hospitals to make improvements that better support breastfeeding.[5] In the most recent 2020 mPINC survey, 44 of 57 eligible Kansas hospitals (77%) that deliver babies participated. Kansas scored 83/100, which was higher than the national average (81/100).[6] Kansas scored higher than three out of four neighboring states - Nebraska 73%, Missouri and Oklahoma 79%, Colorado 85%.[6] Kansas hospitals are doing well in the domains related to Feeding Practices, Feeding Education & Support and Discharge Support, which positively impact early initiation. However, improvement could be made in the domain of Institutional Management.

*The mPINC survey was redesigned in 2018. Results from the mPINC surveys 2018 or later cannot be compared with results from 2007-2015 mPINC surveys.

Objective: Promote and support cross-sector breastfeeding policies, practices, and environments to increase exclusive breastfeeding rates at 6 months.

While Kansas has high breastfeeding initiation rates, there is still plenty of work to do related to increasing the duration and exclusive breastfeeding rates at six months. This requires continued focus on increasing access families' access to strong community breastfeeding education, supports, and practices. Collaboration among key community and state partners, such as the Kansas Breastfeeding Coalition (KBC) and KPCC sites is key to these efforts. Additional strategies have included a focus on increasing referrals to WIC for breastfeeding support and education; expanding WIC Breastfeeding Peer Counseling; shared messaging through WIC and Home Visiting programs, hospitals, and provider offices; building on the *Breastfeeding Welcome Here* and *Business Case for Breastfeeding* initiatives; focus on decreasing racial disparities; and education about behavioral health and breastfeeding.

Kansas Breastfeeding Infrastructure: Title V continued its strong partnership with KBC, expanding work on existing effective strategies to address disparities in breastfeeding and increasing breastfeeding rates among Black mothers. Several strategies were identified to address disparities, and significant progress was made in FY2021:

1. Increase access to lactation support by African American providers such as breastfeeding peer counselors, doulas, International Board-Certified Lactation Consultants (IBCLC), and Certified Lactation Counselors representing high-risk populations to increase the culturally relevant support women of color need to initiate and continue breastfeeding. Fourteen educational stipends were awarded to individuals who self-identified as Black (8), Hispanic (5), and Indigenous (1). Five were funded by Title V/KDHE, five by Kansas Health Foundation, and four by United Methodist Health Ministry Fund. Stipends must be used to achieve a lactation support provider credential such as the Certified Lactation Counselor. In addition, KBC secured additional funding from the Kansas Health Foundation to create the Color-Filled Breastfeeding: Clinical Lactation Training Program to increase the number of IBCLCs of color in Kansas. Additional information about racial inequities in breastfeeding is provided by KBC, here.

2. Support the implementation of community-centered, culturally relevant mother-to-mother, father, and grandparent breastfeeding support clubs for African Americans (e.g., Black Breastfeeding Clubs, Brown Baby Brigade, BSTARS, Reach our Brothers Everywhere (ROBE), Fathers Uplift, Grandmothers Tea Project) to build capacity in the community to support mothers of color in breastfeeding. Eight (8) Black women completed the 2-day leader facilitation training from Chocolate Milk Café (CMC) National May 1-2, 2021. They established three (3) CMC chapters; one each in Wichita, Kansas City, and Topeka with 2-3 trained facilitators for each chapter. Additional culturally congruent breastfeeding support resources for Black, Hispanic, and Indigenous families are maintained on the KBC Resources page.
3. Expand breastfeeding coalitions for African Americans who connect healthcare providers and the community to local information and resources (e.g., African American Breastfeeding Coalition of Wyandotte County) to foster a culture of change. Black Breastfeeding Coalitions were created in Topeka and Wichita, a Latinx Breastfeeding Coalition in Southwest Kansas, and an Indigenous Breastfeeding Coalition to include members of the five (5) Tribes in Kansas.

Title V continues to work with a variety of partners, referred to collectively as the Kansas Breastfeeding Support Network, to advance the work and partnership of the KBC.

Communities Supporting Breastfeeding (CSB): The KBC, in partnership with Title V, has continued to launch and sustain CSB communities. The Kansas CSB program has received state and national attention and was selected as an Emerging Practice for AMCHP's Innovation Station (2016) and was featured in AMCHP's NPM 4 toolkit (2019). The CSB is also included in the Kansas Health Matters database of promising practices. CSB is a designation from the KBC that recognizes communities that are building a culture of supporting breastfeeding across settings including public spaces, work sites, birthing facilities, childcare setting through partnerships with local breastfeeding coalitions and breastfeeding support peers. The goal of a CSB community is to improve exclusive breastfeeding rates for infants at six months of age by integrating six breastfeeding initiatives across sectors. As of October 2021, 28 communities had achieved the CSB designation with support from Title V, Kansas WIC, KBC, Kansas Health Foundation (KHF), United Methodist Health Ministry Fund (UMHMF), and Prime Health Foundation. The KBC adapted the CSB criteria to define "community" as a *cultural community* rather than a geographical community which allowed "ready" African American and tribal communities to achieve the CSB designation. In June 2021, the new "CBS PLUS" designation was launched. This new designation expands upon the CSB foundation to address diversity and new systems of support including physician offices; emergency preparedness; city and/or county governments; faith-based organizations; schools, colleges, and universities; correctional facilities, food pantries; doulas; and local health departments. Read more about CSB here.

Local Breastfeeding Coalitions: Having a local breastfeeding coalition is one of the six required CSB criteria. Over the past 10 years, the number of local breastfeeding coalitions has increased from eight to 27 county

coalitions, five regional coalitions, and five cultural coalitions covering 71 counties or 68% of the state. A list of local breastfeeding coalitions and their contacts can be found here.

The KBC Local Breastfeeding Coalition Section supports local coalitions by providing networking and learning opportunities and fostering the formation of new coalitions. In FY 2021, the KBC's Local Breastfeeding Coalition Section:

- Created the *Toolkit for Kansas Local Breastfeeding Coalitions*, a checklist for 'effective coalitions', resources including links to community partner organizations, breastfeeding data and financial information. The Toolkit and resources for local coalitions can be found here.
- Held bi-monthly meetings for local coalition leaders and advocates interested in forming a coalition, providing an opportunity for resource sharing, networking, and learning from subject-matter experts.

In addition to Local Breastfeeding Coalitions, KBC supported local coalitions through:

- Facilitating four statewide meetings each year featuring speakers who are experts on topics of interest to local coalitions.
- Supporting the 53 local MCH agencies who selected breastfeeding as a priority in FY21, to facilitate the implementation of breastfeeding strategies.
- Planning the *2021 Kansas Breastfeeding Coalitions Conference* drawing 263 attendees with 12 hours of education from national experts in lactation.
- Maintaining the "Tools for Coalitions" webpage with resources such as sample coalition documents, Needs Assessment templates, project ideas for local coalitions, community engagement ideas, and tools for local coalitions.

Local breastfeeding coalitions have demonstrated resilience and resourcefulness during the COVID pandemic. The story, below, illustrates the support KBC provides to local breastfeeding coalitions across the state.

> *Kaw Area Breastfeeding Coalition & Northeast Kansas Breastfeeding Coalition:* Both coalitions moved their meetings online during the COVID pandemic. KBC provided technical support and hosted the meetings on their business platform. The online format had two unanticipated positive outcomes: 1) More local members were able to participate in the local coalition meetings. Busy work schedules that didn't allow for driving to meeting locations across town or even counties away, were no longer an obstacle to attendance; and 2) KBC Executive Director was able to actively participate in meetings on a regular basis. This resulted in greater collaboration and "cross-pollinating" with other local breastfeeding coalitions and state programs.

Child Care Provider Training: To promote using evidence-based breastfeeding practices to families, a partnership between Title V, KBC, and Child Care Licensing was established forming the Kansas Child Care Training Opportunities (KCCTO) program. The KCCTO provides an online course for childcare providers, at no cost, monthly. During the reporting period, a Breastfeeding Friendly Child Care Provider Toolkit was created and disseminated. This toolkit and implementation strategies were presented to stakeholders during the February 2021 Early Childhood Systems Building webinar, and to Child Care Health Consultants with Child Care Aware of Kansas.In addition, , 636 childcare providers completed the online 2-hour course *How to Support the Breastfeeding Mothers & Families*. Over 5,000 child care providers have completed the training since its launch in June 2013 (up from 4,600 in FY20), most through an online course hosted by KCCTO and taught by KBC.

The *Business Case for Breastfeeding* assists employers in providing worksite support for breastfeeding employees and guidance on creating a breastfeeding friendly worksite through education and resources. As of October 2021, 362 (up from 350 in FY19) employers had received the Breastfeeding Employee Support Award which recognizes employers in Kansas that provide workplace levels of support for breastfeeding employees: Gold, Silver, and Bronze. In this reporting period two childcare programs and a hair salon have received the Gold award.

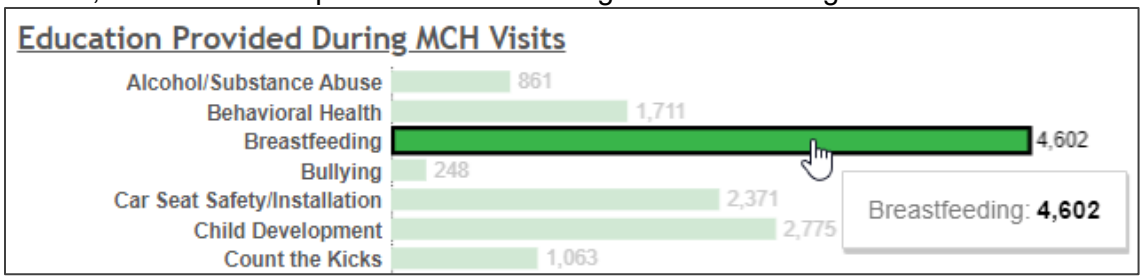
COVID-19 Breastfeeding Guidance: Throughout the pandemic the Title V Perinatal/Infant Clinical Consultant has created and published public guidance on breastfeeding for providers and mothers. This guidance can be

found on the KDHE COVID-19 Resource Center. The guidance is updated regularly based on the latest recommendations from the American College of Obstetricians and Gynecologists, and the Centers for Disease Control and Prevention, among others. In addition, KBC maintains their COVID & Breastfeeding webpage with information about COVID-19 and the COVID-19 vaccine.

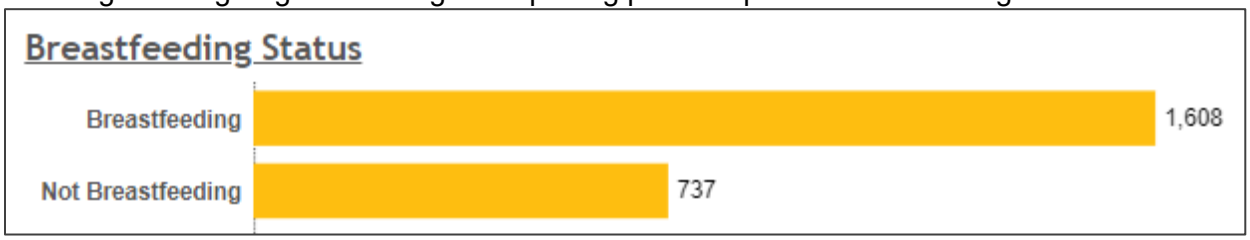
Local MCH Agencies (including affiliate programs PMI/TPTCM): Fifty local MCH agencies selected breastfeeding as a priority in FY21. Many communities have active local breastfeeding coalitions, achieved CSB status, trained staff as breastfeeding educators, and work closely with WIC to provide breastfeeding peer support specialists. Some local examples that illustrate the work include:

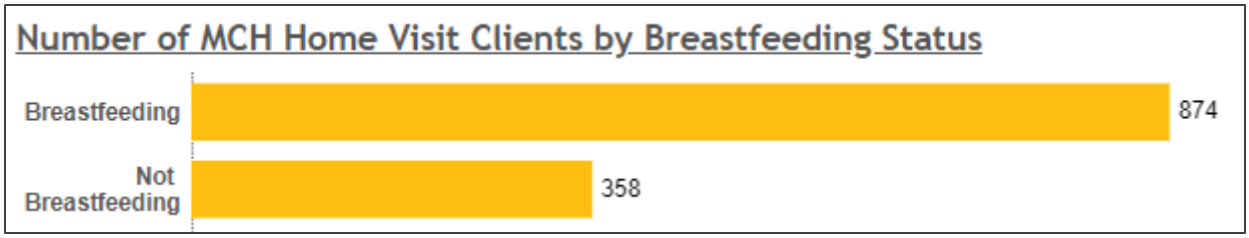
- *Community Health Center of Southeast Kansas*: Has two certified lactation educators on staff who meet with prenatal and postnatal women to provide support with breastfeeding. This message is reinforced by our physicians who deliver along with the lactation specialists at Ascension Via Christi.
- *Chautauqua County*: The MCH Home Visitor is a Certified Breastfeeding Educator and provides education on the subject. MCH HV provides in-home and virtual breastfeeding consultations.
- *Delivering Change*: All breastfeeding women are seen by a Certified Lactation Counselor 24 to 48-hour post-discharge in the Delivering Change Breastfeeding Clinic. Delivering Change Navigators provide education on breastfeeding throughout pregnancy. Additionally, Navigators facilitate the Infant Feeding session of Becoming a Mom classes. Fathers also receive breastfeeding education through the Becoming a Dad class. According to DAISEY MCH data, 74% of MCH patients are breastfeeding.
- *Nemaha County*: Nemaha County Community Health System (NCCHS) and Sabetha Community Hospital renewed their annual agreement to provide a Breastfeeding Clinic in the NCCHS Sabetha Office. The clinic is open to all mothers and babies. No fee is charged to mothers using this service. During this reporting period NCCHS reached its goal by increasing the percent of women receiving MCH Home Visits that initiated breastfeeding in DAISEY – increasing their breastfeeding rate from 84% to 90.9% for SFY 2021.. Additionally, 52% of women receiving MCH Home Visits exclusively breastfed their infant through six months of age (MCH Home Visit Data Log, July 2020-June 2021). This well exceeded the baseline rate of 25% and the goal of 30%.
- *KU School of Medicine*: During FY21, 83% of TPTCM participants received breastfeeding education. "Before Baby Arrives" curriculum and handouts were provided, which includes benefits of breastfeeding, strategies and how to overcome barriers.

Local MCH agencies provided breastfeeding education during 4,602 interactions with prenatal and postpartum clients. A total of 1,877 interactions provided breastfeeding education during a MCH home visit.

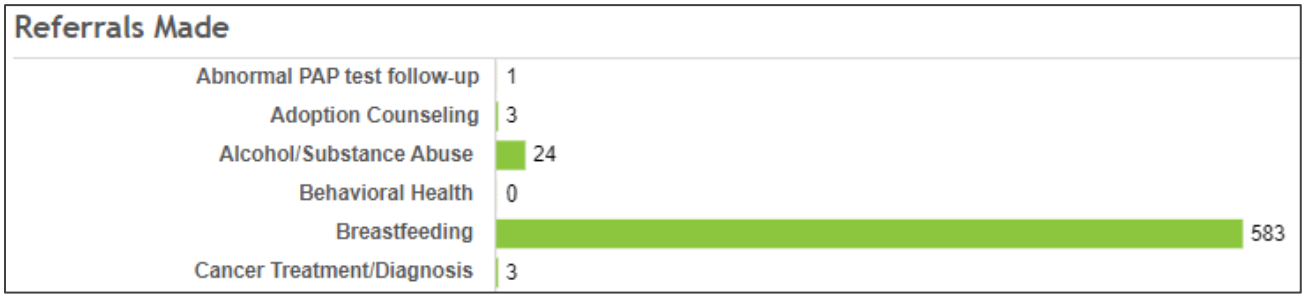


During SFY2021, 69% of all clients who gave birth in the past year reported breastfeeding. In addition, 71% of all home visiting clients giving birth during the reporting period reported breastfeeding.





Referrals for breastfeeding assistance were made by local MCH staff, including MCH Home Visitors. Breastfeeding support was one of the top referrals made and completed among MCH clients. In SFY2021, of the 583 referrals made for breastfeeding, 560 referrals were completed (96%) by the clients accepting the referral. Many MCH staff and home visitors are Certified Breastfeeding Educators (CBE), breastfeeding peer counselors and/or International Board-Certified Lactation Consultants (IBCLC).



Many local agency staff participated in breastfeeding coalitions in their communities/regions. Local MCH agencies collaborate with WIC, hospitals, child care providers, and local physicians to provide consistent messaging about breastfeeding. The MCH Universal Home Visiting program provides education and support related to breastfeeding initiation, exclusivity, and duration. MCH state staff collaborated with WIC staff to increase the number of MCH Home Visitors who are also Breastfeeding Peer Counselors. Several communities in the state hosted virtual 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. Some agencies collaborate with coordinated outreach and referral (centralized intake) programs and the states MCOs to host baby showers open to residents who were pregnant or had an infant less than a month old.

Kansas Breastfeeding Coalition (KBC) Partnership Activities: Title V collaborated with the KBC, UMHMF, and WIC to expand the High 5 for Mom and Baby program (funded and administered by the UMHMF) by increasing the number of hospitals trained and number implementing the program. As of the end of the reporting period, 36 Kansas hospitals and one birthing center demonstrated their commitment to supporting breastfeeding success by participating in High 5 activities. A total of 39 hospitals have achieved High 5 for Mom and Baby program recognition. High 5 for Mom and Baby has created the NEW High 5 for Mom & Baby Premier designation for 2020.Ten (10) Kansas hospitals have achieved the High 5 for Mom and Baby PREMIER recognition.

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, and support from KBC, much progress is being made to improve breastfeeding initiation and continuation rates in Kansas, as is evident by the data provided, above. MCH Home Visitors are working alongside WIC Breastfeeding Peer Counselors (BFPC) to provide breastfeeding support to individuals in their homes and clinic settings in both the prenatal and postpartum periods.

MCH-WIC-KBC-Becoming a Mom® (BaM) Program Collaboration: KBC reviews and updates the BaM curriculum annually, and 2021 revisions included updates on breastfeeding guidance related to the COVID-19 pandemic. The updated infant feeding session now includes information about the new CDC guidelines for alcohol consumption while breastfeeding and information about the Kansas Tobacco Quitline. Alignment with the Kansas Baby-Friendly Hospital efforts also continued, assuring the curriculum meets Baby-Friendly Hospital requirements. Work was completed in early 2019 to produce a recorded training webinar for the

Breastfeeding Integration Toolkit (on the BaM private website with content specific for BaM sites) that is provided as part of the online resources on the BaM private website. This addition reduced reliance on in-person training, thereby promoting greater long-term sustainability of efforts, and proved to be vital during the pandemic. BaM resources continue to be made available to WIC and MCH programs in counties across the state where KPCC/BaM sites are not in place.

MCH Workforce Initiatives with KBC: The KBC provides ongoing education to communities, including the MCH workforce. An overview of key presentations offered throughout the reporting period are depicted below.

Presentation	Audience
Perinatal Maternal Mental Health *Supporting Breastfeeding and Maternal Mental Health*	Maternal and Child Health lead agencies and enrolled KCC Providers
Breastfeeding Makes All the Difference *Maternal Mental Health*	Various
Community Health Workers: Support of Families Prenatally and Postpartum	Community Health Workers Coalition members
Reducing the rates in infant mortality *Breastfeeding is an Evidence-based Strategy*	Various community groups
Breastfeeding 101: Role of the Home Visitor	Kansas Home Visitors
The Intersection of Breastfeeding & Safe Infant Sleep	Kansas WIC agencies
The COVID-19 Pandemic: Infant Outcomes and Feeding in this Emergency	Various
Advanced Topics in Lactation	Various

The following are other activities supported through expanded capacity funded by MCH.

- Issued the 2020 State of Breastfeeding in Kansas report
- Exhibited at Celebrate Day 366 (Black infant mortality awareness event)
- Exhibited at the virtual Community Care Network of Kansas Conference
- Presented a staff lunch and learn to Pediatric Care Specialists of Overland Park, KS
- Presented the Kansas mPINC report to High 5 for Mom and Baby
- Held Breastfeeding Basics courses August 20-21 and August 27 (52 attendees)
- Held Breastfeeding Beyond the Basics course August 27-28 (20 attendees)
- Presented Webinar titled *Synergy in Kansas: The Story of a Relationship between a State WIC Agency & a State Breastfeeding Coalition at the National WIC Association*
- Created Blueprint for Continuity of Care for Breastfeeding (CDC funded project) with Committee of National Association of City and County Health Officials
- Facilitated workgroups to advance breastfeeding in child care, local breastfeeding coalitions, hospitals, and public health (see schedule below)

KBC Sections & Workgroups:

Section	Meeting Dates	Current Work
Child Care	Bi-monthly (odd months), 2nd Wed., 12-1	Integration of 2-hour KCCTO course into community college ECE courses (requiring students to complete the KCCTO course)
Local Breastfeeding Coalitions	Bi-monthly (odd months) 2nd Thurs. 12-1	Sharing and networking between local breastfeeding coalitions, using Toolkit and Tools for Coalitions resources, guest speakers
Hospitals	Bi-monthly, 4th Tuesday, 12-1	Support and staff education; implementing evidence-based maternity care practices, review of CDC's Kansas mPINC survey results
Public Health	Bi-Monthly (even mos.) 2nd Thurs. 10-11	Data visualization and "mini-reports" from "Breastfeeding Support by Kansas County"
Breastfeeding Education Advisory Committee	As-needed	Scholarship selection committee, breastfeeding course curriculum review & KBC conference planning
CSB: Next Steps Workgroup	Monthly, 3rd Wed. 8:30 – 10:00	Began Aug. 2020; convened to determine next steps for CSB communities to build on what they started

KBC also maintained a statewide Local Resources Directory to support families and healthcare providers in finding 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 have been distributed to hospitals and local health departments.

Other Perinatal/Infant Objectives

Objective: Implement at least two quality cross-sector initiatives focused on improving maternal, perinatal, and infant health in partnership with the Kansas Perinatal Quality Collaborative (KPQC).

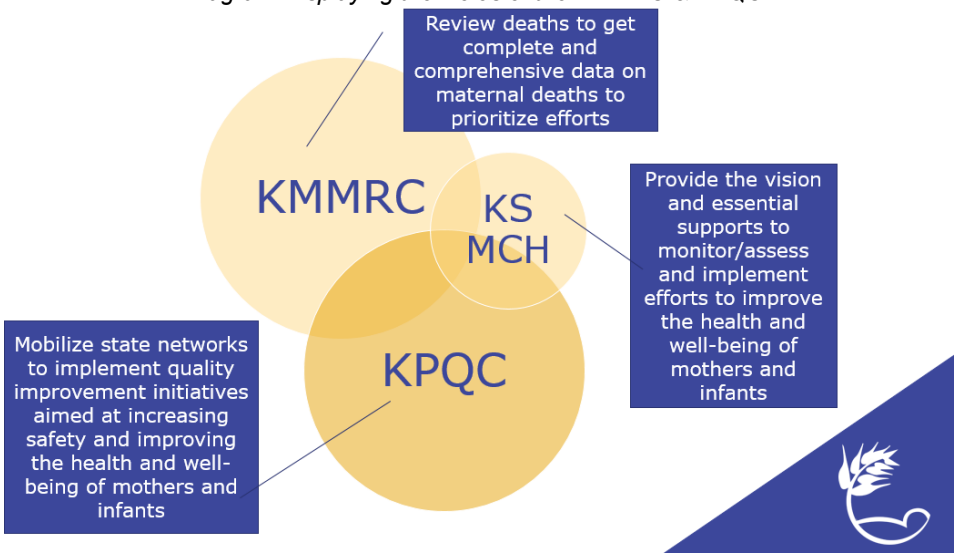
The Title V State Action Plan aligns with collaborative efforts underway for the Kansas Perinatal Quality Collaborative (KPQC). The KPQC is a panel of experts working to improve the quality of care for mothers and infants, affecting measurable improvements in statewide health care and health outcomes. The first initiative was focused on developing a comprehensive approach to Neonatal Abstinence Syndrome (NAS). The initiative, a lifespan approach crossing several critical periods, involved establishing several levels of prevention, education, and intervention (surveillance to clinical practice improvements) as well as points of education to prevent exposure and reduce the impact when exposure occurs.

The KPQC kicked off implementation of a second initiative, the Fourth Trimester Initiative (FTI), in FY21 and this initiative will continue throughout FY22. FTI is a maternal health quality initiative aimed at decreasing maternal morbidity and mortality. Data from KDHE Vital Statistics and the Kansas Maternal Mortality Review Committee (KMMRC) reveal that targeted assessment and intentional intervention in the postpartum period should be the primary care team activities to improve maternal health outcomes. FTI was designed to be a cutting-edge approach to study and improve the experience of mothers and families in Kansas. FTI focuses on chronic disease, behavioral health (mental health and substance use), breastfeeding, health equity, and access to care. The KMMRC's work and recommendations continuously guide the KPQC and MCH activities and initiatives.

Role of State MMRCs & PQCs: State Perinatal Quality Collaboratives (PQCs) and Maternal Mortality Review Committees (MMRCs) function to improve maternal and perinatal health and believe that investing in the mother's health leads to healthier birth/pregnancy outcomes. Roles are different but complementary.

- PQCs: Focus on efforts during the maternal and perinatal periods intended to improve birth outcomes and strengthen perinatal systems of care for mothers and infants
- MMRCs: Focus on reviewing maternal and pregnancy-associated deaths (pregnancy through one year after delivery) to identify gaps in health services and make actionable recommendations to prevent future deaths, improving maternal and perinatal health

Diagram Displaying the Roles of the KMMRC & KPQC



As convener of the Kansas PQC and MMRC, KDHE Title V brings together the work of both entities to translate findings and recommendations to action, in partnership with other state organizations, such as American College of Obstetricians and Gynecologists (ACOG), March of Dimes, Kansas Hospital Association (KHA), and more. As the KMMRC focuses on identifying gaps in health services and making actionable recommendations to prevent future deaths, the KPQC focuses on acting on these recommendations by using data-driven, evidence-based practice and quality improvement processes (e.g., Patient Safety Bundles). This is intended to improve birth outcomes and strengthen perinatal systems of care for mothers and infants.

KPQC & MMRC Collaborative Efforts – Data to Action: The KMMRC worked more collaboratively with the KPQC in FY22 to disseminate action alerts, practice recommendations, and implement the maternal health quality initiative (FTI). In addition, Kansas officially enroll in the Alliance for Innovation on Maternal Health (AIM). AIM is a national, data-driven maternal safety initiative based on proven implementation approaches to improving maternal safety and outcomes in the country. AIM works through state teams and health systems to align national, state, and hospital level efforts to improve maternal and perinatal health outcomes. Any state can join AIM as part of a state-level PQC quality efforts/initiatives. States that enroll in AIM receive:

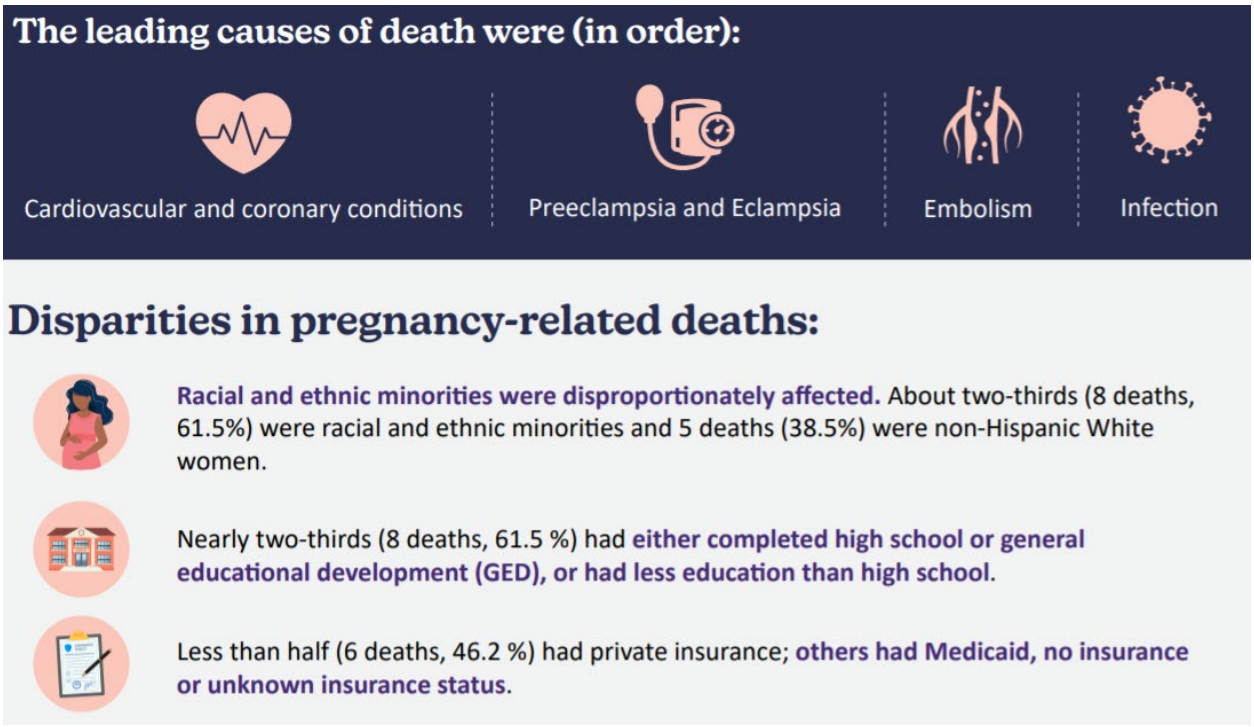
- Access to 12 “safety bundles”;
- Access to Patient Safety Tools; and
- Access to the AIM Community of States.

Kansas has identified the Postpartum Care Transition AIM bundle, identified by data gleaned from completed maternal mortality reviews as well as other MCH priority data for implementation. This bundle also positions Kansas to leverage all existing MCH investments around the Perinatal Community Collaboratives which has been improving and expanding over the last seven years.

AIM-SUPPORTED PATIENT SAFETY BUNDLES

- Maternal VTE Prevention
- Postpartum Care Basics for Maternal Safety From Birth to the Comprehensive Postpartum Visit
- Postpartum Care Basics for Maternal Safety Transition From Maternity to Well-Woman Care
- Obstetric Care for Women with Opioid Use Disorder
- Obstetric Hemorrhage
- Reduction of Peripartum Racial/Ethnic Disparities
- Safe Reduction of Primary Cesarean Birth
- Severe Hypertension in Pregnancy
- Severe Maternal Morbidity Review
- Support After a Severe Maternal Event

Title V will continue to advocate for policy changes, develop action alerts and bulletins, and identify and develop public and patient education initiatives for statewide implementation in response to KPQC and MMRC data/findings. One example: 2016-2018 findings indicate the majority of “pregnancy-related deaths” are related to chronic pre-existing conditions exacerbated by the pregnancy, or conditions of pregnancy that worsen in the postpartum period (e.g., cardiovascular/coronary; preeclampsia/eclampsia; embolism; infection), where symptoms are not recognized as emergent or life threatening and appropriate treatment is not sought/provided quickly enough – 92.3% were found to be preventable.



In response, the *Maternal Warning Signs* (MWS) initiative is now formally underway with the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) to implement their Post-Birth Warning Signs (PBWS) Education Program statewide. Adaptations to resources will support a comprehensive public health approach. Training seats have been purchased and are available for local Title V grantees, KPCC sites and partnering birthing facilities, and facilities enrolled in the FTI. Title V is including resources from multiple other national campaigns such as CDC's Hear Her Campaign and NIH's Mom's Mental Health Matters, as well as state-developed and modified tools and resources targeting families and support persons, as well as racially and ethnically disparate and low-literacy populations. This intent and purpose of this comprehensive *Maternal Warning Signs* (MWS) statewide initiative is to provide consistent and repeat messaging across all health care sectors in all communities. MWS includes the fore-mentioned online training seats, patient education guides, as well as an online toolkit, TA webinars, and other resources to assist with implementation. The MWS and resources are important components of the KPQC's FTI. Internal team members across the BFH sections continue meeting on a monthly basis for MWS coordination.

Most pregnancy-associated Kansas deaths have been the result of motor vehicle accidents and situations with other underlying factors, like substance use and intimate partner violence (IPV). KPQC/KMMRC will promote and incorporate screening, brief intervention, and referral to treatment (SBIRT) across MCH programming and perinatal service providers. The SBIRT process is used as the comprehensive, integrated, public health approach for the early identification and intervention of MCH patients exhibiting health risk behaviors, such as substance use and mental health concerns.

KPQC FTI/Kansas Connecting Communities (KCC) Integration: Kansas' perinatal psychiatric access program, KCC, strives to increase health care providers' capacity to screen, assess, treat, and refer pregnant and postpartum women for depression, anxiety, and substance use disorders (more information is available in the Cross-Cutting Report). KPQC and KCC coordinated to launch a *FTI Mental Health Technical Assistance* cohort in September 2021. During this project, participating clinics will receive individualized implementation technical assistance from a team of perinatal behavioral health experts to develop and implement a maternal mental health screening policy, including identifying and providing needed staff training and ensuring workflows and resources are available to facilitate connections to a variety of effective treatment options. Participants will share their experiences with other FTI Enrollees to support replication. Eight FTI Centers were selected to participate in the first cohort.

MAVIS Project: Through KMMRC case reviews of maternal deaths in Kansas between 2016-2018, homicide was the second leading cause of death with substance use disorder and/or mental health contributing to more

than half of all pregnancy-associated deaths. As such, KDHE will work collaboratively with partners at the Kansas Coalition Against Sexual and Domestic Violence (KCSDV), KCC, KPQC, and the KMMRC to launch the Maternal Anti-Violence Innovation and Sharing (MAVIS) Project to reduce maternal deaths in Kanas due to homicide and suicide. Supported by HHS Office on Women's Health's *SLTT Partnership Programs to Reduce Maternal Deaths due to Violence* cooperative agreement funding, The MAVIS Project will continue to build and expand on the success of the KMMRC to gather additional data related to violence maternal deaths. Additionally, the MAVIS Project will provide cross-training to perinatal care providers and domestic violence service providers related to perinatal mood and anxiety disorders, perinatal substance use, and intimate partner violence.

Birth Defects Surveillance (BDS): Many states are beginning to implement Neonatal Abstinence Syndrome (NAS) as a mandated reportable birth defect. Kansas is no different and the program is beginning to review statues and regulations to begin the arduous amendment process. The first step will include amending the Kansas Administrative Regulations (K.A.R. 28-4-520, 28-4-521) to include NAS as a reportable condition. Once amended, letters will be dispersed to all Kansas physicians notifying them of the new mandate. Reporting of NAS will allow for both mothers and infants to get the adequate follow-up care, intervention and referrals they need. In addition to adding NAS as a reportable birth defect, a foundation of referral services will be established within the BDS Program. At a minimum, all verified core disorders as described by the National Birth Defects Prevention Network, will be referred to internal and external partner groups such as the Kansas Special Health Care Needs, Infant-Toddler Services, Supporting You, March of Dimes, Ronald McDonald House Charities and other specialty healthcare clinics as related/needed for the reported birth defect. These partners will work with engaging the families and children affected by birth defects and ensure they have the proper education and outreach to effectively care for themselves and their children.

Objective: Increase the proportion of pregnant and postpartum women receiving MCH Universal Home Visiting services.

Title V MCH Universal Home Visiting (UHV) services across the state provide prenatal and postpartum care for women, infants, children, and their families. Title V partnered with the University of Kansas Center for Public Partnerships (KU-CPPR) and the state Home Visiting Workgroup to evaluate, align, and refine the MCH UHV curriculum to assure services reach families that need them. Revised requirements, materials, and training are based on updates or changes made to the UHV curriculum.

Title V ensures that the MCH UHV program is aligned with the state early childhood systems building initiative, All in for Kansas Kids, to position UHV as an information source and connection point in communities across Kansas to support safe, stable, nurturing relationships/environments and positive outcomes for infants and families. As part of this alignment, Title V MCH home visitors along with the Maternal, Infant, Early Childhood Home Visiting (MIECHV) home visitors were provided with the Basic Home Visitor Training (BHVT), presented by the Kansas Head Start Association. The BHVT consisted of online trainings that covered a multitude of topics including best practices and beliefs; confidentiality; self-care; dealing with stress; role of the home visitor; trust and respect; power of words; negative consequence of rescuer; boundaries; and home visitor safety.

Other Perinatal/Infant Health Activities

Infant Mental Health/Social-Emotional Development/Early Childhood Literacy: Title V will continue to provide the *Cuddle* board book for home visitors to encourage parents to read and hold/interact with their infants. Additionally, the books are provided to the PRAMS team for dissemination to survey families as participation incentives. These efforts will continue until the current inventory is depleted. Title V will encourage these partners to create a sustainability plan if they would like to continue providing the books or other appropriate books.

Pregnancy Risk Assessment Monitoring System (PRAMS): The Title V Director, MCH Epidemiologist, and primary team have been actively engaged in the PRAMS work since before launch of the current PRAMS survey. Title V staff meet with the PRAMS coordinator and data manager regularly to review and discuss data, assist with media questions and interviews related to the PRAMS reports and consider revisions to the next

questionnaire. The Kansas MCH Council meetings often involve PRAMS updates, sharing of data and stories/input from mothers, and requests for more information. The Women/Maternal and Perinatal/Infant workgroups from the Council have continued to serve in an advisory capacity for PRAMS. Since October 2020, Kansas PRAMS has continued to collect information on the health and experiences of Kansas mothers. PRAMS finished its fourth year of data collection, achieving a 65.8% weighted response rate (minimum threshold set by CDC is 50%). PRAMS staff have networked with a variety of partners to raise awareness about PRAMS in the community, and to share results.

- PRAMS epidemiologist worked with the Title V Perinatal and Infant Health Consultants to provide and update figures and interpretations of data to help make the case for need related to national awareness month and health equity topics. Action Alerts were developed and disseminated to state and local networks for distribution to appropriate service/care providers and the public. These Action Alerts included social media messages.
- The PRAMS epidemiologist collaborated with the Tobacco Use Prevention Program to create a fact sheet about maternal e-cigarette use. The fact sheet will be distributed online, as well as to local partners.
- PRAMS team begun carrying out data collection for a PRAMS follow-up study of moms with a live birth in 2020, which is funded by Columbia University.

Below is a timeline of key activities within PRAMS during the reporting year.

- October 2020
  - Received weighted 2019 data from CDC (63.3% response rate)
- January 2021
  - Provided statistics related to unintended pregnancy, as part of an internal data request from Title V staff.
  - Provided statistics about maternal e-cigarette use by WIC status, as part of a KDHE Tobacco Use Prevention Program presentation on WIC.
- April 2021
  - Released the *Kansas PRAMS 2019 Surveillance Report*
  - Provided updated statistics for the Workplace Indicator Dashboard, developed by the Kansas Power of the Positive coalition. The dashboard serves as a way to track workplace-related indicators, and more broadly, assess areas for improvement in risk/protective factors related to child abuse and neglect.
  - Presented statistics on Black maternal health and experiences, for a KDHE webinar during Black Maternal Health Week
  - Created an infographic on Black maternal health and experiences, for Black Maternal Health Week
  - Presented PRAMS statistics on infant safe sleep, as part of a presentation about infant mortality to the Sedgwick County Maternal and Infant Health Coalition
- May 2021
  - Provided statistics for an action alert related to preeclampsia. The action alert consisted of a fact sheet and social media graphics.
- June 2021
  - Provided statistics for an action alert related to SIDS. The action alert consisted of a fact sheet and social media graphics.
  - Provided statistics for an action alert related to breastfeeding. The action alert consisted of a fact sheet and social media graphics.
- July 2021
  - Submitted 2020 data to CDC PRAMS for weighting
- August 2021
  - Provided statistics about intimate partner violence, to support an application for funding to prevent maternal violent deaths.
- September 2021
  - Provided statistics for an action alert related to prematurity. The action alert consisted of a fact sheet and social media graphics.

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2023 PERINATAL / INFANT HEALTH APPLICATION PLANS

PRIORITY 2: All infants and families have support from strong community systems to optimize infant health and well-being

NPM 5: Safe Sleep (Percent of infants placed to sleep; (A) on their backs; (B) on separate sleep surface; and (C) without soft objects and loose bedding)
SPM 2: Breastfeeding (Percent of infants breastfed exclusively through 6 months)

Local MCH Reach: Based on SFY2022 MCH Aid-to-Local applications received:

- 49 of 55 grantees (89%) plan to provide services to the Perinatal & Infant population
- 44 of 49 grantees (90%) plan to provide breastfeeding services
- 40 of 49 grantees (82%) plan to provide safe sleep services
- 16 of 49 grantees (33%) plan to implement perinatal quality initiatives
- 38 of 49 grantees (93%) plan to provide MCH universal home visiting services

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NPM 5: Safe Sleep (Percent of infants placed to sleep; (A) on their backs; (B) on separate sleep surface; and (C) without soft objects and loose bedding)

Objective: Promote and support safe sleep practices and cross-sector initiatives to reduce the sudden unexplained infant death (SUID) rate.

Title V continues to focus on reducing SUID rates through safe sleep education and professional trainings/resources offered to local MCH agencies, home visiting programs, hospitals, childcare facilities, and other providers to support safe sleep practices and accurate, consistent safe sleep messages across all sectors in a community. Consistent and current safe sleep education and messaging is critical as we strive to eradicate unsafe sleep practices.

KDHE/KIDS Contract - Network Infrastructure, Provider Training, Public/Patient Education & Family Support: Title V will continue the strong partnership with the Kansas Infant Death and SIDS (KIDS) Network. Title V continues to provide organizational infrastructure support for the Executive Director and support staff as necessary to execute the partnership agreement, which focuses on cross-sector initiatives to reduce SUID rates in our state. Objectives of the partnership/agreement include:

- Strengthen and enhance the KIDS Network Safe Sleep Strategy which includes the following components: Safe Sleep Instructor (SSI) Certification program; Safe Sleep Hospital Certification; Safe Sleep Star Outpatient Toolkit; Safe Sleep Community Baby Showers. This will be accomplished by providing technical assistance, advanced training opportunities, and annual reporting requirements for each of these certifications / program models. During the COVID-19 pandemic, little traction was made in advancing/expanding these models in the state. Reenergizing these efforts will be a focus during FY2023. More about the partnership and these strategies can be found in the Perinatal/Infant Report.

- Support continued and expanded alignment of safe sleep messaging between the KIDS Network and Kansas Perinatal Community Collaboratives (KPCC) model. This work includes annual updates to the safe sleep curriculum and integration component of the March of Dimes Becoming a Mom(R) (BaM) prenatal education program, while strengthening KPCC partner engagement in Safe Sleep Strategy components. Training on the SIDS/Safe Sleep integration component is provided to new KPCC's preparing to implement the BaM curriculum. This training is recorded and available on the BaM private website, along with the other integration components for new facilitators to receive comprehensive training on their own timeline and support long-term expansion and sustainability efforts. KDHE plans to adapt the current BaM Toolkit for utilization across the broader MCH network, providing easy access to all the tools and resources related to safe sleep integration across all health sectors in a community. In addition, KDHE will work in partnership with the KIDS Network to grow "Advanced Training" opportunities with Safe Sleep Instructors (SSI) to increase the number of Safe Sleep Hospital Certifications and Safe Sleep Star Outpatient Toolkit settings statewide by five per year through targeting existing SSI communities, Fourth Trimester Initiative (FTI) birth facilities, and KPCCs.
- Provide a statewide support system to assist childcare providers, families, relatives, friends, caregivers, and all others who are affected by the sudden death of an infant. Plans include disseminating information statewide; revising existing evaluation efforts to include findings by parents and/or professionals; and developing assessment tools for caregivers, SSIs, and professionals. As described in the Women/Maternal Plan, the BaM curriculum is being enhanced with the addition of a seventh session, occurring in the postpartum period, which will include a safe sleep component to provide follow-up on education received prenatally. This will provide an opportunity to engage with caregivers who are struggling with the reality of life with a newborn and provide support for engaging in best practice behaviors. It is hoped to stimulate real conversations about the struggles and true barriers they are facing and provide insight into how these can be approached and overcome.

Local MCH Agencies -including affiliate programs Pregnancy Maintenance Initiative (PMI) & Teen Pregnancy Targeted Case Management (TPTCM): Information will continue to be provided to all pregnant and postpartum women regarding the importance of safe sleep practices. Local agency staff will continue to educate and encourage pregnant and postpartum women to discuss safe sleep with all their infant care providers (e.g., family members, friends, child-care providers). They will also continue to collaborate with community partners and other health care providers to promote safe sleep in their community in a consistent manner. A sampling of local efforts include:

- *Barton County:* In SFY23, there will be an increase of at least 15% of women completing the safe sleep education as well as the pre and post-tests at our community baby shower. For those not attending the community baby shower, safe sleep education video along with pre and post tests will be offered in the 3rd trimester during MCH clinic visits. The community baby shower will be promoted through social media and digital signage as well as on the health dept segment of a local radio broadcast.
- *Butler County:* Plans to train 15 professionals (e.g., childcare workers, DCF personnel) in the community on safe sleep with the goal to build relationships with community partners. The Safe Sleep Instructor will attend webinars and training to ensure the most up-to-date information is being provided.
- *Community Health Center of Southeast Kansas (CHC/SEK):* Plans to deliver Safe Sleep education to 100% of parents with newborns in Crawford, Cherokee, Labette and Bourbon counties. All MCH/TPTCM Case Managers will be trained in Safe Sleep guidelines and all expectant MCH clients will participate in one or more educational sessions on Safe Sleep. Halo Sleep Sacks (which replace blankets in the crib) will be provided to all CHC/SEK newborns just prior to delivery.
- *Catholic Charities of Northeast Kansas*: They will provide translated Safe Sleep educational materials (printed guides and verbal training) to their large population of clients that speak Burmese or Swahili, so all clients receive educational materials in their spoken language.
- Kearny County Hospital and Family Health Clinic: Will provide safe sleep education through both the hospital side and clinic side of perinatal care. Their goal is to have more instructors trained to teach the Safe Sleep Educational material provided by Kansas Infant Death and Sleep (KIDS) to accommodate the rising number of pregnant women in their care. They serve multiple counties in SW Kansas and SE Colorado. If patients from Eastern Colorado need assistance closer to home, they will be referred to the Nurse-Family Partnership Foundation in Lamar Colorado.

- *University of Kansas School of Medicine*: TPTCM clients will receive safe sleep education based on various research-based curriculums (e.g., Partners for a Healthy Baby, Before Baby Arrives, Baby's First Year). They will provide handouts about safe infant sleep and receive referrals to the Baby Talk program, which includes a 45-minute portion on infant safe sleep, and referral to Safe Sleep CBS or Virtual Safe Sleep Crib Clinics in Sedgwick County where families can participate in a crib demonstration and receive free materials to create a safe sleep environment for their infant. Staff will maintain certification from the American Academy of Pediatrics Safe Sleep Recommendations and can provide additional information on how to overcome barriers to following the guidelines.
- *Delivering Change:* TPTCM clients will receive safe sleep education (ABC's of Safe Sleep) and the TPTCM Navigator will talk with each client during their pregnancy about practicing the ABC's of Safe Sleep, encouraging clients to keep their baby alone, on their back and in a crib/pack n play/bassinet, reducing the risk of SIDS. The Navigator will help clients ensure that they have a safe sleep area for baby prior to delivery or help them secure a safe sleep area for the baby. During a client's postpartum period, the TPTCM Navigator meets with each client while they are still in the hospital, before discharge, to discuss education and answer questions the client may have before going home with their baby. TPTCM clients must also watch a video while inpatient in the hospital about the ABC's of Safe Sleep and practicing safe sleep. Safe sleep education is also taught during BaM and Infant Care classes.

SPM 2: Breastfeeding (Percent of infants breastfed exclusively through 6 months)

Objective: Promote and support cross-sector breastfeeding policies, practices, and environments to increase exclusive breastfeeding rates at 6 months.

Kansas has high breastfeeding initiation rates, but there is more work to do related to increasing the duration and exclusive breastfeeding rates at 6 months. This will require continued multi-sector collaborative efforts. Title V will increase access for families to strong community breastfeeding education, supports, and practices across settings through collaboration with key community and state partners, such as the Kansas Breastfeeding Coalition (KBC), KPCC sites, State and local WIC and MCH programs, birth facilities and provider practices. In addition to the group prenatal education and support models, other strategies include increasing referrals to WIC for breastfeeding support and education, including expanding WIC Breastfeeding Peer Counseling; shared messaging through WIC and Home Visiting programs, hospitals, and provider offices – building on the "Breastfeeding Welcome Here" initiatives; and education about behavioral health and breastfeeding.

Kansas Breastfeeding Infrastructure: Title V will continue the strong partnership with the KBC to continue existing effective strategies, as well as to support Title V's goal to focus on disparities in breastfeeding and increasing breastfeeding rates among Black mothers. Several strategies are in place to help us achieve this goal.

1. Increase access to lactation support by African American providers such as breastfeeding peer counselors, doulas, International Board-Certified Lactation Consultants, and Certified Lactation Counselors representing high-risk populations to increase the culturally relevant support women of color need to initiate and continue breastfeeding.
2. Support the implementation of community-centered, culturally relevant mother-to-mother, father, and grandparent breastfeeding support clubs for African Americans (e.g., Black Breastfeeding Clubs, Brown Baby Brigade, BSTARS, Reach our Brothers Everywhere (ROBE), Fathers Uplift, Grandmothers Tea Project) to build capacity in the community to support mothers of color in breastfeeding.
3. Broaden the establishment of breastfeeding coalitions for African Americans that connect health care providers and the community to local information and resources (e.g., African-American Breastfeeding Coalition of Wyandotte County) to foster a culture of change within communities.

Title V continues to work with a variety of partners, referred to collectively as the Kansas Breastfeeding Support Network, to advance the work and partnership of the KBC. More about the ongoing work with the KBC can be found in the Perinatal/Infant Report.

Breastfeeding Education & MCH Workforce: Title V encourages and supports staff participation in a variety of breastfeeding education courses. It is important to meet MCH staff where they are and provide information on all the options for breastfeeding education including 1, 3, or 5-day courses. Tools such as the "Landscape of Breastfeeding Support" which provides staff with the various breastfeeding certification programs and the "Lactation Support Provider Training Directory" from the US Breastfeeding Committee will be included in a comprehensive Breastfeeding Integration toolkit. Additional plans can be found under the Cross Cutting - Workforce Development domain.

MCH-WIC-KBC-BaM-KPCC Collaboration: Partnership among several programs will continue in FY23 with annual updates to the BaM Infant Feeding curriculum component. KBC has provided 10 additional toolkits for new sites implementing in FY22 that are still available and include all the supplies needed for activities and visual aids as part of the Infant Feeding session. Additionally, the training webinar for the Breastfeeding Integration Toolkit (located on the BaM private website with content specific for BaM sites) will continue as an online resource to support new BaM staff in their role as facilitators of this comprehensive prenatal breastfeeding education curriculum.

KDHE Title V staff have committed to assisting local partners, including public health departments and BaM sites, as well as KPCC partners and FTI birth facilities, with the development of a comprehensive follow-up process and data collection system related to breastfeeding continuation. As part of this work, additional tools and resources will be added to the existing Breastfeeding Integration Toolkit (e.g., follow-up flow chart/algorithm, home visitation, support/educational resources) as this toolkit is adapted for all public health professionals, with strategies that will target timeframes and situations when mothers are most likely to stop breastfeeding (e.g., in the first week following birth, upon return to work). It will also include a screening tool or triage system for lactation-related concerns, guidance for timely referrals to the appropriate level of care, and rapid remote response options following hospital discharge and outside of normal clinic business hours (e.g., telehealth, texting platforms, hot/warmline services). Title V will recommend referrals to services and lactation support providers (LSPs) be congruent and responsive to the family's culture, language, values, individual needs, and ensure families' ability to access the services they are being referred to. These tools will be co-developed by a workgroup consisting of the KPCC state coordinator, state MCH Consultants, KBC, and BaM/MCH/WIC consumers in late 2022/early 2023.

Technical assistance will be provided to local breastfeeding coalitions, MCH programs and KPCC sites to develop plans for targeted outreach to disparate populations. The BaM DAISEY Dashboard allows sites to compare participant demographic data to identified high-risk groups in their counties to assess if the targeted population (e.g., teen, non-Hispanic black populations) is being reached and whether breastfeeding rates are improving. The current dashboard is being transitioned from a manual data reporting format to a live automated report supported by Tableau. The dashboard is hoped to be live/real time by late 2022 or early 2023. This will assist BaM program sites and their collaborative partners, such as MCH programs and local breastfeeding coalitions, to more easily identify trends in data and engage in responsive and strategic planning around targeted efforts and interventions. KBC will provide targeted outreach to MCH ATL grantees throughout FY2023, offering technical assistance, training, and resources specific to their targeted efforts as conveyed in their FY2023 ATL application.

Local MCH Agencies: The majority of MCH grantees that chose the Perinatal/Infant Health domain in their FY2023 MCH ATL grant application will provide breastfeeding education, support, and services in their community. 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 will continue. Local agencies will continue to participate in local breastfeeding coalitions and engage in activities to achieve goals.

- *Kearny County Hospital:* We are already at a very high rate for breastfeeding mothers, but we are striving to meet a goal of 95% of mothers who are seen in our clinic/hospital. We also have a goal of 80% of mothers that deliver in our facility continue to breastfeed through the first 6 months of life as recommended by the Centers of Disease Control and Prevention (CDC). Our obstetrics floor in the hospital has one night-shift CLC nurses and our day shift has 3 CLC nurses able to educate mothers on

breastfeeding while in the hospital setting. Jessica Maldonado RN is an IBCLC on our MCH team and she is able to do breastfeeding education with Spanish speaking patients. Our MCH Nurse Shaylee Mosher RN is now a CLC as well and is able to see patients in both the clinic and hospital setting. Our facility will continue to encourage and implement continuing educational breastfeeding support classes for staff throughout the year. Our goal is to reach 90% of the KCH nursing staff to obtain at least 2 hours of breastfeeding education courses per year.

- *Shawnee County Health Agency* will offer breastfeeding education, handouts, and referrals to a breastfeeding peer counselor and/or the breastfeeding clinic to 100% of MCH clients. 100% of MCH clients served postpartum will be screened for breastfeeding; initiated at birth, and currently breastfeeding. 90% of Baby Basics clients will indicate they initiated breastfeeding at birth.
- *Delivering Change:* TPTCM Navigator, who is also a Certified Lactation Counselor, will provide education and information about breastfeeding to all clients during the prenatal period, including education on the health, financial and overall benefits of initiating and continuing breastfeeding practices. TPTCM Navigator will follow the recommendation of exclusive breastfeeding for 6 months and answer any questions or concerns a client may have regarding breastfeeding, including helping them access a breast pump. The TPTCM Navigator will work with the client post-delivery, while still in the hospital, on breastfeeding, assessing feeds, answering questions/concerns the client may be having and providing support and education surrounding breastfeeding and the clients breastfeeding goal. Delivering Change holds a Breastfeeding Clinic for all breastfeeding women in the area, free of charge to get support, education and assistance and TPTCM clients are scheduled in the breastfeeding clinic 24-48 hours post discharge, with continual support through the breastfeeding clinic offered to clients.

Other Perinatal/Infant Objectives

Objective: Implement at least two quality cross-sector initiatives focused on improving maternal, perinatal, and infant health in partnership with the Kansas Perinatal Quality Collaborative (KPQC).

The Title V State Action Plan aligns with collaborative efforts underway for the Kansas Perinatal Quality Collaborative (KPQC). The KPQC is a panel of experts working to improve the quality of care for mothers and infants, affecting measurable improvements in statewide health care and health outcomes. The first initiative was focused on developing a comprehensive approach to Neonatal Abstinence Syndrome (NAS). The initiative, a lifespan approach crossing several critical periods, involved establishing several levels of prevention, education, and intervention (surveillance to clinical practice improvements) as well as points of education to prevent exposure and reduce the impact when exposure occurs. Learn more about the impact of the KPQC NAS initiative in the Women/Maternal Report section.

The KPQC kicked off implementation of a second initiative, the Fourth Trimester Initiative (FTI), in FY21 and will continue efforts during FY23. FTI is a maternal health quality initiative aimed at decreasing maternal morbidity and mortality. Data from KDHE Vital Statistics and the Kansas Maternal Mortality Review Committee (KMMRC) reveal that targeted assessment and intentional intervention in the postpartum period should be the primary care team activities to improve maternal health outcomes. FTI was designed to be a cutting-edge approach to study and improve the experience of mothers and families in Kansas. FTI focuses on chronic disease, behavioral health (including mental health and substance use disorder), breastfeeding, health equity, and access to care. The KMMRC's work and recommendations will continuously guide the KPQC and MCH activities and initiatives.

Role of State MMRCs & PQCs: State Perinatal Quality Collaboratives (PQCs) and Maternal Mortality Review Committees (MMRCs) function to improve maternal and perinatal health and believe that investing in the mother's health leads to healthier birth/pregnancy outcomes. Roles are different but complementary.

- PQCs: Focus on efforts during the maternal and perinatal periods intended to improve birth outcomes and strengthen perinatal systems of care for mothers and infants
- MMRCs: Focus on reviewing maternal and pregnancy-associated deaths (pregnancy through one year after delivery) to identify gaps in health services and make actionable recommendations to prevent future deaths, improving maternal and perinatal health

As convener of the Kansas PQC and MMRC, KDHE Title V brings together the work of both entities to translate findings and recommendations to action, in partnership with other state organizations, such as American College of Obstetricians and Gynecologists (ACOG), March of Dimes, Kansas Hospital Association (KHA), and more. As the KMMRC focuses on identifying gaps in health services and making actionable recommendations to prevent future deaths, the KPQC focuses on acting on these recommendations by using data-driven, evidence-based practice and quality improvement processes (e.g., Patient Safety Bundles). This is intended to improve birth outcomes and strengthen perinatal systems of care for mothers and infants.

KPQC & MMRC Collaborative Efforts – Data to Action: The KMMRC will continue working more collaboratively with the KPQC in FY23 to disseminate action alerts, practice recommendations, and implement the Fourth Trimester Initiative (FTI), which includes promotion of the *Maternal Warning Signs* (MWS) work. A media/marketing campaign will be developed for a broader public reach in the upcoming year. Additionally, Title V, Kansas Connecting Communities (KCC), and KPQC staff are currently working to develop a recognition program for Kansas communities who are actively engaged in MWS and FTI initiatives. This recognition program, *Kansas Moms in Mind (KMIM)*, will highlight and celebrate those communities actively engaged in addressing PMADs, MWS and POST-BIRTH awareness and education in both the public health/community (outpatient) and birth facility (in patient) settings.

Additional public health campaigns will be implemented targeting causes of deaths found to be "pregnancy-associated, but not related." Most pregnancy-associated Kansas deaths have been the result of motor vehicle accidents and situations with other underlying factors, like substance use and intimate partner violence (IPV). KPQC/KMMRC will promote and incorporate screening, brief intervention, and referral to treatment (SBIRT) across MCH programming and perinatal service providers. The SBIRT process will be used as the comprehensive, integrated, public health approach for early identification and intervention of MCH patients exhibiting health risk behaviors, such as substance use and mental health. Promotional efforts will also include integration of screening and education on IPV, utilizing resources from the *Futures Without Violence* Initiative. Read more about SBIRT process implementation and addressing health risk behaviors in the Woman/Maternal Plan.

Maternal Anti-Violence Innovation and Sharing (MAVIS) Project: The Kansas Department of Health and Environment (KDHE) has been selected by the U.S. Department of Health and Human Services (HHS) Office on Women's Health to receive funding as part of the State, Local, Territorial, and Tribal Partnership Programs to Reduce Maternal Deaths due to Violence. Through KMMRC case reviews of maternal deaths in Kansas between 2016-2020, homicide was the second leading cause of maternal deaths with substance use disorder and/or mental health contributing to half of all pregnancy-associated deaths. KDHE will work collaboratively with partners at the Kansas Coalition Against Sexual and Domestic Violence (KCSDV), Kansas Connecting Communities (KCC), the KPQC and the KMMRC to launch the Maternal Anti-Violence Innovation and Sharing (MAVIS) Project to reduce maternal deaths in Kansas due to homicide and suicide.

The MAVIS Project will continue to build and expand on the success of the KMMRC to gather additional data related to violent maternal deaths through the establishment of the KMMRC social determinants of health subcommittee. Additionally, the MAVIS Project will provide cross-training to perinatal care providers and domestic violence service providers related to perinatal mood and anxiety disorders, perinatal substance use and intimate partner violence.

Birth Defects Surveillance (BDS): Many states are beginning to implement Neonatal Abstinence Syndrome (NAS) as a mandated reportable birth defect. Kansas is no different and the program has already reviewed statutes and regulations to begin the arduous amendment process. The first step included amending the Kansas Administrative Regulations (K.A.R. 28-4-520, 28-4-521) to include NAS as a reportable condition. These changes are in the concurrence process for approval. Once officially amended, letters will be dispersed to all Kansas physicians notifying them of the new mandate. Reporting of NAS will allow for both mothers and infants to get the adequate follow-up care, intervention and referrals they need. In addition to adding NAS as a reportable birth defect, a foundation of referral services will be established within the BDS Program. The program has begun verifying all core, recommended and extended birth defects, as defined by the National Birth Defects Prevention Network since January 1, 2022. At a minimum, all verified core disorders will be

referred to internal and external partner groups such as the Kansas Special Health Care Needs, Infant-Toddler Services, Supporting You, March of Dimes, Ronald McDonald House Charities and other specialty healthcare clinics as related/needed for the reported birth defect. These partners will work to engage the families and children affected by birth defects and ensure they have the proper education, outreach, and service navigation to effectively care for themselves and their children.

Educational material pertaining to core, recommended and extended birth defects will be created by the Kansas Birth Defects Coordinator in collaboration with the Education and Outreach Coordinator and will dispersed to families upon verification of the birth defect via traditional mail.

Local MCH Agencies:

- *Barton County Health Department* will increase the percent of clients who receive education on Maternal Warning Signs and Count the Kicks. RN and para-professional home visitor takes the Maternal warning signs magnet or flyer as handouts at home visits as well as provides verbal education at clinic visits starting in the 2nd and 3rd trimesters through postpartum. Count the Kicks information is provided in the clinic setting as handouts, flyers and educational topic during clinic visits. Clients are encouraged to download the Count the Kicks App and use starting it in the 3rd trimester. Utilization of the new low literacy brochures and Kick Counting bracelets for unreliable internet access will be available. Screens using Edinburgh for anxiety and depression during prenatal and postpartum visits and screen for the use of alcohol, tobacco and other drugs (ATOD) in pregnancy using WIC program health interviews as well as completion of the Tobacco Use Survey form for Daisey Educate on the dangers of ATOD during pregnancy. Education is provided about second-hand smoke, Neonatal Abstinence Syndrome, March of Dimes, and the State of Kansas Quit line (KanQuit).

Objective: Increase the proportion of pregnant and postpartum women receiving MCH Universal Home Visiting services.

Title V will enhance MCH Universal Home Visiting (UHV) services across the state to increase prenatal and postpartum care for women, infants, children, and their families. The upcoming year will be dedicated to evaluating, aligning, and refining the MCH UHV curriculum to assure that services reach families that need them, and local grantees provide consistent messaging and guidance when providing services. Title V will partner with the University of Kansas Center for Public Partnerships (KU-CPPR) and the state Home Visiting Workgroup to carry out this work. Revised requirements, materials, and training will be based on updates or changes made to the UHV curriculum. Updated information will be disseminated to UHVs upon completion.

Title V will ensure that the MCH UHV program is aligned with the state early childhood systems building initiative, All in for Kansas Kids, to position UHV as an information source and connection point in communities to support safe, stable, nurturing relationships/environments and positive outcomes for infants and families. As part of this alignment, Title V MCH home visitors along with the Maternal, Infant, Early Childhood Home Visiting (MIECHV) home visitors will be provided with the Basic Home Visitor Training (BHVT), presented by the Kansas Head Start Association. The BHVT will consist of five online trainings and two days of in-person trainings, intended to cover a multitude of topics related to home visiting. Some of the topics to be covered include best practices and beliefs; confidentiality; self-care; dealing with stress; role of the home visitor; trust and respect; power of words; negative consequence of rescuer; boundaries; and home visitor safety.

Home Visiting Workforce Training: The Institute for the Advancement of Family Support Professionals is a national home visiting competency training platform with existing content for use by anyone at no cost. Kansas has a custom seamless access point for Title V and MIECHV program staff and Early Childhood stakeholders to securely review data and coordinate all professional development modules completed by KS home visitors and supervisors in the Kansas Learning Management System (LMS). This customized access requires technical linkages and secure tokens to accurately identify and pass data from the Institute into the customized Kansas LMS. Another important aspect of ensuring a strong home visiting system of care will include establishing and increasing consumer/family and provider awareness about the importance of home visitation supports and the impact on family and infant outcomes to increase referrals and numbers of families receiving support thought the MCH UHV program. This will be done through social media blasts as well as infographics

and fact sheets. Incorporating family strengthening and parent training/support skills building sessions in the MCH UHV standardized curriculum will help ensure families are strong and thriving.

MCH Intensive Home Visiting Pilot Project: Title V partnered with the Bureau of Health Promotion to develop an innovative substance use prevention project for the Data Driven Prevention Opioid CDC grant (May 2019). The grant was awarded and a portion of the funds will be used to support a UHV pilot engaging mothers with infants diagnosed with Neonatal Abstinence Syndrome (NAS) in intensive home visiting up to 12 months postpartum. The BFH is partnering with the University of Kansas Medical Center (KUMC) in Wichita to launch this pilot. The project will continue to grow and evolve over the coming grant year.

Other Perinatal/Infant Health Activities

Infant Mental Health/Social-Emotional Development/Early Childhood Literacy: Title V will continue to provide the *Cuddle* board book for home visitors to encourage parents to read and hold/interact with their infants. Additionally, the books are provided to the PRAMS team for dissemination. These efforts will continue until the current inventory is depleted. Title V will encourage these partners to create a sustainability plan if they would like to continue providing the books or other appropriate books. These partners will need to identify funding (they could write these expenses into their MCH budget requests), or work with early childhood partners in their communities to promote healthy development and literacy.

Pregnancy Risk Assessment Monitoring System (PRAMS): In 2023, KS PRAMS will continue data collection, including questions from supplements. The Opioid Supplement and Workplace Leave Supplement will continue through at least 2021 births. Supplements for 2022 births have not yet been finalized. PRAMS will also continue to integrate strategies for promoting the survey/questionnaire to hard-to-reach populations (such as low-income minority mothers). Finally, KS PRAMS plans to strengthen their ties with MCH partners across the state to ensure that they have the data they need to improve the health of mothers and babies in Kansas.

The Title V Director, MCH Epidemiologist, and primary team have been actively engaged in the PRAMS work since before launch and will continue to be closely involved over the next year. Title V staff meet with the PRAMS coordinator and data manager regularly to review and discuss data, assist with media questions and interviews related to the PRAMS reports and consider revisions to the next Questionnaire. The Kansas MCH Council meetings often involve PRAMS updates, sharing of data and stories/input from mothers, and requests for more information. The Women/Maternal and Perinatal/Infant workgroups from the Council will continue to serve in an advisory capacity for PRAMS. Perinatal/Infant Health Consultants will continue to work closely with the PRAMS/MCH Epidemiologist to incorporate PRAMS data into Action Alerts related to applicable Awareness Month and Health Equity topics that are shared with local MCH grantees and partner networks for promotion widely across the state.

Maternal Linkage to Care: Title V staff are collaborating with the STI/HIV Surveillance Section on a new Maternal Care Coordinator position within the Bureau of Disease Control and Prevention (BDCP). This position will provide intensive case management and care coordination services for pregnant women across the state of Kansas who have been diagnosed with communicable infections such as Syphilis, Gonorrhea, Hepatitis, COVID, etc. The Maternal Care Coordinator will work to ensure that pregnant persons identified through the screening and surveillance program are: receiving timely prenatal care; enrolled in prenatal education and home visiting services; and receiving mental health and substance use disorder services, as indicated. Additionally, the Maternal Care Coordinator will screen for social determinants of health (e.g., housing, employment, food security, intimate partner violence, etc.) and connect them to community resources and supports to address any identified needs.

Local MCH Agencies:

- *Doniphan County*: will double the number of home visits conducted since easing of the pandemic. Home visits will be conducted by a social worker, to women that are pregnant or women with an infant 12 months or younger. They'll advertise the home visitor program on social media, and collaborate with WIC, Kan Be Healthy, Immunizations, Parents as Teachers, and Early Head Start for referrals to the

Maternal Child Health Home Visiting Program. The home visitor will provide education, support, and link client to other services. Once contact is made with the mother, an initial assessment is scheduled usually at the client's home. Referrals to other services will be initiated by home visitor by relaying the needed information to complete the referral. Home Visitor will determine if more support is needed and proceed with scheduling a second visit.

- *Unified Government of Wyandotte County* will employ a Maternal and Child Health Community Health Worker (MCH CHW) to address gaps in existing Maternal Health Programs, including perinatal education, safe sleep, parent support groups, health insurance enrollment (Medicaid and Marketplace options), and safety net clinics. The MCH CHW will promote, maintain, and improve the health of clients and their families through successful linkages to various health and social community services. The MCH CHW will work primarily in the community in settings such as clinics, hospitals, and community centers. The MCH CHW can also meet clients in their home. The MCH CHW will receive referrals from a variety of sources including clinics, hospitals, social service agencies, and IRIS. The MCH CHW completes an intake form on each client. All prenatal clients will be referred into the Becoming A Mom program. Families who have high needs are referred into the Healthy Families Wyandotte program or TPTCM program. The MCH CHW makes direct referrals to community programs using the IRIS system. If the agency is not in IRIS, then the MCH CHW will assist the client in obtaining the necessary appointments and paperwork if needed. The MCH CHW will continue to work with families until the families are no longer in need of assistance or are enrolled into case management.

PRIORITY 3: Children and families have access to and utilize developmentally appropriate services and supports through collaborative and integrated communities.

Domain: Child Health

NPM 6: Developmental screening (Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year)

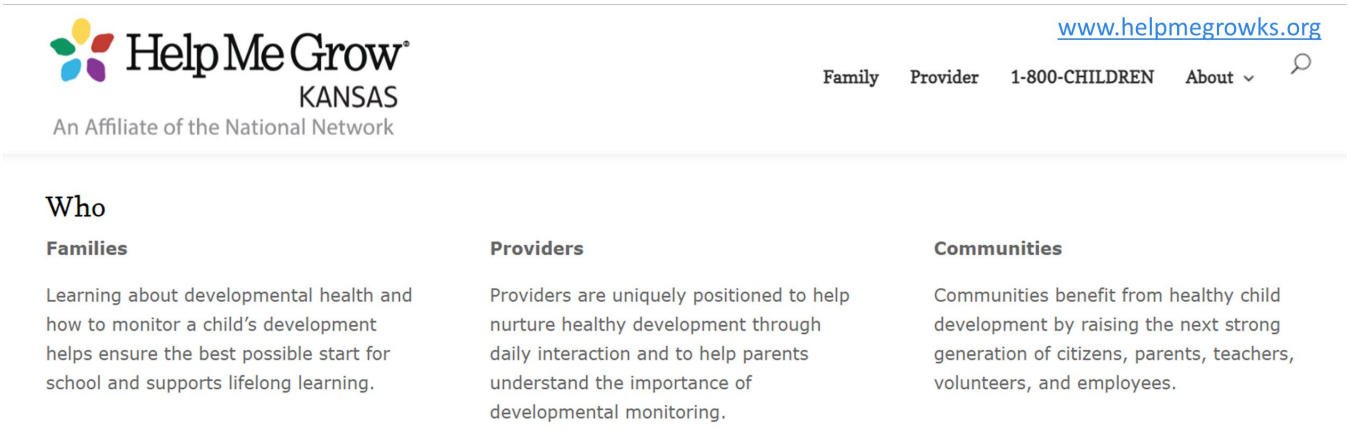
ESM: Percent of children who received a parent-completed developmental screen during an infant or child visit provided by a participating program

2021 CHILD HEALTH ANNUAL REPORT

Local MCH Reach: During SFY2021, 54 of 67 grantees (91%) provided services to the Child population.

Kansas Title V has remained dedicated to assuring the early identification of children at risk for developmental and/or behavioral challenges and for improved linkages between families and the services and supports they need. As such, Title V led the initiative to become a national affiliate of Help Me Grow state in 2019. Help Me Grow (HMG) is a national framework that promotes integrated, cross-sector collaboration to build efficient and effective early childhood systems that mitigate the impact of adversity and support protective factors among families. Successful implementation of HMG leverages existing community resources, maximizes opportunities, and advances partnerships working collaboratively through the implementation and cooperation of four core components: family and community outreach, provider outreach, a centralized access point, and data collection and analysis.

The Kansas HMG mission states, “Kansas families have informed and equitable access to seamless, comprehensive supports and services that ensure the well-being and lifelong success of all children.” The HMG vision is “Connected Families Connected Communities: Every Child Thrives.” The Kansas Help Me Grow website was established in 2019 to share information about the HMG Framework, resources for families and providers on developmental health, and promotion of the statewide centralized access point, 1-800-CHILDREN.



The Kansas HMG effort is not exclusively about health care or developmental screening alone, even though developmental screening is a key component; rather it is focused on forging partnerships to collectively address issues families face in the context of their communities. The areas of focus for this project include access to quality care and services, social determinants of health, enhanced education and training, sustainability and accountability, and vulnerable populations. Community and state MCH and early childhood partners identified the need for resources around children’s developmental health and screening among three audiences: families, communities, and providers. Additionally, this became the foundational framework for

much of the early childhood systems building work and has been integrated into the All in for Kansas Kids Strategic Plan.

The team continues to develop resources and tools for HMG communities and promote existing resources such as the statewide centralized access point (CAP), launched in May 2019. In December 2020, the state agencies contracted with a marketing consultant to review the brand framework around the HMG core components (provider, family, community outreach) after hearing from communities that the HMG brand was not resonating. Overwhelmingly, informant Interviews with key stakeholders and communities revealed the need for increased access to supports and services, including community-based technical assistance (adaptive Technical Assistance). In April 2021 the work was completed, and the *Navigate EC* branding was adopted. The plan is to provide a website, landing page, and coordination for all early childhood efforts across agencies.

Early Childhood Systems Building: Kansas received the Preschool Development Birth to Five Planning Grant (PDG B-5) in early 2019 to support the development of a comprehensive Needs Assessment for early childhood in Kansas. The Kansas Children's Cabinet and Trust Fund, Kansas Department for Children and Families, Kansas Department of Health and Environment, Kansas State Department of Education, and other early childhood stakeholders partnered with Kansas communities to carry out this important work. Throughout the process, young children ages birth through five and their families were at the core of the work. The collective vision of Kansas being "the best place to raise a child" served as the foundation of the efforts, echoed in the aspirations of thousands of Kansans who contributed to our shared understanding of early childhood in our state. Yet the reality for many Kansas families does not match this vision.

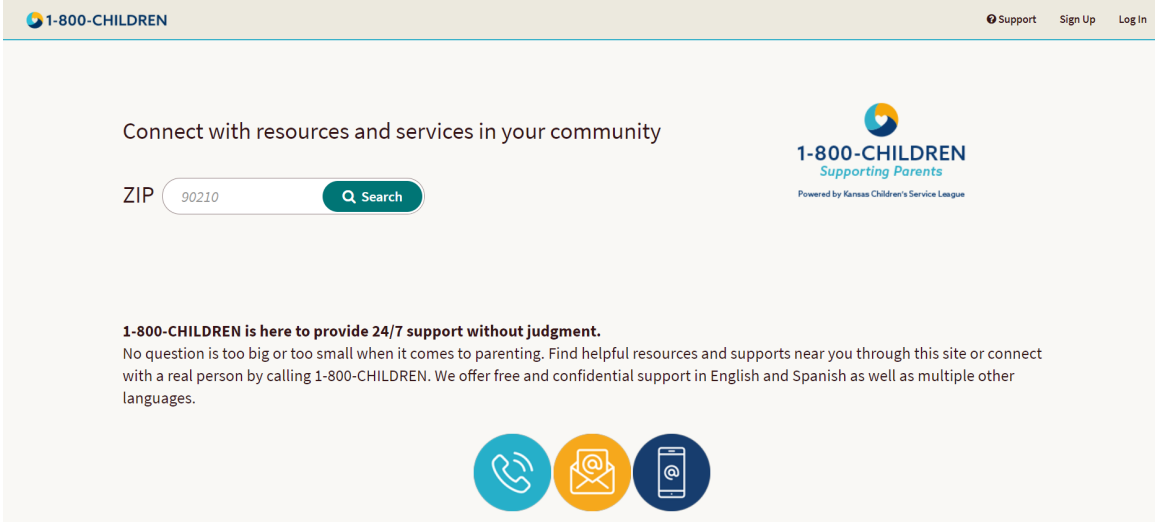
The state applied and received additional PDG funds in 2020 to be able to carry out strategies that would strengthen access to services and supports for families. Outlined in the Strategic Plan, KDHE was assigned five key initiatives:

- *Bridges Project*: Pilot with SHCN satellite offices, in partnership with Kansas Infant-Toddler Services, focused on expanding services to "bridge" services for children aging out of Part C (at age 3) through age 8.
- *Primary Care Provider Care Coordination Expansion Project:* Supports placing holistic care coordination in the medical home in at least two pediatric offices (funds care coordinators).
- *Family Advisory Council (FAC) Expansion*: Backbone support to expand the existing KDHE FAC to include all agencies and serve as the advisory group related to standards for meaningful family and consumer.
- *Supporting You Expansion, Promotion, and Marketing*: Peer to peer network expansion to 2 new programs/target populations (e.g., child care workers, foster parents).
- *Child Care Systems Improvement Team*: Backbone support for the child care system advisory group—focus on review of regulations, removing regulatory barriers, and increasing access.

Each of these initiatives are aligned with the Title V State Action Plan. Additional information about Bridges can be found in the CSHCN narratives. The Holistic Care Coordination, Family Engagement and Leadership, and Peer to Peer Supports are located in Cross-Cutting narratives.

Statewide Resources through 1-800-CHILDREN: In 2019, Kansas merged the former state Title V toll-free "hotline" (the Kansas Resource Guide) to the "Parent Helpline." This provided an ability to expand and support a broader resource directory for families across Kansas. Significant work has happened over the last several years to strengthen this resource such as identifying and developing a robust and reliable statewide resource directory, increasing capacity to continuously maintain listed resources, increasing call line staff capacity, upgrading the mobile app, and rebranding following market research.

1-800-CHILDREN is led by the Kansas Children's Service League (KCSL) and serves as the statewide call line and resource directory. 1-800-CHILDREN provides anonymous, judgment-free support for parents. Families and helpers can easily connect with the information, local resources, and support they need 24/7, even if all they need is a listening ear. No question is off limits. 1-800-CHILDREN is available in English, Spanish, and 200 additional languages. In addition to calling, families can reach 1-800-CHILDREN by sending a text or email to: 1800children@kcsl.org. Additional resources are available online at 1800CHILDRENKS.org, and the mobile app can be downloaded by searching 1800ChildrenKS in iOS or Android app stores.



Title V staff has worked to ensure that 1-800-CHILDREN resources are included on all applicable awareness and educational resources that are disseminated via KDHE and our contract partners. In addition, staff have consistently worked with the KCSL team to ensure that appropriate and up-to-date resources are included in the 1-800-CHILDREN resource management database – ensuring parents and families are connected to the best possible resource in their community that can meet their needs.

NPM 6: Developmental Screening (Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year)

ESM: Percent of children who received a parent-completed developmental screen during an infant or child visit provided by a participating program

Objective: Increase the proportion of children aged 1 month to kindergarten entry statewide who receive a parent-completed developmental screening by 5% annually through 2025.

Based on the *preliminary* Annual Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Report from the Kansas Medical Assistant program, for the federal fiscal year 2021 (10/01/2020-09/30/2021), 36,151 (81.9%) of the 44,153 eligible children, under 1 through 2 years old, received at least one initial or periodic screen. The NPM shows an upward trend of parents reporting the completion of a parent-completed child developmental screen in the past year (34.6% in 2017 -2018; 44.3% in 2019-2020 NSCH). Title V staff continue to work to overcome this disconnect by increasing messaging and information to parents about the importance of developmental screening and the spread of evidence-based screening tools.

Provider & Parent Education/Training: Title V continued coordination with other early childhood partners to promote and offer additional training and technical assistance opportunities for the Ages & Stages

Questionnaire, 3rd Edition (ASQ-3) and ASQ Social-Emotional, 2nd Edition (ASQ:SE-2). Utilizing knowledge and resources acquired from the ASQ-3 and ASQ:SE-2 Training of Trainers Institute hosted by Brookes Publishing, the Child/Adolescent Health Consultant continued to join others around the state to conduct trainings for organizations, their staff members, and communities. Training participants represented public health, family physicians, pediatricians, home visitors, childcare providers, and school personnel. The goal was to spread the awareness and use of these evidence-based screening tools, how/when to conduct screenings, how to analyze and share the results, and follow-up steps if the screening shows potential developmental delays. Title V staff encouraged local MCH agencies to purchase ASQ-3 and ASQ:SE-2 starter kits if they did not already utilize the screening tool at their location and register all staff members for upcoming trainings.

Parents participate in child well visits, home visitations, and local events where developmental screenings take place but may not realize or understand that the questions they are being asked, or that the questionnaires they complete are tied to a developmental screening tool. For that reason, Title V provided partners with a one-page fact sheet and social media messaging in English and Spanish to increase caregiver/parent knowledge. The fact sheet and social media messages are a quick reference and reminder of why it is important to screen, who can complete a developmental screen, names of specific evidence-based screening tools, American Academy of Pediatrics (AAP) recommendations on what age intervals a screening takes place, and what happens after the results are analyzed. The electronic documents were disseminated to local MCH agencies, childcare providers, libraries, healthcare workers, and home visitors to use with families.

Development Milestone Cards & Passports: Title V continued to disseminate the Developmental Milestone and Activity Postcards and Developmental Screening Passports previously created through the Early Childhood Comprehensive Service (ECCS) grant for MCH programs' use with families. The 21 Developmental Milestone Postcards contain developmental milestones provided by the CDC and age-appropriate activities promoted by Vroom. The cards are shared with families to start a conversation about a child's development and to encourage a fun learning experience at home. The Developmental Screening Passports are helpful tools for families in tracking the number of developmental screenings their child received. Local MCH staff including home visitors, early childhood educators, and healthcare providers are reminded that these resources can be downloaded from the Kansas Help Me Grow website, and printed copies are available upon request as long as supplies last.

As part of the pilot implementation for the Bridges Program, a new initiative within the Kansas Special Health Care Needs (KS-SHCN) Program, Care Coordinators received an overview on developmental screening that discussed the differences between monitoring, screening, and evaluation; benefits of screening, AAP's recommendation on developmental screening, types of screening tools and resources (including Help Me Grow Kansas and 1-800-CHILDREN); screening data in Kansas; and their role as a Bridges Care Coordinator in helping families navigate the early childhood system. Developmental Screening Passports (400 English/100 Spanish) and Development Milestone Card Sets (60 English/10 Spanish) were provided to the five locations selected as the Bridges project sites. The KS-SHCN care coordinators are using these resources with up to 60 families across the state. Additionally, KS-SHCN has shared information about the Developmental Miestone Cards and the Developmental Screening Passport with SO staff who are not participating in the Bridges program, so they may also offer them to families they are working with. Read more about the Bridges Program in the CSHCN section narrative.

Coordination and Referrals: In addition to providing ASQ-3 and ASQ:SE-2 trainings and increasing awareness and knowledge about developmental screening to families, Title V supports coordination and two-way referrals with other providers offering community-based services through the utilization of the statewide 1-800-CHILDREN helpline, including referrals to providers and services through local health agencies participating in Integrated Referral and Intake System (IRIS) communities. The 1-800-CHILDREN resource directory includes early childhood programs and early intervention services, as well as numerous resources that address social determinants of health (e.g., food, housing, parenting, employment, education, safety, legal services).

Title V continued to encourage MCH agencies to place the 1-800-CHILDREN logo/weblink on their agency website, show clients how to download the 1-800-CHILDREN app to their phones, update their agency information in the statewide resource directory as needed, and promote the 1-800-CHILDREN helpline on their

social media platforms and at community events. As the resource becomes more widely known, Title V anticipates an increase in the amount of calls and service connections in their counties.

Local MCH Agencies: Local agencies provide developmental screening at least once a year to children they serve. Many local agencies use the ASQ-3 and ASQ:SE-2 for developmental screenings for ages 2 to 60 months (5 years) and use the Bright Futures Pediatric Symptoms Checklist (PSC) for children over 5 years of age. Local MCH agencies continued to provide required ASQ screenings during KanBeHealthy (KBH) well child visits. Developmental screening is a vital component to the continuum of care for children. Educational material is provided to parents regarding developmental milestones during the visit. Local agency activities are highlighted below:

- *Hays Area Children's Center*: MCH home visitors completed ASQ with families who had a child(ren) less than one year of age. Information about the importance of annual developmental screenings was covered with clients and referrals were made, when appropriate, to the local ITS networks..
- *Labette County*: Staff offer parents the tool to be completed on their infant/child when receiving services. The tool is reviewed by nursing staff to identify any risk for delays and then discussed with parents highlighting the child's strengths and any identifying delays. Any child who has identified risks, are referred to their primary healthcare provider, Parents as Teachers, Early Head Start and/or to their local ITS network.
- *Pawnee County*: The MCH staff use the Ages and Stages parent completed questionnaire for developmental screening and Pediatric Symptom checklist for older children. Parents are given referrals &/or information based on the guidelines.
- *Shawnee County*: Screen all MCH infants and children. Referrals are made if not within normal range or if a parent has concerns about their child's development for further evaluation through the local infant toddler network. MCH staff distribute and educate clients about the CDC Milestone Moments booklet and what they should expect of their child's development.
- *Wabaunsee County*: Staff have parents complete the ASQ and counsel them on the growth and developmental expectations for the coming months. Parents are provided with written and verbal health information and education.

Local agencies use multiple screening assessment tools to determine the needs of the child through direct services and indirectly by making referrals. Data is captured in DAISEY related to child development education provided during an MCH visit, including MCH Home Visits.

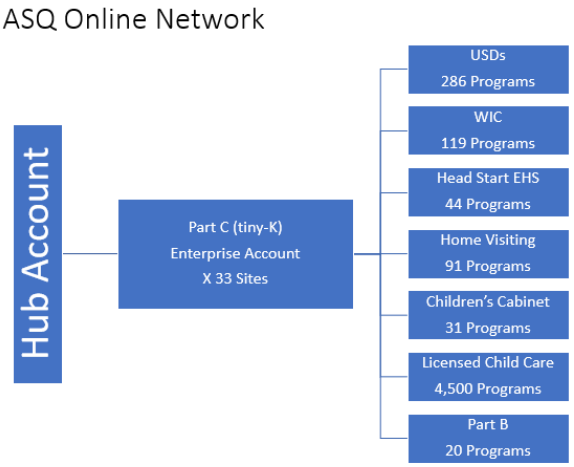
SFY2021 - Local MCH Agencies Entering Client Level Data in DAISEY	
Child Development	**MCH Visits (including home visits)**
Services	**954**
Education	**2,775**

MCH home visitors provide child development and child social-emotional development screenings for families they serve. Universal MCH home visitors provided 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 were provided to local agencies regarding the protocol and expectations for incorporating the developmental screening (parent completed tool) into child well visits. Distinctions between the intent, purpose, and use of Bright Futures and the ASQ were provided to ensure local agencies were not using one or the other, but both per intent and standards related to monitoring and improving child health. Read more about the MCH Universal Home Visiting Program online at: http://kshomevisiting.org (click on Resources – Universal Home Visiting).

Healthy Child Development Programs: Title V staff recognize MCH agencies, home visiting programs, and healthcare providers that currently promote early literacy programs such as AAP's *Turn a Page, Touch a Mind*, the *Dolly Parton Imagination Library*, and other interactive activities recommended by *Learn the Signs. Act Early.* Campaign. Through promotion of local practices and the impact these programs have had in Kansas,

Title V encouraged other partners across the state to incorporate more early literacy and age-appropriate activities that help children develop healthy habits into their services.

Utilizing Statewide ASQ Data: Title V, in partnership with other state agencies, entered into an agreement with Brookes Publishing to establish a statewide ASQ Enterprise for alignment of statewide data. Successful discussions and planning strategies have been ongoing with Brookes Publishing, and a plan is now in place to consolidate multisector development screens into one statewide hub account. Below is an image of the multi-sector structure. Technical assistance was provided to local MCH agencies on how to access the statewide ASQ Enterprise and guidance for documentation of developmental screenings and referrals into the shared data measurement system, DAISEY.



As a partnering program the Kansas Infant-Toddler Services (ITS) networks have become the early childhood hubs for ASQ. This allows all early childhood entities the ability to partner without being responsible for maintenance of the system. Through this partnership ITS networks were provided information and access to the Developmental Milestone Cards and Passports.

Integrated Referral and Intake System (IRIS). Kansas selected IRIS as the tool to support web-based communication for organizations to connect the families they serve to the right resources in their community. IRIS empowers communities to build a family-centered referral network based on common expectations. Title V supports communities who choose to implement IRIS. Title V staff connect communities to technical assistance and help in crafting innovative solutions for communities that currently participate in or want to explore IRIS. Recognizing the potential of local networks to impact health and well-being by facilitating access to resources across the lifespan, state public health leadership address barriers limiting the participation of critical community partners such as behavioral health, primary care, and concrete supports. State public health leadership use the rich, ever-growing data generated from IRIS networks to reveal gaps in services, identify opportunities for increased partnership at the local level as well as determine program priorities and opportunities. For communities that utilize IRIS an uptick in referrals and linking families and children to needed resources is expected.

KS*KidsMAP:* An aim of Kansas' Pediatric Mental Health Care Access Program, KSKidsMAP, is to support pediatric primary care practitioners to diagnose and treat youth with behavioral health concerns while increasing access to specialty care, behavioral health, and community resources by assisting and enhancing referral mechanisms. KSKidsMAP funding was made available to four IRIS Communities in 2021, in support of expanding their community network to include behavioral health and primary care providers. Funding supported Annual IRIS Community Maintenance Costs in Franklin, Johnson, Pottawatomie/Riley, and Saline counties. More information about KSKidsMAP can be found in the Cross-Cutting Report.

Other Child Health Objectives

Objective: Increase the proportion of children, 6 through 11 years, with access to activities and programs that support their interests, healthy development, and learning by 10% by 2025.

In May 2021, the Title V School Health Clinical Consultant for the Kansas Department of Health and Environment (KDHE) distributed an open-ended five-question survey to Kansas school nurses via a link on the Kansas School Nurse Organization (KSNO) website. The purpose of the survey was to better understand what Kansas school nurses perceive as their top COVID-19 and non-COVID-19 school health priorities and support needs. During a four-week distribution period, the survey collected responses from 68 unique respondents, representing 16 of 105 counties and 19 of 286 school districts (15.24% and 6.64% respectively). The small sample size, combined with the disproportionate representation, limited the reliability and generalizability of the survey's findings. The second survey was distributed in August 2021 at the Kansas School Nurse Conference.

The August survey captured responses from 119 unique respondents and had more representative proportions of urban, semi-urban, and rural school districts (by respondent self-reported population type). The top five priorities were relatively consistent between the May and August surveys for both COVID-19 and non-COVID-19 school health priorities. Leading priorities for COVID-19 health included promoting a sense of safety in schools; quickly identifying cases and differentiating COVID-19 symptoms from other COVID-like symptoms; enforcement and compliance with risk mitigation strategies; education about COVID-19 disease, mitigation strategies, and quarantine/isolation protocols; and the mental health impacts of the pandemic. Leading priorities for non-COVID-19 health included meeting acute care illness and injury needs of the school community; health education for students, staff, and families; effective and consistent communication between parents and nurses and nurses and school staff about student health needs; administration of both routine and emergency medications; and behavioral and mental health.

The August survey asked respondents about their resource priorities via a series of matrix questions that allowed respondents to indicate how important it is to have resources for specific topics and which type of resources would be most beneficial for those topics. In both surveys, nurses expressed a need for policy and procedure guidance for COVID-19 and routine daily workflow topics. Results from the August survey reveal that nurses strongly prefer web-based resources for most health topics but prioritize trainings for mental health. Leading COVID-19 topics for which nurses need resources include: identifying cases, school safety, mental health, communication and COVID-19 education. Leading non-COVID-19 resource topics include: health education, behavioral & mental health, acute care, chronic illnesses, and communications.
Overall, survey results indicate that nurses responded from the perspective of their day-to-day workflows (and what they prioritize in those workflows) as opposed to school communities' perceived health needs, which have been identified by other community needs assessments (Adolescent Health Needs Assessment, the 2025 MCH Needs Assessment, and the Kansas Title V State Action Plan). These survey results, and the corresponding report and recommendations, will be used as a guide for school-based Title V work in the coming years.

The BFH has developed *Social and Emotional Development Milestones: An Age-By-Age Guide* to be used in conjunction with the Developmental Milestone & Activity Postcards. Since behavioral health was one of the most addressed concerns in the MCH Needs Assessment, capacity-building of the MCH workforce to address behavioral health concerns has become a top priority. The Guide is a resource that the MCH workforce can provide to families for their use, gain knowledge of healthy social-emotional development, and identify strategies to address concerns they may have. This approach increases early identification of social and emotional development delays, thus allowing interventions to occur earlier and families to be healthier. The Guide offers information on developmental milestones, guidance for talking to children about their mental wellbeing, and other tips for furthering a child's development. There are 12 age groups, ranging from newborn to 18 years, in which Title V plans to partner with community organizations leading efforts on social-emotional health to provide programs with these resources/tools that support the encouragement and empowerment to build healthy relationships with parents/caregivers, teachers, mentors, health care providers, and peers.

Objective: Increase the proportion of MCH program participants, 1 through 11 years, receiving a quality, comprehensive annual preventive services by 10% annually through 2025.

KanBeHealthy Trainings & Bright Futures™: According to the 2019-2020 National Survey of Children's Health (NSCH) 81.6% of children visited a doctor, nurse, or other health care professional for a preventative check-up. KanBeHealthy (KBH) is the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit that provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services. Kansas Medicaid utilizes Bright Futures™ as the EPSDT/KBH standard of care, so all services are expected to be provided in accordance.

Feedback from local health agencies indicated a need to re-train clinical professionals on conducting KBH visits. The Kansas KBH training, including the Orientation Manual, has been updated and trainings are provided by request. Correspondence with the regional Bright Futures representative continues and is

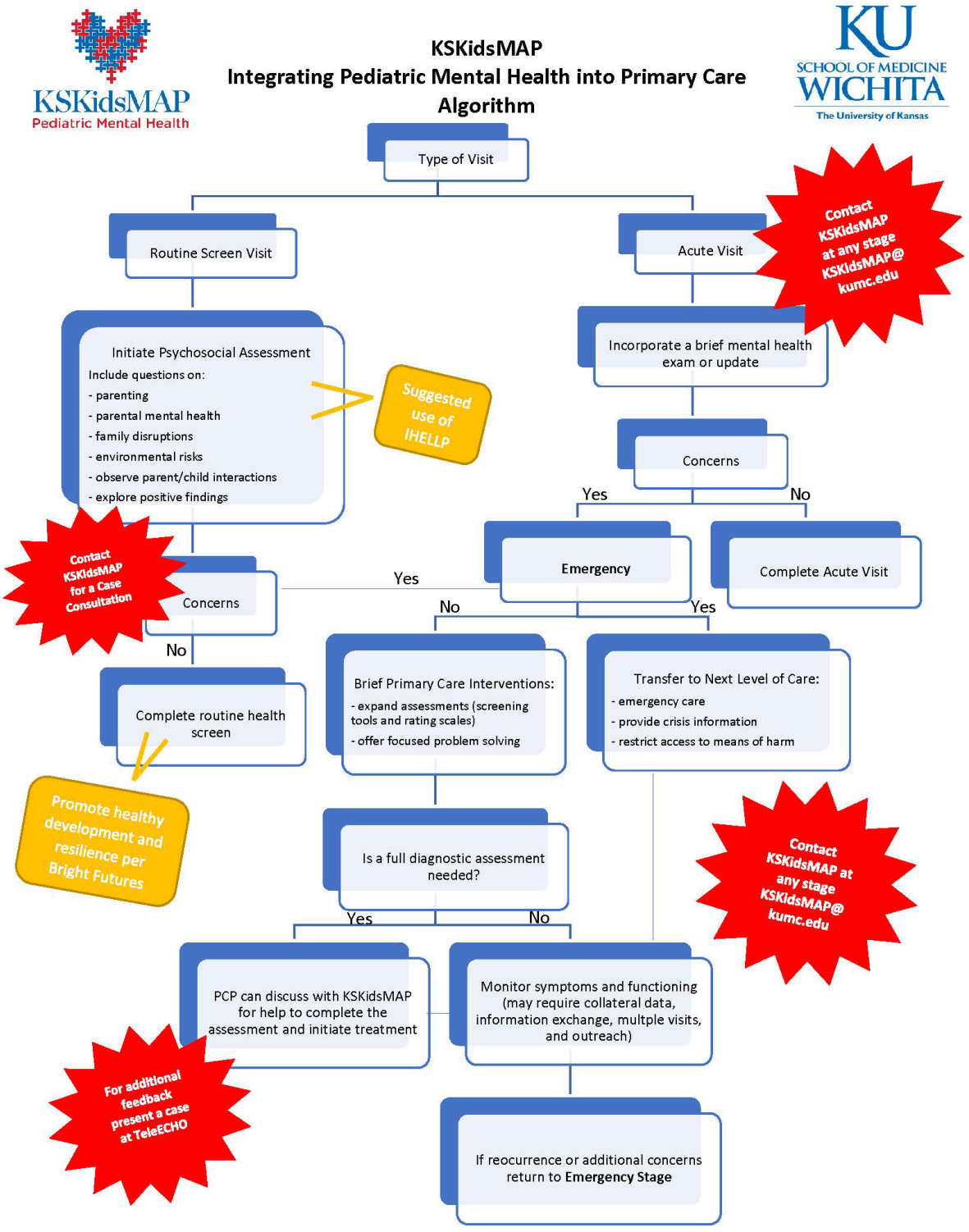
beneficial in identifying free resources, trainings, or membership opportunities for state and local MCH agencies.

The KS-SCHN program continued to address the need for annual preventative care for their uninsured program participants by covering an annual well child visit, vision and dental exam, which mirrors the EPSDT benefit, through the Medical Services direct assistance program (DAP-MS). Additionally, the importance of this yearly visit is reiterated to all families on the program, as this can be lost amongst the specialist and therapy visits their child requires. Some families have shared that they use their child's specialist, for example the pediatric pulmonologist, for their child's primary care in lieu of a pediatrician or family practice physician. These families are encouraged by care coordination staff to find a primary care physician in their area and assist them in this search, upon request.

Title V facilitated the acquisition of a statewide license for the online Bright Futures Tool and Resource Kit, 2nd Edition. The online toolkit includes resources such as: age-specific client forms that apply the Bright Futures Guidelines; supplemental and just-in-time topical handouts for parents in English and Spanish; the AAP Periodicity Schedule that includes the recommended evidence-based screening tools to be used at various ages; and guidance to implement the Bright Futures forms into electronic health record systems. All local health departments and other MCH-funded agencies are given access to the site and resources at no cost upon completion of an online course with a demonstration of navigating the toolkit. The Child/Adolescent Health Consultant contacted representatives in each county that had not yet received access to offer the resource. The consultant also provided ongoing technical assistance to agencies regarding the online Bright Futures Toolkit. Targeted and intentional technical assistance was provided to communities that show low well visit participation rates, immunization completion rates and uninsured children ages 5-10 years of age. Communities that show gaps in services were invited to meet with Title V staff to review available data, brainstorm solutions and collaboration between partners with shared goals, create an action plan and marketing strategy.

Along with general inquiries about the toolkit, utilization strategies and best practices, the consultant focused on promoting mental health conversations during well visits. In October 2020, Bright Futures published an updated Implementation Tip Sheet on this topic. By the age of 11 years, children can show onset symptoms of anxiety and impulse control disorder. The AAP Periodicity Table recommends screening for depression beginning at age 12 years. Title V staff encouraged and promoted the Patient Health Questionnaire (PHQ) recommended by AAP, as well as the KSKidsMAP modified AAP algorithm for integrating mental health care into well-child visits. This algorithm demonstrates how the Bright Futures behavioral health screening recommendations can be integrated into well-visits, and highlights decision points in which the KSKidsMAP Pediatric Mental Health Care Team could be contacted via Consultation Line to support the practitioner in identifying next steps for appropriate care and treatment.

The algorithm (below) and support materials serve as a reminder of the recommended components of a well-child/adolescent visit, increase the identification of those exhibiting signs and/or symptoms, strengthen the quality of the visit, and enhance treatment mechanisms of children and adolescents with behavioral health concerns. More information about KSKidsMAP can be found in the Cross-Cutting narrative.



Title V and KDHE's Local Public Health Program (LPHP) utilized the Regional Public Health meetings and other communication venues for local public health administrators as an avenue for communicating updated changes on KBH visits and exams/EPSDT and other important issues related to child health. The program worked to increase access to training and resources for local health departments related to developmental screenings.

Other Activities Related to Children's Developmental Health

Early Childhood Systems Building: The Preschool Development Grant Birth through Five (PDG B-5) funding provided through the Department of Health and Human Services (HHS) Administration for Children and Families (ACF) Every Student Succeeds Act (ESSA), was awarded to the Kanas State Department of Education in early 2020. The KCCTF, DCF, and BFH leveraged these funds to complete a statewide early childhood needs assessment and develop an early care and education system strategic plan. The initiative has been branded, All in for Kansas Kids, Ensuring Every Child Thrives.

This plan strives to provide equitable, high-quality care and education to all Kansas families regardless of where they live. The aim is to strengthen local systems by empowering communities with the flexibility they need to deliver connected, high-quality services. The plan was grounded in data to ensure that resources are strategically directed, and the work focused to achieve the greatest impact. As one of four state agencies involved in the early childhood systems building initiative, KDHE serves as the lead to carry out certain work under the plan as the lead agency. There are opportunities through several of these projects to collect information/data around ACEs, potentially including education, screening, referral, and follow-up.

Cross-System Referrals: The KS-SHCN program has continued to expand and strengthen referral processes among other screening programs (e.g., genetic/metabolic, hearing, and heart newborn screenings), surveillance programs (e.g., birth defects), home visiting and early intervention programs (e.g., MCH UHV, MIECHV, infant-Toddler Services), and external systems (e.g., foster care, Medicaid).

Formal referral protocols were developed for the BFH screening and surveillance programs along with a shared referral tracking sheet that ensures the loop has been closed on referrals. KS-SHCN promotes and uses the "Decision Schema" to help them determine who to refer to the KS-SHCN program and when, specifically with the Infant-Toddler Services Program. Additionally, the KS-SHCN Care Coordinator work in collaboration with the child's family and any BFH referral program/service provider to make sure that the child and family's needs are being met and that there is no duplication of services between programs. More information can be found on the referral process in the CSHCN section.

The realignment of the BFH continues to create new alignment opportunities across programs serving shared MCH populations (both Title V and non-Title V supported). A critical shift within this realignment moved Infant-Toddler Services, KS-SHCN, MCH, Teen Pregnancy Targeted Case Management, Pregnancy Maintenance Initiative, Family Planning, Universal Home Visiting, and Maternal Infant Child Early Childhood Home Visiting Programs together in one section. The intent and purpose was to better align these programs with each other and help staff begin to see the collaboration in services and supports that could occur to improve services to the MCH populations.

To help staff identify and understand how working collaborative and promoting referrals among programs, the Community Partnership Director lead some team collaboration activities within the C&F section and then partnered with the Screening and Surveillance team Director to show both sections the benefit of collaboration and how all services and supports cross. This helped staff gain a better understanding of each program and how they interlock throughout the life span to create seamless services for families in Kansas. More collaborative trainings are planned in the future.

2023 CHILD HEALTH APPLICATION PLANS

PRIORITY 3: Children and families have access to and utilize developmentally appropriate services and supports through collaborative and integrated communities

NPM 6: Developmental Screening (Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year)

Local MCH Reach: Based on SFY2023 MCH Aid-to-Local applications received: 39 of 55 grantees (71%) plan to provide services to the Child population

- 35 of 39 grantees (90%) plan to provide developmental screening services24 of39 grantees (62%) plan to provide activities and programs that support the interests, healthy development, and learning of children
- 21 of 39 grantees (54%) plan to provide quality, comprehensive annual preventive services

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NPM 6: Developmental Screening (Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year)

Objective: Increase the proportion of children aged 1 month to kindergarten entry statewide who receive a parent-completed developmental screening by 5% annually through 2025.

According to the Kansas Annual Early and Periodic Screening, Diagnostic and Treatment (EPSDT) report, 45,101 (91.3%) of eligible children received at least one initial or periodic screen in FFY2019. However, the NPM shows a downward trend of parents reporting the completion of a parent-completed child developmental screen in the past year (37.8% in 2017; 34.6% in 2018; 36.9% in 2019 NSCH). Title V staff will continue to work to overcome this disconnect by increasing messaging and information to parents about the importance of developmental screening and spread use of evidence-based screening tools.

Provider & Parent Education/Training: Title V will continue to coordinate with other early childhood partners in promoting and offering additional training and technical assistance opportunities for the Ages & Stages Questionnaire, 3rd Edition (ASQ-3) and ASQ Social-Emotional, 2nd Edition (ASQ:SE-2). Utilizing knowledge and resources acquired from the ASQ-3 and ASQ:SE-2 Training of Trainers Institute hosted by Brookes Publishing, the Child/Adolescent Health Consultant will continue to join others around the state to conduct trainings for organizations, their staff members, and communities. Training participants will represent public health, family physicians, pediatricians, home visitors, childcare providers, and school personnel. The goal is to spread the awareness and use of these evidence-based screening tools, how/when to conduct screenings, how to analyze and share the results, and follow-up steps if the screening shows potential developmental delays. Title V staff will encourage local MCH agencies to purchase ASQ-3 and ASQ:SE-2 starter kits if they do not already utilize the screening tool at their location and register all staff members for upcoming trainings.

Parents participate in child well visits, home visitations, and local events where developmental screenings take place but may not realize or understand that the questions they are being asked, or that the questionnaires they complete are tied to a developmental screening tool. For that reason, Title V will supply partners with a one-page fact sheet and social media messaging in English and Spanish to increase caregiver/parent knowledge. The fact sheet and social media messages will become a quick reference and reminder of why it is important to screen, who can complete a developmental screen, names of specific evidence-based screening tools, American Academy of Pediatrics (AAP) recommendations on what age intervals a screening takes place, and what happens after the results are analyzed. The electronic documents will be disseminated to local MCH agencies, childcare providers, libraries, healthcare workers, and home visitors to use with families. Documents will be made available on state and local health websites for public use and at state/local community events.

In the coming year, developmental screening will be incorporated into the Becoming a Mom (BAM) curriculum for the Kansas Perinatal Community Collaboratives (KPCCs) across the state. The Child and Perinatal/Infant Health Consultants will work together to introduce an overview on developmental screening into Session 5 – Newborn and Infant Care. Families located in the 20 BAM/KPCC communities that enroll and attend this session will receive the one-page fact sheet and their own full set of developmental milestone activity cards and a developmental screening passport. All of these resources will be available in both English and Spanish. Ongoing discussions and planning to include more detailed information about developmental screening, recommended screening tools used, screening results, and the referral process/connection for early intervention services in a future Session 7 of the BAM curriculum are currently taking place.

Development Milestone Cards & Passports: Title V will continue to disseminate the Developmental Screening Passports previously created through the Early Childhood Comprehensive Service (ECCS) grant for MCH programs' use with families. The Developmental Screening Passports are helpful tools for families in tracking the number of developmental screenings their child received. More information about these tools can be found

in the Child Report. Local MCH staff including home visitors, early childhood educators, and healthcare providers will be reminded that these resources can be downloaded from the Kansas Help Me Grow website.

As part of the pilot implementation for the Bridges Program, a new initiative within the Kansas Special Health Care Needs (KS-SHCN) Program, Care Coordinators received an overview on developmental screening that discussed the differences between monitoring, screening, and evaluation; benefits of screening, AAP's recommendation on developmental screening, types of screening tools and resources (including Help Me Grow Kansas and 1-800-CHILDREN); screening data in Kansas; and their role as a Bridges Care Coordinator in helping families navigate the early childhood system. All Bridges Care Coordinators share information with the families in the program about the importance of developmental screening and help link them to the appropriate resources in their area to complete a developmental screening on their child. Care Coordinators provide families with the developmental passport and share the Developmental Milestone Cards regularly. As more cards and passports are needed at Bridges locations across the state these are provided to them upon request and no cost. The KS-SHCN care coordinators will use these resources with up to 60+ families across the state. As new Bridges sites are developed in FY23 additional trainings will be held to encourage ASQ screenings and the use of the passports and postcards. All bridges and SHCN care coordinators will receive training on how to do an ASQ during the FY2023 year.. Read more about the Bridges Program in the Special Health Care Needs Plan narrative.

Coordination and Referrals: In addition to providing ASQ-3 and ASQ:SE-2 trainings and increasing awareness and knowledge about developmental screening to families, Title V will build MCH capacity to support coordination and two-way referrals with other providers offering community-based services through the utilization of the statewide 1-800-CHILDREN helpline, including referrals to providers and services through local health agencies participating in an Integrated Referral and Intake System (IRIS) communities. The 1-800-CHILDREN resource directory includes early childhood programs and early intervention services, as well as numerous resources that address social determinants of health (e.g., food, housing, parenting, employment, education, safety, legal services).

Title V will continue to encourage MCH agencies to place the 1-800-CHILDREN logo/weblink on their agency website, show clients how to download the 1-800-CHILDREN app to their phones, update their agency information in the statewide resource directory as needed, and promote the 1-800-CHILDREN helpline on their social media platforms and at community events. As the resource becomes more widely known, Title V anticipates an increase in the amount of calls and service connections in their counties. For communities that utilize IRIS an uptick in referrals and linking families and children to needed resources is expected.

Local MCH Agencies: Local agencies will continue to provide developmental screening at least once a year to children they serve. Many local agencies use the ASQ-3 and ASQ:SE-2 for developmental screenings for ages 2 to 60 months (5 years) and use the Bright Futures Pediatric Symptoms Checklist (PSC) for children over 5 years of age. Local MCH agencies will continue to provide required ASQ screenings during KanBeHealthy (KBH) well child visits. Developmental screening is a vital component to the continuum of care for children. Educational material is provided to parents regarding developmental milestones during the visit. Local agency activities are highlighted.

- *Barton County:* Plans to increase the number of times "child development" is chosen as an education topic. They will provide education about developmental milestones for parents during home visits (for the infant, and for older children) and support use of the Developmental screening passport and milestone cards. They are pursuing a new partnership with Sunflower Early Education as a referral source for children whose developmental screening scores indicate the need for intervention.
- *Shawnee County*: Screen 100% of MCH infants and children served using the ASQ-3 and ASQ:SE2. Refer all screens that are not within normal range or if a parent has concerns about their child's development for further evaluation through our tiny k local infant toddler network. Follow up with parents to make sure further evaluation took place. Distribute and educate clients about the CDC Milestone Moments booklet or website if no booklets are available and what they should expect of their child's development. The Bright Futures Toolkit is used as a resource for all MCH staff providing home visits. Bright Futures handouts are utilized for distribution to families focusing on nutrition and development. Assure that all MCH staff get signed up for use of the online KDHE MCH Toolkit.

- *Lawrence-Douglas County:* Will administer ASQ and ASQ:SE screenings for 70% of children in the home visiting program. All child development screens that indicate potential for delay are referred to local tiny k services and results are sent to the child's primary care provider. Home visitors and staff will offer the families assistance in contacting tiny K and offer a joint visit with all parties. Additionally, Growing Great Kids curriculum and ASQ child activities will be shared with the parents to educate and promote techniques parents can use with their children to strengthen the developmental area of concern.
- *Pawnee County:* Will increase the number of developmental screenings provided during the year by attending "school entry screening days". They will search the state database when youth come in for immunizations to see if they are due for a well child exam and schedule if parents approve. They've observed many PCPs in their area approach development concerns in a less proactive manner and want to be a leader in this area to help families access child development services as soon as possible.
- *Southeast Kansas Multi-County Health Department*: Increase the percentage of appointments with a child developmental screening that are completed from 58% to 80%. This will be tracked using Appointment Plus Software. Screening tools will be mailed to families ahead of time as a strategy for completing screenings.

Healthy Child Development Programs: Title V staff will recognize MCH agencies, home visiting programs, and healthcare providers that currently promote early literacy programs such as AAP's *Turn a Page, Touch a Mind*, the *Dolly Parton Imagination Library*, and other interactive activities recommended by *Learn the Signs. Act Early.* Campaign. Through promotion of local practices and the impact these programs have had in Kansas, Title V will encourage other partners across the state to incorporate more early literacy and age-appropriate activities that help children develop healthy habits into their services.

Utilizing Statewide ASQ Data: Title V, in partnership with other state agencies, entered into an agreement with Brookes Publishing to establish a statewide ASQ Enterprise for alignment of statewide data. Through successful discussions and planning strategies with Brookes Publishing, strong ASQ hubs have been established and are monitored by the local Infant-Toddler Programs. As the graph above shows a variety of partnering programs are and will continue to be added in the development of consolidate multisector development screens into one statewide hub account. Technical assistance will continue to be provided to local MCH agencies on how to access the statewide ASQ Enterprise and guidance for documentation of developmental screenings and referrals into the shared data measurement system, DAISEY. During SY 23, the SHCN/Bridges program staff will receive training on how to conduct, document and submit ASQ screenings into the local Infant Toddler Hubs across the state.

Early Childhood Systems & Collaboration: Title V will continue to partner with other early childhood agencies, including the Kansas State Department of Education (KSDE), Department for Children and Families (DCF), and Kansas Children's Cabinet & Trust Fund (KCCTF), to focus on children's developmental health and emphasize the importance of early and ongoing developmental screening. Title V is dedicated to assisting communities in creating seamless and coordinated systems that connects families to local services and resources. In addition to partnering around the ASQ screening and data utilization, Title V will build MCH capacity to support the Help Me Grow Kansas Connected Families, Connected Communities vision; facilitate access to available resources through the statewide 1-800-CHILDREN helpline; and support coordinated, two-way referrals with other providers offering community-based services through use of IRIS at the community level.

- *Help Me Grow (HMG):* Kansas adopted the national HMG framework to promote developmental screening to monitor children's developmental health and connect families to needed interventions, services, and supports. Implementation of HMG in communities across the state is ongoing; however, the use of existing developmental screening materials has been integrated. The team will continue to develop resources and tools for HMG communities and promote existing resources such as the statewide centralized access point (CAP), launched in May 2019. In December 2020, the state agencies contracted with a marketing consultant to review the brand framework around the HMG core components (provider, family, community outreach) after hearing from communities that the HMG brand was not resonating. Overwhelmingly, informant Interviews with key stakeholders and communities revealed the need for increased access to supports and services, including community-based technical assistance (adaptive Technical Assistance). In April 2021 the work was completed, and

the *Navigate EC* branding was adopted. The plan is to provide a website, landing page, and coordination for all early childhood efforts across agencies.

- *1-800-CHILDREN/Helpline*. Administered by the Kansas Children's Service League and funded through multiple sources, the 1-800-CHILDREN helpline serves as the statewide CAP for HMG Kansas (anonymous information and referral line). Trained volunteers listen, empathize and offer support to any parent, provider, or individual who calls. The service is free and available 24/7 for English- and Spanish-speaking callers. State agencies are promoting the line as one centralized access point for services anywhere in the state.
- *Integrated Referral and Intake System (IRIS).* Kansas selected IRIS as the tool to support web-based communication for organizations to connect the families they serve to the right resources in their community. IRIS empowers communities to build a family-centered referral network based on common expectations. In the upcoming grant year, Title V will continue to promote and support communities who choose to implement IRIS. Title V staff will continue to connect communities to technical assistance and help in crafting innovative solutions for communities that currently participate in or want to explore IRIS. Recognizing the potential of local networks to impact health and well-being by facilitating access to resources across the lifespan, state public health leadership will address barriers limiting the participation of critical community partners such as behavioral health, primary care, and concrete supports. State public health leadership will use the rich, ever-growing data generated from IRIS networks to reveal gaps in services, identify opportunities for increased partnership at the local level as well as determine program priorities and opportunities.

More information about the history of HMG, the Helpline, and IRIS can be found in the Child Report.

Other Child Health Objectives

Objective: Increase the proportion of children, 6 through 11 years, with access to activities and programs that support their interests, healthy development, and learning by 10% by 2025.

Title V plans to continue partnering with local school districts and the Bureau of Health Promotion to align statewide messaging around child health initiatives. Local communities will receive guidance on healthy campaigns (e.g., Move Your Way, Let's Move; Turn a Page-Touch a Mind; Dolly Parton's Imagination Library), farmer's market resources, and other food programs that are available. Through CDC Workforce Development grant funds related to the COVID_19 pandemic, the Bureau of Family Health is supporting the expansion of school-based health services in seven school districts in Southeast and Southwest Kansas, including the provision of behavioral health services at each location. The goal is for each school district to have services established and self-sustaining by the end of the grant period in summer of 2023, ensuring the provision of behavioral services through and expanded clinical workforce in areas that are currently designated as Health Professional Shortage Areas.

Another focus is the safety and inclusiveness of school and community playgrounds. Many play areas are not inclusive for children with disabilities who also need to be physically active. Holding true to the BFH belief that "children with special health care needs (CSHCN) are children first and foremost," our focus will be on assisting communities and schools with understanding how they can make playgrounds accessible for all

children. Title V will engage communities and partners to conduct an assessment/review of safe school routes and inclusive playgrounds across the state to identify best practices and support expansion of communities with limited/no safe and inclusive play spaces. Title V will identify key partners who can provide technical assistance and establish guidance on adapting play equipment for children with mobility and sensory needs to communities and schools. Additionally, mini-grants will be made available for communities interested in building inclusive public spaces, such as school and community playgrounds. MCH local agencies will be prioritized to receive these resources and supports as they become active in ensuring that ALL children are able to enjoy community spaces.

Local MCH Agencies:

- *Linn County Health Department* will promote the use of the community's new splash pad to get more physical activity and enjoy time outside with friends. They will also promote health when we do our developmental screenings by providing them educational material about their health ranging from hand washing to physical activity. The WIC nurse will provide materials and education during WIC appointments. They will use educational materials from the CDC, Be Active Kids, and Kids Health. They will have "Funshine Days" during the summer and incorporate fun activities that can be done outside to stay active along with education on how to stay cool during the summer when it is hot out. They'll hold an outreach event with the schools to promote good handwashing.
- *Nemaha County Community Health Services* will become the lead for Nemaha County Safe Kids Coalition. An application will be submitted to the National Safe Kids Coalition and the first Safe KidsEvent will be held once it is approved. The coalition will include local safety partners such as EMS, fire, and police departments.

Objective: Increase the proportion of MCH program participants, 1 through 11 years, receiving a quality, comprehensive annual preventive services by 10% annually through 2025.

KanBeHealthy Trainings & Bright Futures™: According to the 2018 National Survey of Children's Health (NSCH) 72.6% of children visited a doctor, nurse, or other health care professional for a preventative check-up. KanBeHealthy (KBH) is the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit that provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services. Kansas Medicaid utilizes Bright Futures™ as the EPSDT/KBH standard of care, so all services are expected to be provided in accordance.

Feedback from local health agencies indicates a need to re-train clinical professionals on conducting KBH visits. The Kansas KBH training, including the Orientation Manual, has been updated and trainings will be provided by request. Correspondence with the regional Bright Futures representative continues and is beneficial in identifying free resources, trainings, or membership opportunities for state and local MCH agencies.

The KS-SCHN program will continue to address the need for annual preventative care for their uninsured program participants by covering an annual well child visit, vision and dental exam, which mirrors the EPSDT benefit, through the Medical Services Direct Assistance Program (DAP-MS). Additionally, the importance of this yearly visit is reiterated to all families on the program, as this can be lost amongst the specialist and therapy visits their child requires. Some families have shared that they use their child's specialist, for example the pediatric pulmonologist, for their child's primary care in lieu of a pediatrician or family practice physician. These families are encouraged by care coordination staff to find a primary care physician in their area and assist them in this search, upon request.

Title V facilitated the acquisition of a statewide license for the online Bright Futures Tool and Resource Kit, 2nd Edition. The online toolkit includes resources such as: age-specific client forms that apply the Bright Futures Guidelines; supplemental and just-in-time topical handouts for parents in English and Spanish; the AAP Periodicity Schedule that includes the recommended evidence-based screening tools to be used at various ages; and guidance to implement the Bright Futures forms into electronic health record systems. All local

health departments and other MCH-funded agencies are given access to the site and resources at no cost upon completion of an online course with a demonstration of navigating the toolkit. The Child/Adolescent Health Consultant plans to reach out to representatives in each county that has not yet received access to offer the resource. The consultant will also provide ongoing technical assistance to agencies regarding the online Bright Futures Toolkit. Along with general inquiries about the toolkit and utilization strategies and best practices, the consultant will focus on promoting mental health conversations during well visits. In October 2020, Bright Futures published an updated Implementation Tip Sheet on this topic. By the age of 11 years, children can show onset symptoms of anxiety and impulse control disorder. The AAP Periodicity Table recommends screening for depression beginning at age 12 years. Title V staff will encourage and promote the Patient Health Questionnaire for Teens (PHQ-A) (ages 11-17) while recommending use of the Pediatric Symptom Checklist-17 (PSC-17) for children ages 4-16.

Targeted and intentional technical assistance will be provided to communities that show low well visit participation rates, immunization completion rates and uninsured children ages 5-10 years of age. Communities that show gaps in services will be invited to meet with Title V staff to review available data, brainstorm solutions and collaboration between partners with shared goals, create an action plan and marketing strategy.

Title V and KDHE's Local Public Health Program (LPHP) will continue to utilize the Regional Public Health meetings and other communication venues for local public health administrators as an avenue for communicating updated changes on KBH visits and exams/EPSDT and other important issues related to child health. The program will also work to increase access to training and resources for local health departments related to developmental screenings.

Local MCH Agencies: Northeast Kansas Multi-County Health Department will form a partnership with Northeast Kansas Community Action Program to ensure that all children that attend their program are receiving their KBH and developmental screenings to identify any potential needs as well as referring families to specialists, PAT, etc.

Other Activities Related to Children's Developmental Health

Early Childhood Systems Building: The Preschool Development Grant Birth through Five (PDG B-5) funding provided through the Department of Health and Human Services (HHS) Administration for Children and Families (ACF) Every Student Succeeds Act (ESSA), was awarded to the Kanas State Department of Education in early 2020. The KCCTF, DCF, and BFH leveraged these funds to complete a statewide early childhood needs assessment and develop an early care and education system strategic plan. The initiative has been branded, All in for Kansas Kids, Ensuring Every Child Thrives.

This plan strives to provide equitable, high-quality care and education to all Kansas families regardless of where they live. The aim is to strengthen local systems by empowering communities with the flexibility they need to deliver connected, high-quality services. The plan is grounded in data to ensure that resources are strategically directed, and the work focused to achieve the greatest impact.

Cross-System Referrals: The KS-SHCN program will continue to expand and strengthen referral processes among other screening programs (e.g., genetic/metabolic, hearing, and heart newborn screenings), surveillance programs (e.g., birth defects), home visiting and early intervention programs (e.g., MCH UHV, MIECHV, infant-Toddler Services), and external systems (e.g., foster care, Medicaid).

Formal referral protocols were developed for the BFH screening and surveillance programs along with a shared referral tracking sheet that ensures the loop has been closed on referrals. KS-SHCN will continue to promote and use the "Decision Schema" to help them determine who to refer to the KS-SHCN program and when, specifically with the Infant-Toddler Services Program. Additionally, the KS-SHCN Care Coordinator will work in collaboration with the child's family and any BFH referral program/service provider to make sure that the child and family's needs are being met and that there is no duplication of services between programs. Referral partnerships will be expanded during FY23 to include foster agencies, Hearing Aid Bank recipients, and home visiting programs.

Behavioral Health Integration: Title V will continue to promote the KSKidsMAP modified AAP algorithm for integrating pediatric mental health into well-child visits. This algorithm demonstrates how the Bright Futures behavioral health screening recommendations can be integrated into well-visits, and highlights decision points in which the KSKidsMAP Pediatric Mental Health Team could be contacted via provider consultation line to support the practitioner in identifying next steps for appropriate care and treatment. KSKidsMAP will continue development of subsequent sections to the Pediatric Mental Health Toolkit prioritizing new topic sections based on emerging needs identified via case consultation requests and TeleECHO Clinic sessions. More information about this effort can be found in the Cross-Cutting narrative.

In support of best practice recommendations, Title V added several behavioral health screening forms to DAISEY, Title V's data collection system, to increase availability of evidence-based screenings to local MCH agencies in July 2021. While most behavioral health screening tools added are not validated for use with children under the age of 11, Title V did include both the parent and child versions of the Pediatric Symptom Checklist (PSC-17), which is validated for use with children, or caregivers of children, ages 4-16. The ASQ continues to be available for local MCH programs' use in DAISEY.

Guidance was published when the forms were added to DAISEY in July 2021. The guidance includes a 1-page overview of each screening tool and scripts for introducing the tools to a client, administering the screening, details on scoring the screen, determining risk-level, and appropriate interventions. Additionally, A Plan of Action form is populated in DAISEY for moderate or high-risk screening results. This form allows for local MCH staff to document that a brief intervention was conducted, the type of brief intervention provided, indicate referral(s) made, and summarize any emergency or support services initiated for a client experiencing a crisis.

PRIORITY 4: Adolescents and young adults have access to and utilize integrated, holistic, patient-centered care to support physical, social, and emotional health.

Domain: Adolescent Health

NPM 10: Adolescent well-visit (Percent of adolescents, 12 through 17, with a preventive medical visit in the past year)

ESM: Percent of adolescent program participants, 12 through 17, that had a well-visit during the past 12 months

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Local MCH Reach: During SFY2021, 38 of 67 grantees (56%) provided services to the Adolescent population.

The focus and activity around the Kansas Title V adolescent population has increased over the last several years. A greater emphasis on adolescent health in the past five years has helped Title V spread and scale work in the adolescent domain. As a result of the 2016 Adolescent Health Needs Assessment, Title V has addressed the disparities in the adolescent well visit through a variety of means including technical assistance focused on the components of a high-quality, comprehensive visit. Additionally, elevating the youth voice and intentionally providing opportunities for Kansas youth to play a role in activities within our objectives continues to be a Title V priority.

NPM 10: Adolescent well visit (percent of adolescents, 12-17, with a preventative medical visit in the past year)

ESM: Percent of adolescent program participants, 12 through 17, that had a well-visit during the past 12 months

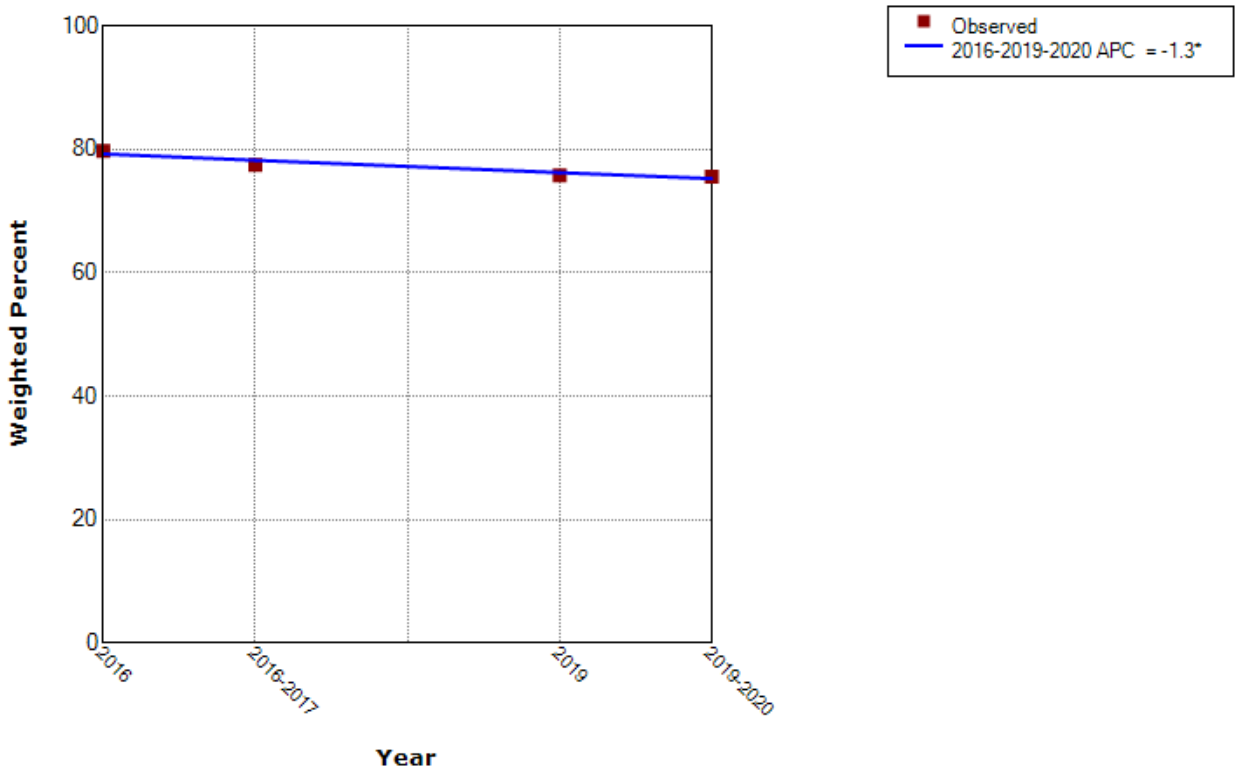
According to the 2019-2020 National Survey of Children's Health (two years combined), 75.6% of Kansas adolescents, 12-17 years of age, had a preventive medical visit in the past year (95% confidence interval [CI]: 69.3%-81.1%).

The percentage differed significantly by special health care needs status, whether the adolescent had a medical home, and the education level of an adult in the household. Among adolescents with special health care needs, 89.5% had received a preventive medical visit in the past year (95% CI: 82.9%-93.8%), compared to 70.4% among those without special health care needs (95% CI: 62.3%-77.3%). For adolescents whose care met the criteria for being a medical home, 84.1% had had a preventive visit in the past year (95% CI: 76.9%-89.4%), compared to only 66.4% of those whose care did not meet the criteria for being a medical home (95% CI: 56.0%-75.4%). Across adult education categories, the percentage of adolescents with a preventive medical visit in the past year was highest (83.2%) among those for whom an adult in the household reported having a college degree or higher education (95% CI: 76.4%-88.4%) – which was significantly higher than the estimate among those for whom an adult in the household reported that their highest level of education was a high school diploma or GED* (65.5%; 95% CI: 50.1%-78.2%).

* Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution.

From 2016 (one-year estimate) to 2019-2020 (two-year estimate), this indicator experienced a statistically significant decrease, with an annual percent change of -1.3% (95% CI: -2.5%, -0.01%). Note that due to a difference in wording for this indicator in 2018, data are not available for 2017-2018 or 2018-2019.

Weighted Percent of Kansas Adolescents, Ages 12-17, with a Preventive Medical Visit in the Past Year, 2016-2020†‡



* Indicates that the Annual Percent Change (APC) is significantly different from zero at the alpha = 0.05 level.
† After 2016, state-level estimates have been produced using two-year combined data. However, due to a difference in wording in the 2018 version of this question, data for 2017-2018 and 2018-2019 are not available.
‡ The 2019 estimate has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution.
Source: U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), National Survey of Children's Health (NSCH)

Objective: Increase the proportion of MCH Program participants, 12 through 17 years, receiving quality, comprehensive annual preventive services by 5% annually through 2025.

Bright Futures™: Often, a quality comprehensive annual preventive visit is not delivered, and insurance doesn't require documentation of all components reflected in the claim data for reimbursement. This results in care gaps for young adults. To address this issue, Title V continues to recommend that local MCH grantees adhere to the Bright Futures guidelines for preventive care/well visits for adolescents. Title V engaged with partners across the state including the Kansas American Academy of Pediatrics (KAAP), Kansas Academy of Family Physicians (KAFP), Immunize Kansas Coalition, and Medicaid to promote shared recommendations for health care professionals to utilize the guidelines, tools/resources, and anticipatory guidance.

Title V worked with state partners to assess the current messaging and screening policy to promote a stronger cross-sector recommendation. The goal of the policy and subsequent messaging is to ensure adolescents receive a comprehensive annual well visit that utilizes all elements of the Bright Futures guidelines. MCH funds were used to purchase a statewide license in 2019 for the most current edition of the Bright Futures Toolkit, eliminating cost as a barrier of conducting a complete and quality visit. The Child and Adolescent Health Consultant serves as the point of contact for this training for the state and provided technical assistance related to the use of the Bright Futures toolkit and materials. Targeted technical assistance was offered to MCH grantees that have identified adolescent well visits as an area for improvement. Guidance was provided on the following: marketing strategies for preventative well visits; providing simple low-cost ideas to create youth-friendly environments through tools created by the Adolescent Health Initiative; and supplying resources on how to incorporate appropriate procedures on transitioning youth, with and without special health care needs to adult care, starting at the age of 12. Evidence-based tools and resources through Got Transition, Bright Futures, and best practices from other states were reviewed and included as part of the technical assistance service. Read more about Title V's health care transition plans in the CSHCN Plan narrative.

Youth-Friendly Care: Title V used the youth-friendly care tools from the University of Michigan Adolescent Health Institute (AHI) to offer youth-friendly care quality improvement strategies to MCH agencies that were targeting services for adolescents. Technical assistance is offered to agencies individually, and as a cohort to support them in recognizing their goals to improve adolescent health measures; identify their status in meeting those goals; and identify steps to enhance, or improve, current policies and practices. The tools from AHI were provided which outline the different levels of providing youth-friendly care (e.g., SPARK trainings for staff meetings, Youth-led Health Center Assessment Tool, Creating and Sustaining a Youth Advisory Council, Adolescent-Centered Environment-Assessment Process, and Becoming an Adolescent Champion Model). With this guidance, MCH agencies are equipped to confidently and clearly state their goals and identify MCH funding needs.

Adolescent Well Visits for Youth with SHCN: The KS-SHCN program continues to provide holistic care coordination for youth and their parents/guardians and support increasing knowledge and understanding on the importance of receiving a comprehensive, annual well visit. Families of CSHCN experience more medical appointments than peers who do not have SHCN. It's not uncommon that the annual well visit is put as a lower priority, or lost amongst the specialist and therapy visits, however KS-SHCN is working with youth and families to increase understanding through education around how these visits can help maintain optimal health and well-being. If the youth does not have a primary care provider, the care coordinator helps identify one in the area who accepts new clients and is in-network with their insurance provider.

KS-SHCN Care Coordinators discuss future transitions and nurturing independence in children and youth early in the child's life, but request that the youth participate in the transition planning conversations on or before the youth reaches a developmental age of 12 years. Each youth over the age of 12 has at least one transition goal listed on their KS-SHCN Action Plan. Care coordinators assist the adolescent and family in a variety of ways to help them learn how to navigate the health system independently as an adult. Some things the care coordinators assist the adolescent with include: developing a list of questions and concerns to share during medical visits; developing and updating medication list; scheduling appointments and ensuring they work within the adolescent's schedule; filling out medical paperwork; understanding insurance; planning for co-pays; understanding their disability; and advocating for their needs. Based on their individual needs and action steps outlined in the Action Plan, Care coordinators provide applicable assistance and supports. Read more about the HCC model and KS-SHCN protocols in the CSHCN report/plan narratives.

Provider Trainings: Title V staff developed strategies to create a more robust and unified message around the importance of taking time with youth to conduct a full wellness check with appropriate screening recommendations from AAP and Bright Futures guidance. These checks should include assessing for additional supports, providing guidance on age appropriate preventative topics, building a relationship of dual trust and respect, and making the necessary referrals in a timely manner. KanBeHealthy (KBH) in-person trainings were not able to occur due to the COVID-19 pandemic. In response, KBH training materials have been updated and organized so that when trainings can be conducted in an in-person setting safely, the Bureau of Community Health Services staff and Title V will schedule and provide regional professional development on all of the components of a quality well-visit utilizing Bright Futures guidance.

Local MCH Agencies (including affiliated programs PMI/TPTCM): MCH agencies provide adolescent well visits and behavioral health screenings in accordance with recommendations, standards and guidelines. Smaller agencies that do not provide clinic-based services educate parents and adolescents about the importance of the well visit and refer them to their Family Planning clinic or local providers. MCH local agencies provided 721 adolescents with well visit education Local agency activities are highlighted below:

- Ten local health agencies with co-located MCH/TPTCM programs provide all adolescents served, and their children, early and periodic screenings and immunizations. In addition to ensuring pregnant adolescents receive prenatal medical care, TPTCM staff provide education regarding routine preventative well-visits annually, prevention of illness and injury, as well as information and referrals to related available healthcare resources in the community. Case managers use evidence-based approaches, including motivational interviewing. These skills are used to coach adolescents in developing goals related to education, employment or financial stability.
- *Barton County*: Screened all clients to determine if they have had an adolescent well visit in the past year. In addition, all clients are educated on the importance of annual well exams. The agency utilizes

social media, a digital sign outside the office, and newsletters to help promote the importance of well visits for this population.
- *Miami County*: Educates adolescents and young adults on the importance of annual well visits and the benefits of healthy lifestyle choices. All adolescent clients receive education from AAP Healthy Habits and physical activity resources.
- *Wyandotte County*: MCH staff provide anticipatory guidance recommended for each age-based visit which includes screenings, assessments, physical examinations, and educational information utilizing Bright Futures guidelines. Public health educators, specializing in adolescent/sexual health, meet with all adolescents one-on-one at the clinic to educate on the importance of annual preventative visits, birth control options, healthy relationships, and safety at home.

Peer to Peer Awareness Campaign: Kansas has made youth across the state equal partners in deciding what health topics are important to address. Youth driven efforts have resulted in a set of best practice marketing strategies that get critical health information and resources into the hands, phones, and minds of adolescents. The end product was the WHY (Whole Healthy You) campaign. The launch in the spring of 2021 was a success and Title V and the 60 partnering agencies continue to utilize the WHY campaign to bring attention to health awareness events and highlight portions of the Youth Health Guide throughout the year. A fall WHY campaign was launched for the back to school period in fall of 2021. Wallet-sized cards with a QR Code directing to the WHY website were made available for dissemination to participating schools, community mental health centers, health departments, pediatricians, and local youth clubs.

Behavioral Health Integration: Title V promotes the KSKidsMAP modified AAP algorithm for integrating mental health care into well-adolescent visits. This algorithm demonstrates how the Bright Futures behavioral health screening recommendations can be integrated into well visits, and highlights decision points in which the KSKidsMAP Pediatric Mental Health Care Team could be contacted via Consultation Line to support the practitioner in identifying next steps for appropriate care and treatment. The algorithm (below) and support materials serve as a reminder of the recommended components of a well child/adolescent visit, increase the identification of those exhibiting signs and/or symptoms, strengthen the quality of the visit, and enhance treatment mechanisms of children and adolescents with behavioral health concerns. More information about KSKidsMAP can be found in the Child and Cross-Cutting Reports.

Other Adolescent Health Activities

Objective: Increase the proportion of adolescents and young adults that have knowledge of and access to quality health and positive lifestyle information, prevention resources, intervention services, and supports from peers and caring adults by 10% by 2025.

Youth Health Guide: During FY21, adolescent focus groups provided data on topics youth and young adults were most interested in learning more about. One topic noted was the need for reputable and quality information, rather than taking their chances searching for information on the internet. Eight major themes emerged from the focus group data analysis: healthy eating, fitness, mental wellness, substance use prevention, managing stress, technology and social media use, healthy relationships, and well visits and transitioning to adult care. The *Youth Health Guide* provides vetted information on these topics and are an integral part of the back to school 2021 WHY campaign efforts. This resource continues to be promoted by Title V staff and incorporated to training and technical assistance, where applicable.

Awareness of 2-1-1 and 1-800-CHILDREN: Kansas youth indicated during the Needs Assessment process that they are not always aware of all the community resources that are available. Title V work to learn the extent youth and young adults in the state are aware of resources that can link them to community service organizations such as 2-1-1 and 1-800-CHILDREN. The Adolescent Health Consultant connected youth from across the state with staff from Kansas Children's Service League, the 1-800-CHILDREN helpline, and 2-1-1 representatives to begin brainstorming ideas on how to build awareness about the statewide resource directory for the adolescent population.

Awareness of Community Services: As adolescents learn to be more independent, knowing what community services and resources are available to them can be a daunting and overwhelming task. Title V is commited to making sure youth know where to go if they need assistance in navigating adulthood and the responsibilities that go along with transitioning into the adult stage of life. The following strategies assist with this effort:

Teen Pregnancy Targeted Case Management (TPTCM): In FY21, eleven local agencies across the state provided services to an estimated 384 KanCare-eligible pregnant and/or parenting adolescents through the TPTCM program. Program goals are to: reduce negative consequences of teen pregnancy for KanCare-enrolled teens and their children, increase levels of self-sufficiency; support youth-directed goal-setting for their and their children's futures; expand education/training opportunities; and support youth-defined successes prior to subsequent pregnancies or until they reach 21 years of age. Ten of the TPTCM lead agencies also serve as the local MCH agency. The co-location of both MCH and TPTCM within a local agency increases opportunities to collaborate to ensure adolescents receive coordinated care and support across programs.

> ***TPTCM Client Story:***
>
> *Unified Government of Wyandotte County*
> *Sarah (name changed to protect client confidentiality) enrolled into the TPTCM program in January during the first trimester of her pregnancy at the Wyandotte Health Department. This teen mom was interested in learning about her pregnancy and needed additional support and resources outside of her OB/GYN doctor. Each time the case manager meets with Sarah, they discussed how she was doing with her pregnancy and covered a topic like breastfeeding, infant care, and common discomforts during pregnancy. The case manager provided support and resources to Sarah and listened to her concerns about being a teen parent and finishing high school in a nonjudgmental way. The case manager was glad to receive this feedback from Sarah: " You help me during the pregnancy and understanding things that are very important, so I won't be scared when it happens, you help me out with any questions that come up randomly and find care. You also checked up on me when I felt alone, and you still checked on me when things got better."*

Systems Navigation Trainings & Transition: Youth with SHCN will continue to be encouraged to participate in the *Systems Navigation Trainings* held by the KS-SHCN Program. Covering a wide variety of topics such as: communicating with providers; self-care; transition; advocacy; and local resources. Youth will be encouraged to participate in leadership programs such as the Kansas Youth Leadership Forum (YLF) and the Faces of Change program offered by the Kansas Youth Empowerment Academy, and transition workshops conducted by Families Together, Inc..

Objective: Increase the number of local health agencies and providers serving adolescents and young adults that screen, provide brief intervention and refer to treatment for those at risk of experiencing behavioral health conditions by 5% by 2025.

Title V continued efforts to increase provider education and utilization of the evidence-based process *screening, brief intervention, and referral to treatment (SBIRT)*. To further support the integration of behavioral health SBIRT into pediatric primary care settings and well-adolescent visits, Title V promotes the modified AAP algorithm developed by KSKidsMAP (as previously mentioned in this section). The KSKidsMAP Pediatric Mental Health Team also began developing a Pediatric Mental Health Toolkit for practitioners that will cover the SBIRT process for several mental health conditions/concerns. Each section of the Toolkit is focused on different topics, but all sections include the same core components: using screening tools; first line treatment and interventions; monitoring, follow-up, referrals; and, brief interventions. Each section includes a written summary report, as well as video recordings of didactic training. Planned Toolkit sections include: depression, anxiety, ADHD, and suicide prevention. Additional topics will be added based on types of inquiries received through the Consultation Line and/or during TeleECHO Clinic sessions. Once finalized, each Pediatric Mental Health Toolkit section will be published on the MCH Integration Toolkits page. More information about KSKidsMAP is available in the Cross-Cutting Report.

In July 2021, Title V added behavioral health screening forms to DAISEY, Title V's data collection system, to increase availability of evidence-based screenings to local MCH agencies. Title V published behavioral health

screening tools guidance that includes a framework for administering behavioral health screenings (e.g., selecting a validated screening tool for the population, preparing your agency, establishing and formalizing a local system of care), support resources, and a 1-page overview of each behavioral health screening tool available in DAISEY:

- CRAFFT – Substance Use, Ages 11-21
- Generalized Anxiety Disorder (GAD-7) - Anxiety, Ages 12+
- Patient Health Questionnaire (PHQ-9) - Depression, Ages 11+
- PHQ Modified for Adolescents (PHQ-A) - Depression, Ages 11-17
- Pediatric Symptom Checklist (PSC-17) - General Mental Health Screening, Ages 4-16

Title V staff added three questions to the DAISEY Services Form: *Was an anxiety/depression/substance use screening administered?* Question responses, as well as screening results and plan of action form responses, are reviewed and used to identify any training or technical assistance needs. See the Cross-Cutting Report for more information about these screening tools and subsequent guidance published for local programs.

Title V Health Consultants are partnering with Wichita State University's Community Engagement Institute (WSU-CEI) to create additional SBIRT resources focusing on adolescent substance use. During this reporting period, WSU-CEI began work to: a) customize a SBIRT 101 Resource Guide and Adolescent Substance Use Toolkit based on nationally recognized evidence-based resources, AAP/Bright Futures™ recommendations, Kansas-approved SBIRT trainings, organizational policies and procedure development and implementation guidance; and b) present the new adolescent SBIRT resources to the MCH grantees during the Third Thursday Webinar series session in November 2021. Once finalized, the SBIRT 101 Resource Guide and Adolescent Substance Use Toolkit will be published on the MCH Integration Toolkits page.

Youth-Driven/Centered Approaches: Increasing youth voice related to planning to address youth mental health across the state is a top priority. A statewide youth suicide prevention art contest was conducted Spring 2021. KDHE created a press release and posted social media messaging to encourage youth in grades 6-12 to use any creative medium that resonates with how they express themselves and communicates a message of hope and healing. Each of the 29 participants received a swag bag and sunglasses with the hashtag #WeAretheHopeful! WHY campaign frisbees and electronic decal stickers, a certificate signed by KDHE Secretary Dr. Lee Norman and Department for Children and Families/Department of Aging and Disability Services Secretary Laura Howard. A letter of thanks was also included and signed by Governor Laura Kelly (see picture at right with items). All submissions are available for viewing on the Kansas Suicide Prevention Headquarters and can be used by any state or local organization for youth suicide prevention awareness purposes.

Cross-agency Collaboration for Improved Adolescent Health & Well-Being: Highly collaborative, ongoing work across agencies and systems will specifically assist with the creation of a unified cross-agency standardized list of best practices to be disseminated to health care providers, community mental health centers (CMHCs), schools, and community youth-serving organizations to support whole adolescent health in their communities. Title V is also working to improve partnerships with the Kansas Department for Children and Families (DCF) and Kansas Department of Corrections' Juvenile Justice Services, specifically to engage youth in the child welfare and/or corrections systems in MCH programs. With the upcoming initiation of the Family First Program

in the state, DCF is as a critical partner to improve programming for youth and adolescents at the community level.

Suicide Prevention: The KMCHC designed two series of social media posts based on the #BeThe1To's - 5 Action Steps for Helping Someone in Crisis. One series targets adults and the other adolescents; however, both have the same message: "Be the one to help save a life." These messages were promoted via social media during Suicide Prevention (September) and Mental Health Awareness (May) months. In addition, Title V staff participate as members of the Kansas Suicide Prevention Coalition and the Maternal Mortality Review Committee, both of which focus on causes, and prevention, of youth suicide.

In partnership with the Kansas Division of Emergency Management, KDADS, and the Kansas Department of Agriculture, Title V played a lead role in securing FEMA crisis counseling program funds and creating a Crisis and Counseling Toolkit during the COVID-19 response—these resources apply to any crisis, related or unrelated to the pandemic. Read the July 2, 2020, press release and access the Kansas: Stronger Together resources online. Title V continues promoting the information to increase awareness of available crisis supports and services. The Toolkit includes three sections:

- *Kansas Crisis & Counseling Services*: Overview of crisis services and supports (e.g., helplines and CMHC crisis services)
- *Kansas Hotlines & Helplines*: 1-page snapshot of the COVID-19 hotlines, crisis helplines, other resources/support lines, and medical provider consultation lines
- *Resource Guide*: Directory of resources, information, and other toolkits (Note: The linked toolkits offer self-help tips and ideas for maintaining positive mental wellbeing during COVID-19. Subsections of the Resource Guide include: COVID-19, Mental Health, Substance Use, Anti-Violence, and Parenting Resources.)

Kansas Maternal and Child Health Council (KMCHC) Listening Session: During the KMCHC held in July of 2021, Title V staff facilitated a session with council members and stakeholders regarding the mental health impacts of screen time on children and adolescents. Topics of discussion included the need for realistic guidance for parents relating to screen time usage as well as an overview of available screen time monitoring/management tools and tips for parents of young children and adolescents.

2023 ADOLECENT HEALTH APPLICATION PLANS

PRIORITY 4: Adolescents and young adults have access to and utilize integrated, holistic, patient-centered care to support physical, social, and emotional health.

NPM 10: Adolescent well visit (percent of adolescents, 12-17, with a preventative medical visit in the past year)

Local MCH Reach: Based on SFY2023 MCH Aid-to-Local applications received:

- 25 of 55 grantees (45%) plan to provide services to the Adolescent population.17 of 25 (68%) grantees plan to provide quality, comprehensive annual preventive services
- 16 of 25 (64%) grantees plan to provide education and access to quality health and positive lifestyle information, prevention resources, intervention services, and supports from peers and caring adults
- 15 of 25 (60%) grantees plan to screen, provide brief intervention and refer to treatment those at risk of experiencing behavioral health conditions

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Objective: Increase the proportion of MCH Program participants, 12 through 17 years, receiving quality, comprehensive annual preventive services by 5% annually through 2025.

Bright Futures™: Often, a quality comprehensive annual preventive visit is not delivered, and insurance doesn't require documentation of all components reflected in the claim data for reimbursement. This results in care gaps for young adults. To address this issue, Title V continues to recommend that local MCH grantees adhere to the Bright Futures guidelines for preventive care/well visits for adolescents. Title V will continue state-level

partnerships and will engage the Kansas American Academy of Pediatrics (KAAP), Kansas Academy of Family Physicians (KAFP), Immunize Kansas Coalition, and Medicaid to promote shared recommendations for health care professionals to utilize the guidelines, tools/resources, and anticipatory guidance.

Title V will reach out to state partners to assess the current messaging and screening policy to promote a stronger cross-sector recommendation. The goal of the policy and subsequent messaging is to ensure adolescents receive a comprehensive annual well visit that utilizes all elements of the Bright Futures guidelines. MCH funds were used to purchase a statewide license in 2019 for the most current edition of the Bright Futures Toolkit, eliminating cost as a barrier of conducting a complete and quality visit. The Child and Adolescent Health Consultant is the point of contact for this training for the state and is available for any and all questions or requests for technical assistance related to the use of the Bright Futures toolkit and materials. Additional targeted technical assistance will be offered to MCH grantees that have identified adolescent well visits as an area for improvement. Guidance will be provided on the following: marketing strategies for preventative well visits; providing simple low-cost ideas to create youth-friendly environments through tools created by the Adolescent Health Initiative; and supplying resources on how to incorporate appropriate procedures on transitioning youth, with and without special health care needs to adult care, starting at the age of 12. Evidence-based tools and resources through Got Transition, Bright Futures, and best practices from other states will be reviewed and included as part of the technical assistance service. Read more about Title V's health care transition plans in the CSHCN Plan narrative.

Youth-Friendly Care: Title V will use the youth-friendly care tools from the University of Michigan Adolescent Health Institute (AHI) to offer youth-friendly care quality improvement strategies to MCH agencies that are targeting adolescents. Technical assistance will be offered to agencies individually, and as a cohort to support them in recognizing their goals to improve adolescent health measures; identify their status in meeting those goals; and identify steps to enhance, or improve, current policies and practices. The tools from AHI will be laid out in a chart depicting the different levels of providing youth-friendly care (e.g., SPARK trainings for staff meetings, Youth-led Health Center Assessment Tool, Creating and Sustaining a Youth Advisory Council, Adolescent-Centered Environment-Assessment Process, and Becoming an Adolescent Champion Model). With this guidance, MCH agencies will be equipped to confidently and clearly state their goals and identify MCH funding needs. During future Governor's Public Health Conferences, agencies and community youth will be recognized for their role in raising the level of youth-friendly care and reaching improvement milestones.

Adolescent Well-Visits for Youth with SHCN: The KS-SHCN program continues to provide holistic care coordination for youth and their parents/guardians and support increasing knowledge and understanding on the importance of receiving a comprehensive, annual well visit. Families of CSHCN experience more medical appointments than peers who do not have SHCN. It's not uncommon that the annual well visit is put as a lower priority, or lost amongst the specialist and therapy visits, however KS-SHCN is working with youth and families to increase understanding through education around how these visits can help maintain optimal health and well-being. If the youth does not have a primary care provider, the care coordinator will help identify one in the area who accepts new clients and is in-network with their insurance provider. For those on the KS-SHCN program who do not have insurance, one well visit appointment is provided in accordance with Bright Future recommendations.

KS-SHCN Care Coordinators discuss future transitions and nurturing independence in children and youth early in the child's life, but request that the youth participate in the transition planning conversations on or before the youth reaches a developmental age of 12 years. Each youth over the age of 12 will have at least one transition goal listed on their KS-SHCN Action Plan. Care coordinators assist the adolescent and family in a variety of ways to help them learn how to navigate the health system independently as an adult. Some things the care coordinators might assist the adolescent with includes: developing a list of questions and concerns to share during medical visits; developing and updating medication list; scheduling appointments and ensuring they work within the adolescent's schedule; filling out medical paperwork; understanding insurance; planning for co-pays; understanding their disability; and advocating for their needs. Based on their individual needs and action steps outlined in the Action Plan, Care coordinators will provide applicable assistance and supports. Read more about the HCC model and KS-SHCN protocols in the CSHCN report/plan narratives.

The KS-SHCN team will be developing and implementing a new Transition Direct Assistance Program (TR - DAP) over the coming months. All adolescents who meet medical and financial eligibility for the KS_SHCN program will receive this as one of their DAPS. This will allow the program to strengthen the supports the care coordinators are able to provide by giving more choice to adolescents and their families in choosing an adult medical provider, supporting quality patient transfer of care between pediatric providers and adult providers, and offering incentivized training modules for youth on a variety of transition topics. While the TR-DAP will only be offer to adolescents on the KS-SHCN program the modules will be made available to all youth across that state who would like assistance in transition planning. Information will be shared with all MCH grantees to pass on to the adolescents they are working with. For more information on the TR-DAP go to the Special Health Care Needs Plan Narrative.

Provider Trainings: Discussions will occur on strategies to create a more robust and unified message around the importance of taking time with youth to conduct a full wellness check with appropriate screening recommendations from AAP and Bright Futures guidance. These checks should include assessing for additional supports, providing guidance on age-appropriate preventative topics, building a relationship of dual trust and respect, and making the necessary referrals in a timely manner. KanBeHealthy (KBH) in-person trainings were not able to occur due to the COVID-19 pandemic. In response, KBH training materials have been updated and organized so that when trainings can be conducted in an in-person setting safely, the Bureau of Community Health Services staff and Title V will schedule and provide regional professional development on all the components of a quality well-visit utilizing Bright Futures guidance.

Local MCH Agencies: MCH agencies will continue to provide adolescent well visits and behavioral health screenings in accordance with recommendations, standards and guidelines. Smaller agencies that do not provide clinic-based services will educate parents and adolescents about the importance of the well visit and refer them to their Family Planning clinic or local providers. Title V MCH and KS-SHCN staff will create a discussion board on the MCH Workstation to receive feedback and address technical assistance needs.

- *CareArc:* Will increase the percentage of adolescent patient base with a well visit in the last year from 77% to 85%. They will instruct clinical staff and schedulers to discuss the importance of preventative care starting at an early age and continuing throughout the life span. They will market their extended hours, providers, and benefits of becoming a medical patient (such as sliding fee scale discounts) on social media.
- Unified Government of Kansas City Kansas and Wyandotte County Health Department: The goal of the UGPHD is to increase the proportion of adolescents ages 12-22 who have had a well visit in the past 12 months by implementing portions of the Bright Futures guidelines which includes a physical examination, discussion of health-related behaviors, and immunizations in SFY 2023. Another goal of the UGPHD is to increase the percentage of adolescents in Wyandotte County that receive comprehensive preventive health care that addresses social and emotional aspects of health. This is promoted through collaborations with schools, community partners, and health care providers. The overall goal of the UGPHD is to build partnerships and strengthen capacity to address adolescent health from a resiliency and strength-based approach, and to empower youth to choose not to engage in risky behaviors. The UGPHD seeks to facilitate discussion of multiple health-related topics, including healthy eating, physical activity, substance use, sexual behavior, and violence in adolescents as part of the well adolescent visit.

Behavioral Health Integration: Title V will continue to promote the KSKidsMAP modified AAP algorithm for integrating pediatric mental health into well-adolescent visits. This algorithm demonstrates how the Bright Futures behavioral health screening recommendations can be integrated into well-visits, and highlights decision points in which the KSKidsMAP Pediatric Mental Health Team could be contacted via provider consultation line to support the practitioner in identifying next steps for appropriate care and treatment. KSKidsMAP will continue development of subsequent sections to the Pediatric Mental Health Toolkit prioritizing new topic sections based on emerging needs identified via case consultation requests and TeleECHO Clinic sessions. More information about this effort can be found in the Cross-Cutting narrative.

Other Adolescent Health Activities

Objective: Increase the proportion of adolescents and young adults that have knowledge of and access to quality health and positive lifestyle information, prevention resources, intervention services, and supports from peers and caring adults by 10% by 2025.

Awareness of 2-1-1 and 1-800-CHILDREN: Kansas youth indicated during the Needs Assessment process that they are not always aware of all the community resources that are available. Title V will work to learn the extent youth and young adults in the state are aware of resources that can link them to community service organizations such as 2-1-1 and 1-800-CHILDREN. The Adolescent Health Consultant will convene youth from across the state with staff from Kansas Children's Service League, the 1-800-CHILDREN helpline, and 2-1-1 representatives to begin brainstorming ideas on how to build awareness about the statewide resource directory for the adolescent population.

Youth Transition Booklets: Several years ago the Family Advisory Council (FAC) created a series of transition planning booklets called *The Future is Now, THINK BIG!! Preparing for Transition Planning*. There are three booklets available in English and Spanish that incldue a booklet for youth/young adults ages 14 to 19 years. The booklet consists of an easy-to-use checklist on: Self-advocacy; Health & Wellness; Healthcare System; Social & Recreation, Independent Living Skills; and School & Work. The KS-SHCN program will request FAC assistance in reviewing these transition booklets to determine if updates or additions are needed, or if they could be more appealing to end consumers. Feedback and suggestions for improving the transition booklets will be solicited thorugh the SHCN FAC work group, the Adolescent FAC workgroup, and the partners listed above through an evaluation survey. Modifications and updates will be made as indicated by the evaluation and revised transition booklets will be made available when the product is finalized.

Title V will continue partnering with school pofessionals such as school nurses and special education directors in supplying materials to disseminate transition booklets to families at events such as school enrollment, orientation, and IEP meetings. Other statewide programs such as Part C/tiny-k, the Early Childhood State Directors Team, KAAP, KAFP, Kansas MCOs, and the Community Care Network of Kansas (CCN) who provide training, technical assistance, and guidance to federally qualified health centers will receive a sample of the tranisition booklets with an order form and return envelope to express interest in receiving this resource for their clients. KS-SHCN Care Coordinators will continue to use this booklet to help adolescents with transition discussions and the adolescents in developing goals and objectives for their Action Plan. Youth without disabilities or special health care needs can utilize these as well and it is desired to convene a group of adolesecents and families to revise these booklets to be inclusive for all youth and prepare them for adulthood.

Life Skills Community-Based Education: The youth focus groups revealed a need for life skills education and a greater understanding about developmentally appropriate risk-taking vs. risky behaviors that could negatively impact youth lives. Initial planning was underway, but is now paused due to the Child/Adolescent Health Consultant position vacancy. Once a qualified candidate is identified and completes onboarding/training, they will review progress, reasses needs, and determine opportunities to reengage system partners on this project. Prior to personnel changes, it was Title V's intent to partner with the foster care and juvenile justice agencies to discern what current educational offerings are available for adolscents at risk. Upon completion of the environmental scan analysis, Title V will engage youth and young adults who are currently or have previously been served by these programs and document any gaps on topics that youth wish to learn about (e.g., budgeting, independent living skills, furthering education, gaining employment, stress management, healthy relationships). Subject matter experts across the state will work together to build a curriculum that will meet the needs of youth. Title V will work to identify a community in which to pilot these skills building sessions in the coming years.

Awareness of Community Services: As adolescents learn to be more independent, knowing what community services and resources are available to them can be a daunting and overwhelming task. Title V is commited to making sure youth know where to go if they need assistance in navigating adulthood and the responsibilities that go along with transitioning into the adult stage of life. The following strategies will assist with this effort:

- The KS-SHCN program will be partnering with a college Intern in the creation of a Systems Navigation Training for Adolescent (SNTA) based on the Systems Navigation training for Families. By having the

curriculum and interactive activities developed by adolescents/young adults it will cover key topics and, in a language/format that youth will find engaging and helpful. While much of the curriculum will be generic for all youth, there will be key components developed for those with special health care needs. This training will be open to all adolescents in Kansas. Not only will this training be developed by adolescents/young adults but a train the trainer model, mirrored from the family training model, will be developed and implemented based on the recommendation from the intern and adolescent/young adult developers. For more detail on SNTA go to the Special Health Care Needs Plan Narrative.

- Youth with special health care needs will be encouraged by the KS-SHCN care coordinators to participate in leadership programs such as the Kansas Youth Leadership Forum (YLF) and the Faces of Change program offered by the Kansas Youth Empowerment Academy, and transition workshops conducted by Families Together, Inc..

Local MCH Agencies:

- Unified Government of Wyandotte County and Kansas City, KS (UGPHD) will increase the number of adolescents in the county receiving the recommended childhood immunization schedule as to minimize the risk of a serious infectious diseases. These include COVID, Meningococcal, Tdap, Influenza, and HPV. UGPHD will promote the availability of free vaccines through the Vaccines for Children Program (VFC) and MERCK Patient Assistance Program for HPV vaccine. The school nurse will notify parents which vaccines their child needs, with the hours and location of the UGPHD immunization clinic. The immunization staff will also set up back-to-school events offering childhood vaccines at different locations throughout Wyandotte County. This includes clinic times late in the day to accommodate working parents, and at least one back-to-school event on a Saturday. Another way UGPHD will break down barriers to getting the vaccine is to offer free transportation. UGPHD will work with Sunflower Health Care Plan who serves members of KanCare Medicaid. Sunflower shares a list of members who reside in Wyandotte County and currently need one or more immunizations. The UGPHD immunization staff will contact the families to help them get the adolescents up-to-date on their immunizations.

Objective: Increase the number of local health agencies and providers serving adolescents and young adults that screen, provide brief intervention and refer to treatment for those at risk of experiencing behavioral health conditions by 5% by 2025.

Title V will continue their efforts to increase provider education and utilization of the evidence-based process *screening, brief intervention, and referral to treatment (SBIRT)*. To further support the integration of behavioral health SBIRT into pediatric primary care settings and well-adolescent visits, Title V will continue to promote the modified AAP algorithm developed by KSKidsMAP (Kansas' pediatric mental health care access program for primary care physicians and clinicians; more details found in the Cross-Cutting Plan). KSKidsMAP also developed a Pediatric Mental Health Toolkit for providers that will cover the SBIRT process for several mental health conditions. Each section of the Toolkit focuseson a different mental health topic, but all sections include the same core components: using screening tools; first line treatment and interventions; monitoring, follow-up, referrals; and, brief interventions. Additional topics will continue to be added to the Toolkit based on types of inquiries received through the KSKidsMAP provider consultation line and in the TeleECHO Clinic.
Three behavioral health pre-screeners will be added to the DAISEY MCH Service Form in July 2022 to further support universal screening and early identification practices. Local programs will administer the pre-screens at every MCH visit. Guidance and workflows will be developed to address appropriate next steps based on responses to pre-screen questions. The three pre-screeners are:

- Generalized Anxiety Disorder-2 (GAD-2) - Anxiety
- Patient Health Questionnaire-2 (PHQ-2) – Depression
- NIDA Quick Screen – Substance Use (alcohol, tobacco, prescription drugs for non-medical reasons and illegal drugs)

Title V Consultants are partnering with Wichita State University's Community Engagement Institute (WSU-CEI) to create additional SBIRT resources focusing on adolescent behavioral health. During this reporting period, WSU-CEI will: a) customize a SBIRT 101 Resource Guide and Toolkit for the adolescent population based on nationally recognized evidence-based resources, AAP/Bright Futures™ recommendations, Kansas-approved SBIRT trainings, organizational policies and procedure development and implementation guidance among other items.

Suicide Prevention: The KMCHC designed two series of social media posts based on the #BeThe1To's - 5 Action Steps for Helping Someone in Crisis. One series targets adults and the other adolescents; however, both have the same message: "Be the one to help save a life." These images/resources are available on the KMCHC website. Increased promotion of the images will occur during Suicide Prevention (September) and Mental Health Awareness (May) months.

In partnership with the Kansas Division of Emergency Management, KDADS, and the Kansas Department of Agriculture, Title V played a lead role in securing FEMA crisis counseling program funds and creating a Crisis and Counseling Toolkit during the COVID-19 response—these resources apply to any crisis, related or unrelated to the pandemic. Read the July 2, 2020, press release and access the Kansas: Stronger Together resources online. Title V will continue promoting the information to increase awareness of available crisis supports and services. The Toolkit includes three sections:

- *Kansas Crisis & Counseling Services*: Overview of crisis services and supports (e.g., helplines and CMHC crisis services)
- *Kansas Hotlines & Helplines*: 1-page snapshot of the COVID-19 hotlines, crisis helplines, other resources/support lines, and medical provider consultation lines
- *Resource Guide*: Directory of resources, information, and other toolkits (Note: The linked toolkits offer self-help tips and ideas for maintaining positive mental wellbeing during COVID-19. Subsections of the Resource Guide include: COVID-19, Mental Health, Substance Use, Anti-Violence, and Parenting Resources.)

Local MCH Agencies:

- *Community Health Center of Southeast Kansas (CHC-SEK)* will continue to identify adolescents in need of behavioral health services -- a growing concern in the aftermath of COVID – by completing all screening for depression, SUD, etc. during routine medical exams with referral to a behavioral health consultant, if needed; and ongoing follow up until formally resolved. *Incorporation of an on-line screening tool on our website for self-identification for depression with follow up available; *Promotion of adolescent-targeted applications for managing depression or anxiety in-clinic and through social media; Immediate access to medication management through our Psychiatry Department; and the availability of no cost medications; targeted smoking cessation activities/resources for adolescents coming to clinics and served by CHC/SEK in their districts; Working with School Nurses/School Behavioral Health staff; created an adolescent-age advisory group; pilot an evidence-based initiative focused on improving self-esteem/self-image in USD #250; the opening of at three additional school-based health centers; expansion of health services to local community colleges including medical and behavioral health; additional expansion of behavioral health services (counselors) through direct contracts with districts; continued contracting with Greenbush Educational Center for crisis-response to area school districts (e.g. counseling following death of a student).
- *Riley County Health Department* will ensure all MCH adolescent clients receive SBIRT for behavioral health needs by assuring the following:
    - All MCH staff will be trained in SBIRT and review the MCH policy and procedures for screening and referring as well as review the MCH mental health crisis intervention plan.
    - MCH will partner with KSU Family Center to provide onsite student therapy services at no cost to adolescent clients.
    - MCH will explore resources for adolescent mental health services and support groups and make referrals as needed.
    - MCH will create social media posts to bring awareness to adolescent mental health. Mental health educational materials will be shared with all adolescent clients.
    - MCH staff will be trained in Mental Health First Aid, as available.
    - MCH staff will use the PASS tool on adolescent clients, as needed.
    - Clinic staff will screen adolescents for behavioral health risk factors and refer, as necessary.

PRIORITY 5: Communities, families, and providers have the knowledge, skills, and comfort to support transitions and empowerment opportunities.

Domain: Children with Special Health Care Needs

NPM 12: Transition (Percent of adolescents with and without special health care needs, ages 12-17, who received services necessary to make transition to adult health care)

ESM: Percent of youth with special health care needs, ages 12 to 21, who have one or more transition goals achieved on their action plan by the target completion date

2021 CHILDREN WITH SPECIAL HEALTH CARE NEEDS ANNUAL REPORT

MCH Local Reach: During SFY2021, 11 of 67 grantees (16%) provided services to the children with special health care needs population; 8 agencies served as Satellite Offices for the Kansas Special Health Care Needs Program.

The Title V program, within the Bureau of Family Health, has authority and provides guidance for services for children with special health care needs (CSHCN), pursuant to Kansas Statute (K.S.A. 65-5a01, et seq). The Kansas Special Health Care Needs (KS-SHCN) program must meet certain expectations to provide medical treatment services to families with defined and limited diagnoses and disabilities. However, it should be noted that programmatic activities align with Title V requirements, recommendations, and guidance to engage as a key stakeholder and catalyst for improving systems of care for all CSHCN. The vision in Kansas spans far beyond the state mandate for services and aims to assess and address needs of all CSHCN through quality improvement and evaluation to advance sustainable and systemic changes.

The KS-SHCN program provides services to children and youth birth to age 21 with eligible medical conditions. The program provides care coordination and financial assistance and support to approximately 1440 individuals with special health care needs and their families. The program saw a increase in the numbers of families served in SFY 2021, which was surprising, due to the COVID-19 pandemic, as families were fearful of taking their child into clinical settings, unless absolutely necessary. We believe this growth was due to the program ensuring that medical specialty services were accessible through external partnerships and contracts to provide diagnostic evaluations, authorization changes to make sure clients were able to access medication/medical supplies in 3 month amounts and by providing 30 day emergency supplies for metabolic formula for clients with PKU or MSUD. Families who were fearful of in-person medical appointments were encouraged and supported by the KS-SHCN staff in utilizing telehealth services to meet their child's medical needs as an alternate option to in-person appointments. Additional information about the program, including the eligible medical conditions (per KS Statute), is available on the website. The term "children with special health care needs" (CSHCN) will be utilized to refer to the general population as defined by Title V, as compared to the population served directly through KS-SHCN as determined by program eligibility.

The KS-SHCN staff were pleasantly surprised by the increase in the number of families served during FY21, since it was feared that due to COVID-19 increases and to a change in the KS-SHCN program's funding to special projects and clinics there would be a decrease vs. and increase. Over the last few years program staff worked with several contractors to identify and implement sustainability plans to ensure programs were able to continue with services without funding or reduced funding from the SHCN program. The program staff also closely evaluated how the grantees were utilizing funding and discontinued funding on projects that were not shown to be cost effective. Strengths, effectiveness and need for the special health care needs population now drive what will be funded. Some funded projects are short term, 3-5 years, and are able to bill for services or seek additional funding sources based on data collected, while others receive on-going funding based on the services (e.g., Medically complex clinic, Cerebral Palsy Research Foundation) they provide and the high needs of the CSHCN population. It is the goal of the SHCN program to increase the number of clients serviced by the program by 5% annual.

Aligned and expanded from the 2020 Title V Needs Assessment and State Action Plan (SAP), the KS-SHCN Action Plan implementation continued and while some activities have not been fully completed others, such as holistic care coordination, continue to be expanded to new and higher levels to reach not only children with special needs, but all children in Kansas. . The full KS-SHCN Action Plan can be found as Appendix A of the State Plan for Systems of Care for CSHCN. As a critical component to the work of the program, KS-SHCN priorities and strategies are assessed each year by the Family Advisory Council (FAC) to monitor progress and make recommendations as needed. Each year the KS-SHCN staff review both the Title V State Action Plan and the KS-SHCN Action Plan to monitor progress, assure alignment between plans and strategize next activities/steps to be completed, while incorporating in recommendation from the FAC.

Families continue to express the need for ongoing assistance with both medical and non-medical needs that support them with meeting their most critical health concerns. The program regularly reviews funding and support for direct services, including multi-disciplinary clinics, and makes modifications as needed. One such change that occurred in the last couple of years includes coverage for those with metabolic or genetic conditions screened through the newborn screen. While historically the program has covered persons of all ages with these conditions, the program made the difficult decision to change the eligibility criteria for these conditions to match the same age eligibility as others on the program. This means that as of October 1, 2020 the program no longer accepted new applications for those past their 21st birthday for individuals with these conditions, with the exception of applicants who are requesting metabolic formula assistance only for Phenylketonuria or Maple Syrup Urine Disease (per Kansas Statute K.S.A. 65-180). Exceptions were made for those over 21 years of age with genetic/metabolic conditions who had been on the program before this change. They were grandfathered in and allowed to continue the program with support from state funds, but only if they maintain their active program status. This means that they must submit their yearly renewal application on or before their next birthday and meet program eligibility criteria. This change provides the capacity for the program to focus on the child population, first and foremost, and allow for the expanded care coordination and service delivery the program hopes to achieve. As the program strives to focus on the overall system of care for CSHCN, rather than direct service delivery, and expand the ability to better understand the needs of the CSHCN from a population health perspective, difficult (albeit necessary) decisions are anticipated that will increase the program's ability to put more focus on the infrastructure component of the MCH pyramid.

KS-SHCN Infrastructure and Program Activities/Services

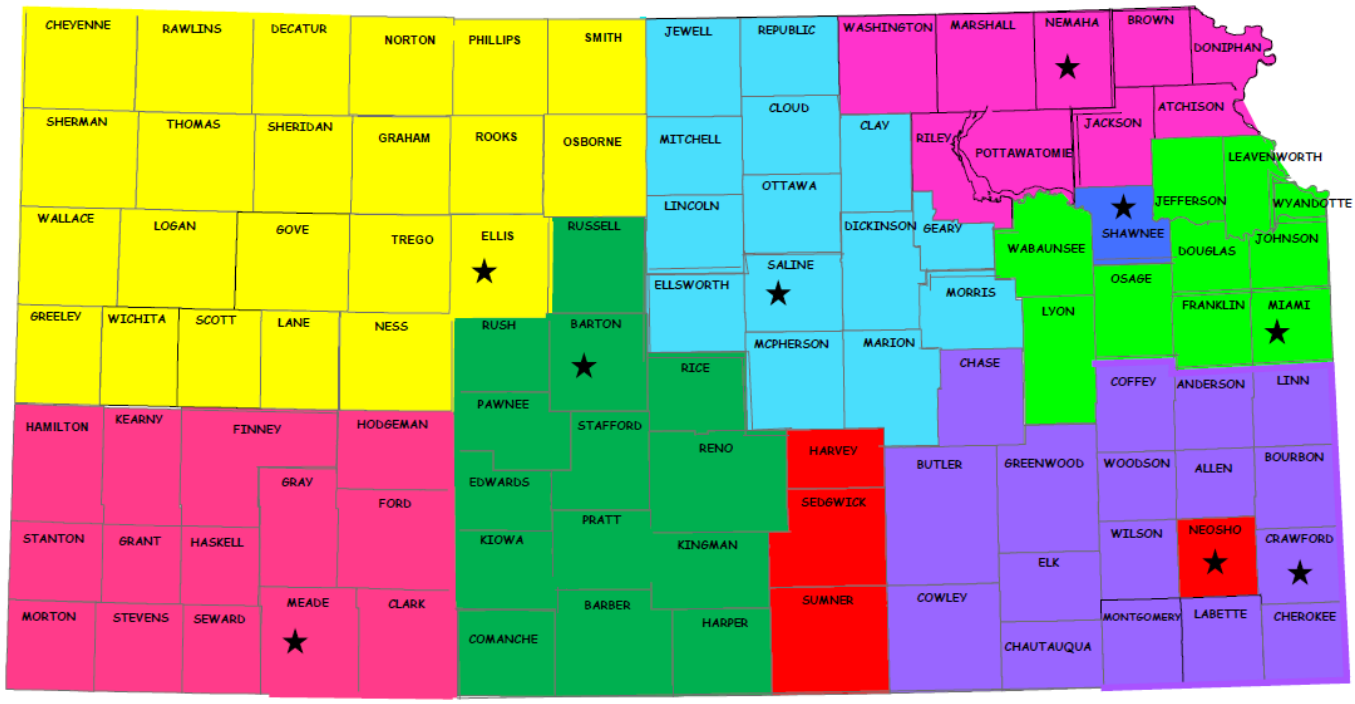
The KS-SHCN Action Plan objectives and strategies complement the Title V SAP, with many of the KS-SHCN priorities and strategies integrated across several of the domains. This reflects the integrated and cross-systems approach to the Kansas work. While the medical home continued to be a central focus of the program, it was recognized that the needs of children and families have shifted, especially after the COVID-19 pandemic, and the continued focus on stronger collaboration and integration across systems of care is essential now more than ever.

During the 2020-2025 Block Grant period the KS-SHCN program determined that while medical home was still an ongoing focus, the program's national Performance Measure would shift to transition. When looking at everything through a holistic lens transition is an important component of medical home and an area where the program-identified improvements were needed. While there was not much additional work on transition done in FY 2021, due to the staff developing and implementing the COVID Health Care Fund, there is much planned for 2022. Some transition work will be specific to the KS-SHCN program while other transition work will be a partnership effort for all adolescents between MCH and SHCN.

KS-SHCN Workforce: KS-SHCN regularly assesses the workforce and service delivery needs of the families served through the program. Satellite offices (SO) are established across the state through local health agencies and one area children's center that provide broader MCH services through the MCH Aid to Local (ATL) program. Each year, a review of KS-SHCN program data is conducted to assess the need for SO staffing, placement, and coverage. As a result, it is not uncommon to realign the SO service area. During the FY21 year, a new office was added in the southeast portion of the state to better support families who primarily speak Spanish. This did lead to a realignment of the SO service areas.

The KS-SHCN program staff participate in specific trainings for their role in the program, but also participate in other trainings and conferences offered by the Bureau of Family Health (BFH), KDHE, other partner agencies and MCH Navigator training. BFH and Title V leadership know and understand the importance of a well-trained work force, so every effort is made to give staff training opportunities for growth. Not only does this lead to a well-trained staff, but a happy and more productive staff. When SHCN staff attend a new training, they are asked to come back and share with the rest of the team what they learned, so all team members can learn with them. This leads to great team building between peers and strengthens the on-going support they provide to each other and the KS-SHCN SO team members.

SHCN Satellite Offices – SFY 2021



SPECIAL HEALTH CARE NEEDS SATELLITE OFFICES	
Barton County HD	Nemaha County HD
Crawford County HD	Neosho County HD
Ellis County (Hays Area Children's Center)	Saline County HD
Meade County HD	Topeka Administrative Office
Miami County HD	

The KS-SHCN workforce consisted of a total of 16 individuals, with 7 full-time positions with the remaining staff SO staff working an average of 10 hours or less per week. Staffing needs are assessed annually to ensure adequate coverage to provide holistic care coordination. This might mean a shift in the number or location of SO or the number of hours funded for each SO. SO changes will be monitored carefully to determine how to reach more families and grow the program, so we are able to continue the increase in clients served we experienced in SY21.

Workforce Credentials	SFY2020	SFY2021
Registered Nurses	7	3
Social Workers	5	2
Other	9	11
Total	21	16

Many of the SO staff also work on other Title V programs and because of the KS-SHCN integration with the MCH ATL process, local health agencies can learn more about services available for the CSHCN population and the need for MCH services and supports. These efforts help increase understanding that CSHCN are

children first and need the same services and supports as non-CSHCN children, while gaining awareness and appreciation for the specialized needs or challenges of the CSHCN population.

In addition to training and support provided through the MCH ATL network, SO staff receive technical assistance and training from KS-SHCN through bi-monthly webinars or "Brain Trust" calls, site visits, and an annual in-person training held annually in July (although this event was cancelled in 2021 due to the COVID-19 pandemic).

Direct Assistance Programs (DAPs): KS-SHCN provides financial assistance for direct services for families through DAPs (full list of DAPs available in the Overview of the State Section).

Staff monitor and review DAP utilization data annually to determine if any changes need to be made prior to the next program year. Changes may be based on actual or anticipated increases due to changes within the insurance industry, Medicaid/KanCare, and shifts in coverage for CSHCN services. In SFY21, no changes were made to any DAP's, however due to the pandemic the KS-SHCN program authorized an emergency month supply of Metabolic Products. If clients needed other accommodations and authorizations due to the pandemic the program staff worked with the client to assist in any way possible. Many times, clients have turned to their care coordinators for emotional support during the pandemic.

One major hurtle that the KS-SHCN staff worked to overcome is the supply shortage for metabolic product. The pandemic has led to supply shortages and made it very difficult for clients to get their normal metabolic formulas, making it necessary for the care coordinator to work closely with the client/family, doctor and nutritionist to find available alternative formulas. This has been very stressful on clients and their families. In order to assure clients are getting what they need before running out, the program has authorized beyond the normal DAP limit and increased the metabolic formula order amounts each time an order is placed. Some of the metabolic supply companies have not only had formula shortages, but staff turnover that have led to much confusion for all involved and extra time and effort from the care coordinators to make sure correct orders are being filled and are getting to clients as soon as possible.

Since the inception of the DAPs, the program has become more effective and efficient at providing services to clients, monitoring expenses, identifying gaps/barriers in service authorizations, and ensuring greater fiscal responsibility. With the DAPs in place, the program has prevented the need for waiting lists and decreasing services due to a lack of funds by only authorizing services as needed and setting limits per annual authorization. This change has resulted in better accountability and an ability to identify when funds are running low and cease authorizations for that DAP, if needed, until funds are released. It has allowed for flexibility to shift funds from one DAP to another if necessary, to make sure all DAPs have funding when needed.

KS-SHCN Enhanced Data System: The KS-SHCN care coordination and data management system (Welligent) continues to be reviewed for efficiencies and enhancements recommended. The focus for 2021 was to ensure all components of the system work efficiently, following the full launch in 2018, but the challenges brought on by COVID and staff shortages has delayed this. The program is still working to assure they can track all care coordination activities and report quality data. The Welligent system includes components needed for care coordination services such as: client demographics, applications, supporting documentation, financial calculation, level of care tracking, authorizations, action plans, budget (client and program), DAPs, correspondence, clinic information, follow up reminders for Care Coordinators, and more.

The Welligent data system was flexible enough to allow KS-SHCN staff to modify the data system in order to track and monitor clients who were part of the COVID Health Care Fund and Bridges program, along with the normal SHCN clients. Staff were able to track all demographics, medical needs, authorizations, funding usage, monitor health conditions, Action Plans, education information and other important client data. Without the ability to add needed components to the data system for client care, the program would not have been able to provide the services to essential health care workers who contracted COVID and Bridges clients (see additional information about the COVID Health Care Fund and Bridges later in this section).

Aid-To-Local (ATL) Funding Process: KS-SHCN continued to provide an opportunity for community partners to apply for funding for special projects through an online survey. Applicants were provided the KS-SHCN key priorities and objectives and asked to share the "problem" or "community need" they can best impact, as related to the plan. For each objective addressed by the applicant, strategies or activities were to be described to implement and address the need(s) identified, anticipated health outcomes, and long-term sustainability plans. A review team was developed to review all applications consisting of the Title V CSHCN Director, Unit Director, KS-SHCN Program Manager, KS-SHCN Topeka team, and FAC members. Each proposal was evaluated by at least four members of the review team, including one family reviewer. Reviewers were provided training on the review process, timeline, and reviewer expectations.

All reviewers were provided a scoring rubric which can be found in the SHCN supplement document, with their assigned ATL application(s) and deadline for completion. Responses from the scoring rubric are compiled, calculated and comments noted prior to internal review by program staff. Internal reviewers discuss each proposal and make one of the following recommendations: do not fund, fund with conditions, or fund as written. In FY2021, the KS-SHCN program awarded four grants. A summary is provided below.

Specialty and Outreach Clinical Services
Cleft Lip/Palate Clinic
Medically Complex Clinic
Seating Center Clinic
Outreach: Wheelchair Seating Clinics

Youth Leadership Development
KYEA: Faces of Change

Due to the pandemic, the Special Health Care Program Manager and Lead Care Coordinator held virtual meetings in lieu of in-person meetings with each grantee to collaborate, support and monitor the grantees progress in meeting the goals they outlined in their ATL application. During these meetings, program updates, grantee project progress, technical assistance needs, and next steps were discussed. The program also worked with grantees to identify additional collaboration opportunities to meet the needs of the CSHCN population. While in-person meetings are preferred, the KS-SHCN Program Manager kept in close contact with each partner to see how the pandemic was affecting their work and their clients. Many of the partners moved to a telehealth format while others like Kansas Youth Empowerment Academy (KYEA) FACES of Change had to adjust their scope of work to focus on the development of review and updating of their curriculum.

Grantees were required to submit quarterly reports and the KS-SHCN Program Manager provided written feedback to build better partnerships. Upon request of the Title V FAC, the program created a SFY2021 Special Health Care Needs Program Annual Report that highlights funding, objectives and outcomes, key accomplishments of each grant initiative and KS-SHCN program accomplishments.

Wheelchair Seating Services: The Cerebral Palsy Research Foundation (CPRF) Wheelchair Seating Clinics provide critical wheelchair/posture-seating services in Wichita and satellite outreach clinics. To assure the quality standards of its program, CPRF focuses on three means of feedback: family satisfaction surveys (following each clinical visit and longer-term assessment of clinic services); process measures; and long-standing collaborative partnerships (e.g., medical professionals, nonprofit disability services providers, durable medical equipment providers, public school districts, and the Wichita State University College of Engineering).

During FY21, the CSHCN Director and Community Partnerships Director worked with Medicaid partners to develop protocols, procedures, applications and polices for agencies who were interested in becoming

Wheelchair Seating Centers. Applicants complete an application process and then can be vetted for approval. Though this process agencies who met strict criteria can become a Kansas Seating Center and bill both Medicaid and the SHCN program.

KS-SHCN and Cerebral Palsy Research Foundation Partnership: In 2020, Cerebral Palsy Research Foundation (CPRF) developed a contract with a Durable Medical Equipment (DME) provider, which resulted in significant discounts on Convaid equipment. CPRF has passed these discounts on to the KS-SHCN program allowing for cost savings that can then be used for additional services and supports for other clients. CPRF also partners with the KS-SHCN program to cost share on more costly equipment, if their funding allows. By doing so, clients have been provided needed DME that our program was unable to previously provide, due to cost exceeding our funding capacity.

KS-SHCN and Medicaid Partnership: The KS-SHCN program has built a strong partnership with Medicaid and the Managed Care Organizations (MCOs) to support a holistic approach to care coordination. The program shares a monthly report with each MCO to identify dually enrolled clients' for the MCO Case Managers/Service Coordinators and KS-SHCN Care Coordinators to work collaboratively to provide quality services for the clients without duplication of effort or service. The Care Coordinators work with the clients to assist with filling any gaps not addressed by the MCOs (e.g., appointment scheduling, filling prescriptions, effectively communicating with providers, identifying community resources). The partnership between the MCO Case Managers/Service Coordinators and the KS-SHCN Care Coordinators has helped maximize resources and provide quality services for CSHCN.

During SFY2021, the KS-SHCN Program Manager presented SHCN program overviews to MCO staff, upon request. Participants included MCO Case Managers/Services Coordinators and other staff as determined by the MCO. These yearly presentations have assisted to improve collaboration and strengthen partnerships. The program continues to collaborate with the assigned State Medicaid liaison to assure services are not duplicated and identify gaps or barriers that could be addressed between the two programs to improve services for CSHCN. This partnership continues to grow each year with improved outcomes for children. Improvements in services from both programs have been identified, including but not limited to a decrease in client denials for services, reduced wait times related to the appeal and approval process, and development of a single case agreement for orthodontic providers serving cleft lip/cleft palate patients.

NPM 12: Transition: Percent of adolescents with and without special health care needs, ages 12-17, who received services necessary to make transition to adult health care.

ESM: Percent of youth with special health care needs, ages 12 to 21, who have one or more transition goals achieved on their action plan by the target completion date

According to the 2019-2020 NSCH (two years of data combined), only 33.5% of Kansas adolescents with SHCN, ages 12-17, received services necessary to make transitions to adult health care (95% confidence interval [CI]: 24.6%-43.8%). However, this was significantly higher than the nationwide estimate for adolescents with SHCN, which was only 22.5% (95% CI: 20.6%-24.6%).

Components of receiving necessary transition services:

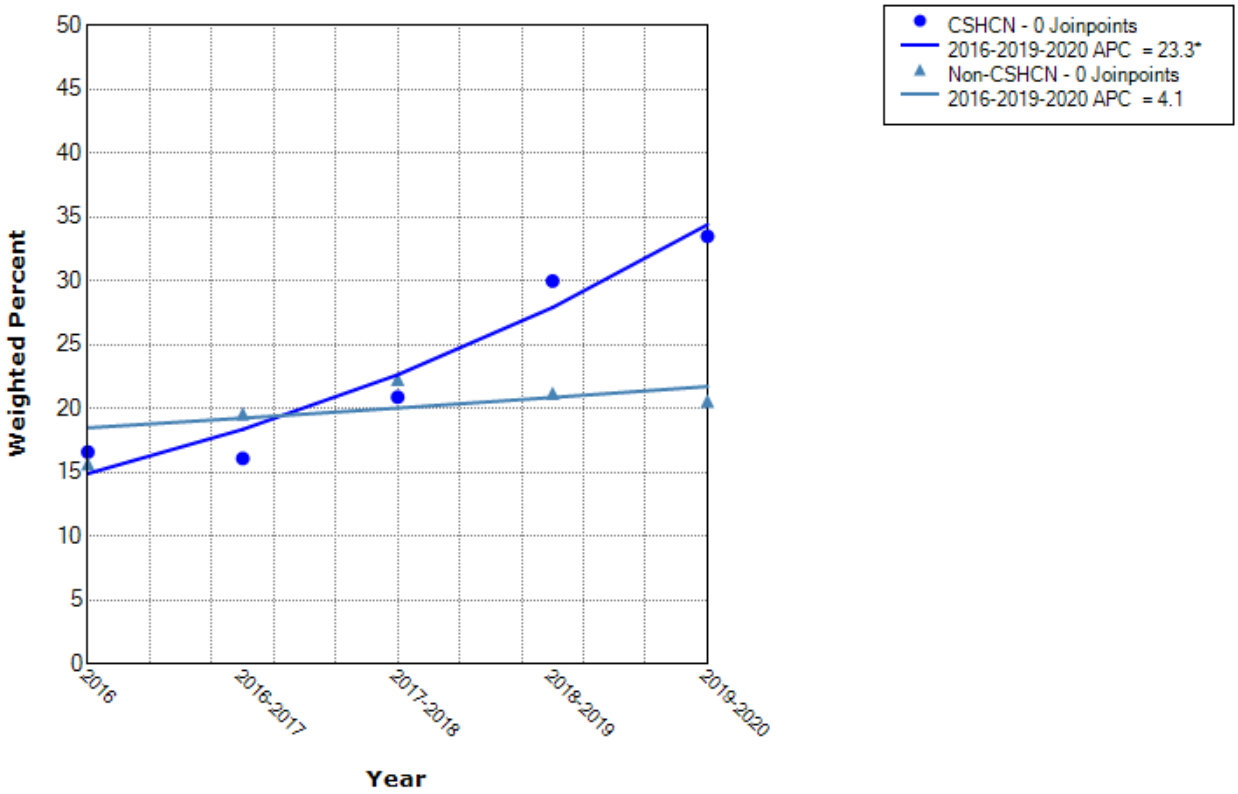
- Around half (53.4%) of Kansas adolescents with SHCN had a chance to speak with a doctor or other health care provider privately at their last medical care visit (95% CI: 44.1%-62.5%).
- For 76.5% of adolescents with SHCN, the provider had worked with the adolescent to gain skills to manage health/health care and understand health care changes at age 18 (95% CI: 67.8%-83.5%).
- For only 28.1% of adolescents with SHCN,* the provider discussed the shift to adult health care providers (if needed) (95% CI: 18.8%-39.6%).

* Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution.

From 2016 (single-year estimate) to 2019-2020 (two-year estimate), Kansas adolescents with SHCN experienced significant improvement in receiving services necessary to make transition to adult health care,

with an annual percent change of 23.3% (95% CI: 10.3%-37.7%). Although those without SHCN also experienced an increase, it was not statistically significant.

Weighted Percent of Adolescents with and without Special Health Care Needs (SHCN), Ages 12-17, Who Received Services Necessary to Make Transition to Adult Health Care, Kansas, 2016-2020†



* Indicates that the Annual Percent Change (APC) is significantly different from zero at the alpha = 0.05 level.
† Note: After 2016, state-level estimates were produced using two-year combined data.
Source: U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), National Survey of Children's Health (NSCH)

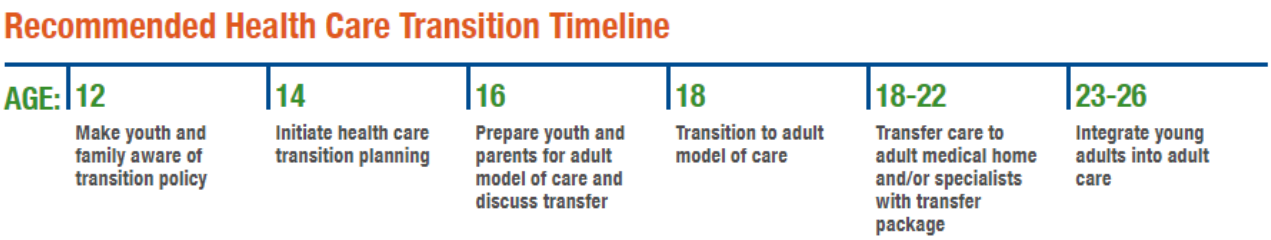
Objective: Increase the proportion of adolescents and young adults who actively participate with their medical home provider to assess needs and develop a plan to transition into adult health care systems by 5% by 2025.

The partnerships and supports developed through the KS-SHCN Holistic Care Coordination (HCC) model provide a strong foundation and infrastructure to maintain the focus of assuring CSHCN have access to medical homes. Program evaluation and the needs assessment process identified the need for an increased focus around transitions for the CSHCN population in the future. Transition to adulthood for youth with SHCN is one of the many components of a comprehensive and coordinated medical home. The focus on transitions will integrate and align well with the existing HCC model, supporting and strengthening the overall system of care.

Throughout the Title V Needs Assessment and implementation of the HCC model, transition planning for youth and adolescents ages 12 and older has been an identified service gap. Youth with special health care needs (YSCHN) and their families generally do not receive guidance on transition planning from their health care providers or other support systems. Additionally, health professionals continue to note the importance of health care transition (HCT), but many struggle to incorporate transition planning into their practices. Providers state that they lack the capacity and resources to effectively plan for transition with their adolescent patients, despite an interest in doing so.

The KS-SHCN program policy requires the development of at least one transition goal for any client (ages 12 to 21 years old) with an action plan. To help ensure a successful transition for all clients on the KS-SHCN program, age and developmentally appropriate transition materials and tools are disseminated to families,

regardless of their participation in care coordination services or client's level of care. The program has adopted the GotTransition recommended HCT timeline (below).



As per the holistic care coordination model, transition is not only focused on transitioning from pediatric to adult health care systems but transitioning in all aspects of life (e.g., self-advocacy, health and wellness, health care systems, social and recreation, independent living skills, education). Care Coordinators work with YSHCN and family to develop goals that meet their needs and help them grow and become proficient in self-care and advocacy when possible. HCT is also part of the SHCN programs Systems Navigation training for Family's curriculum.

During FY21, internal discussion with the SHCN staff have occurred focused on improving transition services to both adolescents and their families. Plans have been outlined for SY23 to add a Transition Direct Assistant Program, Systems Navigation Training for Adolescents/Young Adults and ways to improve transition data tracking to the program. Please see the CSHCN plan for more details.

KS-SHCN team in collaboration with the Adolescent Heath Consultant began discussions on conducting a review and update of existing transition materials and tools, such as *The Future Is Now, Think Big* resources designed for both youth with and without special health care needs, utilized by Care Coordinators to streamline transition practices across Satellite Offices (SOs). This work was slowed in SY21, due to the resignation of the Adolescent Health Consultant but is being continued by the KS-SHCN team.

Title V engaged in state-level discussions around telemedicine for all populations, while the KS-SHCN program engaged in this effort as it related to the direct 1:1 Care Coordination supports for YSCHN and their families to support program transition planning, as well as included this as part of the technical assistance offered to health care providers. Telemedicine can also be utilized by a client's care provider to easily consult with others, such as medical specialists and therapists, who are part of the care team. Additionally, the COVID pandemic spotlighted the need for effective telemedicine options, especially for those who are medically fragile or live in rural areas of Kansas.

Objective: Increase the proportion of families who receive care coordination supports through cross-system collaboration by 25% by 2025.

Holistic Care Coordination (HCC): The KS-SHCN program continues to provide HCC services as describes in the KS-SHCN Annual Report. The SHCN team conducts an annual program review that includes input from clients and families and other members of their care team to strengthen the supports and services provided. Based on these reviews, gaps/barriers are identified, and changes are made to improve the program. The COVID-19 pandemic introduced new and different kinds of challenges that were new to the program. As previously mentioned, the biggest one was problems with backlog or lack of formula for those with PKU. To assist families in overcoming this issue the program provided everyone a one-month emergency supply and has work closely with the families, the child's nutritionist, and formula vendors to offer substitute formulas when theirs are out of stock. Other barriers were addressed were authorizing 3-month prescription refills, COVID test/vaccinations and telehealth services. Another aspect that was new for the care coordination team was assisting families with translation for community and school services, since schools moved to on-line education and the closing of many daycare centers. Care Coordinators were called upon by families to help problem solve balancing school, work, and changes to normal family routine due to COVID. Care coordinators also provided families with information and resources about their COVID needs (e.g. testing locations, vaccination information, safety recommendations). The COVID-19 pandemic emphasized the continued need for flexibility and out-of-the-box strategizing to maintain a high level of care.

Due to the pandemic it was necessary to supply KDHE internal staff with work cell phones so communication with families was not hampered. This proved to be more valuable that staff expected. They have been able to improve their communication with families using text messaging, since many families have stated that they prefer communication via text. Satellite office staff have been supporting in communicating with families via text if that is supported by their local agency.

Bridges Care Coordination Pilot: During FY21,KS-SHCN began implementation of the Bridges Program to provide HCC to transitioning children exiting early intervention services (Part C of IDEA) and their families to assist them in navigating the complex systems of care for a smooth and stress-free transition experience. Any child served through Infant Toddler Services (ITS) exiting services are eligible to receive care coordination through the KS-SHCN program until 8 years of age, regardless of movement to school-based early childhood special education program (Part B/619) or community services. These services are offered to all families in participating regions of the state and are voluntary and allow families the ability to opt out at any time. The pilot target goal is to enroll 60+ families (50 English speaking and 10 Spanish). ITS providers and families have indicated this is something that has been needed for a long time and they are happy to see a program to assist with the transition process. This was also identified as a need within the needs assessment conducted by the Kansas Council on Developmental Disabilities.

The program began with five pilot communities, comprised of KS-SHCN Satellite Offices and the local ITS program partners. Bridges care coordination tools (e.g. application, initial assessment, follow-up contact, letters, action plan) and the Bridges Care Coordinator Manual were developed, implemented and refined using Plan/Do/Study/Act (PDSA) processes to evaluate all tools and processes. As the pilot progress all aspect of the program is being monitored and refined as needed. Updates and changes were made to the KS-SHCN data system to accommodate the needs of the Bridges program. A Bridges brochure was developed and disseminated to partners. Training for the Bridges Care Coordinators (BCC) occurred in March/April 2021 that included the following curriculum:

- Infant-Toddler tiny-k presentation
- Families Together, Inc. (PTI) presentation
- Bridges Overview
- LifeCourse
- Step Ahead Workshop
- FAPE and Evaluation section of the Law
- IEP Components & IEP Development
- The Infant-Toddler Partnership Structure
- Understanding the Impact of Toxic Stress and the Hope of resilience Building
- Strategies for Dealing with Challenging Behaviors
- Bridges: The Step-by-Step Process (included role playing)
- Developmental Screening (ASQ)

The pilot started in April 2021 and with monthly touch point meetings held between program leads and care coordinators to provide on-going TA support while charting progress and monitor changes that may need to occur. Monthly surveys were developed and implemented to gather data and program change recommendations. A data tracking sheet was developed to monitor progress and show improvement to be able to support future funding streams. Program leadership (including KS-SHCN and ITS) are engaging in regular data quality improvement activities to design the most beneficial program for children and families. Data collected is being synthesized and reviewed regularly to identify the following: gaps, staff training and capacity needs, program cost analysis, and family feedback. Through careful monitoring, data collection, use of quality improvements measures, and listening to the families it is anticipated that within the next year, the program can be refined and integrated as additional service offered from KS-SHCN, rather than a pilot project.

CSHCN Systems Alignment and Integration: Title V and public health recognize the importance of an integrated approach for optimal health outcomes, therefore learning about services offered across the state and building partnerships and referral sources is critical to meeting the needs of the CSHCN population. During SFY21 KS-SHCN and the Newborn Screening programs (blood, hearing, and heart screening) collaborated to restructure a referral process to increase referrals between the programs and streamline services and supports

for families. Data continues to be reviewed regularly to identify gaps and barriers and adjustments made as needed for improvement. To assist with this process, it was determined that the SHCN team was having trouble reaching families who had been referred to the program. It was determined that the cold call approach was proving to be ineffective and a new process was developed. KS-SHCN program staff determined that they wanted to develop postcards as the first step to introducing the program to families. Postcards and a new referral process will be developed and refined over the next year. Program set the following target goals based on current data and will continue to make changes until they are successful in obtain and surpassing these goals.

- Goal #1: Target referrals connection rate of 90% (this includes phone and/or postcards)
- Goal #2: Target number of clients to complete and send in an application within a 3-month period at 25%.
- 5 Year Goal: Increase goal #2 in subsequent years by 5% annually.

The CSHCN population is widely recognized as an at-risk, vulnerable population; however, there are additional factors that put the CSHCN population at greater risk for inequities and disparities. In addition to the traditional social determinants of health approach, there are additional risk factors such as adverse childhood experiences, food insufficiency, unsafe housing, foster care and lack of access to behavioral health services. Additionally, as Kansas is a state with large rural areas, the lack of medical specialists (or, in some cases, any medical provider) necessitates families travel hundreds of miles, several times throughout the year, for the services and supports their child requires. As a result, working parents miss work, often without pay, which further impacts the financial struggles they already face. Some families do not have a reliable mode of transportation, which impacts their ability to get their child to scheduled appointments. Care coordinators will continue to determine transportation assistance and other risk factors and assist families in locating resources and supports in their area that are needed. Care Coordinators collaborate with MCO case managers to assist covered families in obtaining travel assistance supports through their provider, ensuring requests are completed and submitted in the required timeframe prior to an appointment, as well as partnering with the MCO to assist with other identified family needs.

According to the National Survey for Children's Health (NSCH) 2019-2020 combined data indicate that CSHCN experience two or more ACEs at a much greater rate (37.9%), as compared to non-CSHCN (15.1%). Additionally, only 40.3% of families of CSHCN reported no ACEs, as compared to 67.6% of non-CSHCN families. Families of CSHCN experience food insufficiency/insecurity at higher rates than non-CSHCN families with nearly half (42.7%) of CSHCN families reporting they had trouble eating good, nutritious meals in some way. Access to mental health treatment or counseling is also more challenging for the CSHCN population, age 3-17 years old, with 11.6% reporting that the child had not seen a mental health specialist but needed to compared with 1.2% of non-CSHCN population – about ten times as many as the non-CSHCN population.

Furthermore, some CSHCN populations experience challenges with interpersonal communication that can make it more difficult to effectively express feelings of sadness and depression to their families and providers. The KS-SHCN program will continue to work with families and provide educational supports for non-verbal children and youth, including potential technology solutions that can help bridge these communication barriers.

The Title V CSHCN program continues to work to identify opportunities to partner and strategies to deploy to help address some of these disparities and partner with organizations that are working on family resiliency to address the impact and availability of support for CSHCN with high ACEs and food insufficiencies. KS-SHCN and the Title V Family Advisory Council (FAC) have been working on efforts to partner more with the behavioral/mental health community to provide stronger supports to families, specifically to work on access to service concerns noted by families.

Another great concern from a systems perspective are CSHCN in the foster care system. The FAC members have reported concerns with the lack of dedicated training, supports, and consideration of the specialized needs of the CSHCN population in the foster system. KS-SHCN has expanded eligibility criteria to support the automatic qualification of foster children into the program who meet medical eligibility criteria. Since this policy was put in place, KS-SHCN Care Coordinators have seen a significant increase of applications for children within the foster system and expect this trend to continue. KS-SHCN will continue to work on building stronger partnerships with foster agencies to support their understanding of the program's services and supports.

Additionally, the KS-SHCN team are planning meetings to work with the varies programs within the foster system to develop shared protocols and processes around referrals, care coordination services, communication and collaboration between social workers, foster families and the Title V team and to offer Systems Navigation Training for foster parents who are supporting children with special needs. By working collaboratively together the KS-SHCN team hopes to lessen the case managers burden and assist in navigating the various systems of care for the child/youth/foster family/child's care worker.

The Medically Complex Clinic in Wichita, a grantee of the KS-SHCN program that provides HCC to mutual clients, reported an upsurge of children and youth who are in the foster care system attending their clinic. Per an agreement with the state, foster families are now being offered a program application and are provided assistance to complete the application. This process not only increase clients from the foster care system enrolling in the program but it is believed that it will also increase requests for program presentations from foster care and family preservations entities in the future.

Family Systems Navigation Trainings: IN FY20, a train-the-trainer curriculum was developed and the first train-the-trainer session was started with the goal of expanding until there are a total of six trainers (three English and three Spanish-speaking). Due to the pandemic this Train-the-Trainer session was put on pause until in-person trainings could be held, or a virtual format developed. Two trainees were part of this first session and close to completion when the pandemic occurred. There has been much discussion about doing this in a virtual platform but due to the group activities and the in-person connections that are formed between the families it has not been moved to a virtual format instead efforts have gone into developing this training for Spanish speakers. Once in-person meetings can occur again, the two current trainees will complete their training and new trainee will be recruited.

Other CSHCN Health Objectives

Objective: Increase the proportion of families of children with special health care needs who report their child received care in a well-functioning system.

Title V CSHCN has fully embraced the implementation and advancement of the National Standards for Children with Special Health Care Needs. The Bureau realignment described in the Workforce Development and Capacity section has created new capacity for the Title V Directors and KS-SHCN Team to engage in higher system level discussions to advance systems of care work and better support the KS-SHCN program. This allows the program to focus on state mandated work and align with federally mandated expectations. Throughout this reporting period, the State Plan was reviewed by the FAC and priority areas were identified for the program to work on with the focus on insurance and financing.
Through the use of the holistic care coordination model families are engaged in discussions on what a "well-functioning system" looks like and how they can advocate for one. The KS-SHCN program staff educate families on what they can and should expect from their care team and monitor their responses to questions such as "Do you feel your provider actively listens to your child?", "Are you given the time to ask questions and express concerns?" and "Are you and your child an active participant in the care planning?" Questions like these are an integral part of initial and update assessments conducted with our care coordination families. Additionally, staff will continue to conduct post-appointment follow-up to help ensure family's needs, questions and concerns are being met by their provider.

There is a distinct need for Kansas to establish a local, state-level set of data to inform about the CSHCN population and support the work of KDHE in building strong, well-functioning systems of care. An intern through the Leadership Education in Neurodevelopmental and Related Disabilities (LEND) assisted in a systems of care project that was designed as the first steps to:

- Creating a shared dataset (list of measures, metrics, or information shared across public and private health systems to determine if systems of care are "well-functioning");
- Telling the story of what systems look like for the CSHCN population – in Kansas;
- Establishing a model of partnership to support cross-system data sharing practices to enhance systems of care; and

- Providing a pathway for patient-level data sharing among public and private health systems to improve access to continuous, comprehensive, and coordinated care.

The National Survey for Children's Health (NSCH) utilizes over 50 questions within the survey, related to family partnership, medical home, early screening, adequate insurance, easy access to services, and preparation for adult transition. Data indicate that only 20.8% (NSCH 2019-2020) of families of CSHCN receive care in a well-functioning system. An internal Title V team was formed to begin looking at the questions from this survey and considering the possibility of establishing a Kansas-specific "Systems of Care" Survey. After connecting with MCHB, we learned that Illinois had conducted a similar survey in their state for their most recent needs assessment. They shared the data dictionary and survey tools and we established a Task Order with the University of Kansas to create this survey in REDCap, a HIPAA-compliant tool to collect survey responses. The team is still working through design and dissemination of this survey to pause for a discussion with the MCH Epidemiologists regarding oversampling of the National Survey for Children's Health to capture state specific CSHCN data. However, there is still a desire to launch a convenience-sampling survey to learn more from Kansas CSHCN families.

KS-SHCN and Medicaid Partnership: The KS- SHCN program continues to partner with Medicaid through a monthly shared report. This allows the SHCN team and MCO care coordinators to collaborate on mutual clients to make sure the SHCN program is gap filling and not duplicative of the MCO work. This has been a very collaborative and beneficial partnership for many years now. The shared report is part of the MOU between Title V and Medicaid (see the Medicaid section for more information).

Over the past year the SHCN program has worked with Medicaid to refine policies and protocols to authorize wheelchair seating services. Currently the state has only two wheelchair seating centers approved by Medicaid and a process needed to be developed to authorize others who may be interested in applying. It is expected that this will increase the wheelchair seating services in Kansas while holding providers to a high standard of care.

Insurance and Financing Systems of Care for CSHCN: The KS-SHCN program continues to see gaps in services for the CSHCN population due to their unique health care needs. In SFY21 the Title V and KS-SHCN program staff began putting together a plan to identify gaps in insurance coverage, inadequacies across coverage options, and review the affordability of coverage for CSHCN. The plan includes aligning with the National Standards, building from the System of Care State Plan, and engaging key partners, families, and communities, Title V will build strategies, partnerships and policies to overcome identified challenges.

To date, KS-SHCN has identified the following considerations for this work: coverage and availability of DME's and medications; proper provider reimbursement; limited approval for necessary medical supplies; care coordination and transition services; and adequacy of family-friendly Medicaid policies. Staff know that there are many other things that will be added to the list and will need to work with families and consumers to determine priorities for the CSHCN population and actions to be taken.

Other KS-SHCN Program Activities

COVID: During FY21, The KS-SHCN team was asked to take on an additional task and develop and implement a program that mirrored the SHCN program for essential workers, including childcare workers, who contracted COVID. The team was given a couple of weeks to develop the program which included data system capacity changes, application, materials, tracking documents, process & procedures and assist with the advertisement component. Qualification criteria was that they had to be an essential work and were diagnosed with COVID. While the team was already very busy, they knew how important this project was and wanted to help. It required lots of extra work to juggle not only their current case loads but additional ones for COVID. One new care coordinator was added to the staff for support but many others within the Bureau stepped up to assist. This project was funded through the ARPA funds and allowed the KS_SHCN program staff to authorize for COVID medical services, pay lost wages, provide a stipend to help with unexpected COVID expenses, reimburse for lost wages, and reimburse those with insurance for co-pays, deductibles and co-insurance costs.

While providing holistic care coordination services. Within a 5-month period the program process 704 applications and paid out $1,734,195.23 to individuals who qualified.

The KS-SHCN team has developed a new SHCN brochure that better captures the program changes, additions and qualification for participation to be shared with the public. This brochure reflects the shift in the SHCN program components as it moves down the MCH pyramid. While the program will always offer some forms of direct services due to state statues, leadership is working to make sure that enabling services and infrastructure are key areas to be addressed as well.

Additional diagnoses are added based on changes to the newborn screen panel, with XLD expected to be added soon. When newborn screening conditions are added the SHCN team does a review of all DAPs to see if anything new needs to be added to accommodate for the new condition or if a new DAP needs to be developed.

Peer Supports for CSHCN: KS-SHCN continued to engage as a Supporting You Network Program within Supporting You. The program will continue to promote these services to families who may benefit from additional peer support. During FY21, the SHCN program determined that their Supporting You Program should expand and offer supports for all special health needs conditions not just those as determined by state statue. The KS-SHCN program continues to identify parents who have become experts in navigating the various systems of care for recruitment as a Support Peer. The CSHCN Director continued to work with the Peer Support Administrator to determine other recruitment strategies and conduct ongoing monitoring of support matches. Read more about Supporting You in the Cross-Cutting Report and Plan. Specifically, KS-SHCN would like to offer both English and Spanish Support Peers and will work with the Network to determine the feasibility of doing this.

Care Coordinator Training and Workforce Development: The annual Satellite Office (SO) training focused on a series of webinars/zoom meetings, rather than a two-day in-person meeting due to COVID-19. It was determined by the Topeka SHCN team that with all the changes in staffing both internal and SO along with focus for many on COVID supports the trainings needed to concentrate on getting back to basics. Therefore, Webinar trainings were held twice a week for four weeks and began with basic data-based training review, the full care coordination training series and additional care coordination newly adopted practices. The program then continued the tradition of the bi-monthly webinars, with guest speakers regarding services and supports available across the state, and “brain trust calls,” to allow peer support/learning with the presentation of case examples to help brainstorm ideas and solutions that can address the needs of specific problems. All SO staff not participating in Bridges were offered the opportunity to participate in Bridges training too.

During FY20, all SHCN staff were required to participate in Mental Health First Aid training to improve their support for families. Mental Health continues to be an ongoing discussion between staff who work to brainstorm more ways to provide assis to families.

Program Policy & Service Delivery Changes: Remaining relevant among ongoing shifts to the health care industry and changing needs of communities is critical for a program like KS-SHCN. The program reviews program data annually to adapt and provide meaningful and coordinated supports to families. This generally includes: HCC data review; a determination of statewide or local clinical support needs; DAP service utilization; and policy revisions.

- *New HCC Eligibility:* KS-SHCN has continued to offer HCC service to applicants who qualify medically, removing financial eligibility requirements. Prospective clients are still required to complete the full application, to provide opportunity for the Care Coordinators to determine if they are eligible for other supports too, however this is expected to increase the number of families the program can reach. Careful monitoring will assure program staffing capacity is assessed regularly to meet the needs of the additional clients.
- *SO Changes:* Data is reviewed annually around the reach and impact of each SO, to determine if a shift in staffing, regional boundaries, or resources is needed. In the upcoming year, efforts will be made to identify a new satellite office partner for the north central region of the state that was formerly covered by the Salina Health Department. It is hoped that Meade county will be able to resume as a SO office once the pandemic slows a little more. This region is very rural and frontier and with Meade County

Health Department being so small they did not have the ability to address the COVID needs and do SO work too. If they are unable to begin their SO work soon a new SO office will be located in the Southwest region of the state. While all SO offices have really felt the strain of COVID their dedication to serving those with special Health care needs in their community. By being part of the KS-SHCN team So staff have not only learned the SHCN program and structure, but has also led them to an exploration of additional MCH initiatives and trainings to incorporate these services into their health department.

2023 CHILDREN WITH SPECIAL HEALTH CARE NEEDS APPLICATION PLANS

PRIORITY 5: Communities, families, and providers have the knowledge, skills and comfort to support transitions and empowerment opportunities.

NPM 12: Transition: Percent of adolescents with and without special health care needs, ages 12-17, who received services necessary to make transition to adult health care.

Local MCH Reach: Based on SFY2023 MCH Aid-to-Local applications received:

- 9 of 55 grantees (16%) plan to provide services to the Children with Special Health Care Needs (CSHCN) population
- 6 agencies plan to serve as a KS-SHCN Satellite Office
- 7 of 9 grantees serving CSHCN (78%) plan to provide services necessary to make transition to adult health care
- 6 of 9 grantees serving CSHCN (67%) plan to provide care coordination supports to CSHCN and their families
- 3 of 9 grantees serving CSHCN (33%) plan to improve the function of systems of care for CSHCN

Objective: Increase the proportion of adolescents and young adults who actively participate with their medical home provider to assess needs and develop a plan to transition into adult health care systems by 5% by 2025.

According to the National Survey of Children's Health (NSCH), in 2020, the percent of adolescents with and without health care needs, ages 12-17, who received services to prepare for the transition to adult health care was 24.2%. The CSHCN population was 33.5% and those without 20.6%. While these percentages have slowly been increasing over the last 5 years, it still shows that the majority of adolescents are not receiving this much needed service.

The KS-SHCN program policy will continue to require the development of at least one transition goal with an action plan for any CSHCN client (ages 12-21 years). The program's goal is to assist clients in accomplishing a successful transition that takes into consideration not only the clients age but also their developmental abilities when offering appropriate transition materials and tools. All transition age clients and their families, regardless of their participation in care coordination services or client's level of care, are offered these tools and resources (e.g; Think Big Transition planning booklets, transition websites, information on how to talk to your doctor, filling a prescription, understanding your medical condition). The program will continue to adopt the GotTransition recommended HCT timeline (see report for timeline).

The KS-SHCN staff understand that in order to provide effective holistic care coordination transition services, care coordinators must utilize a patient- and family-centered approach based on the person, their circumstances, and their medical, behavioral, educational, social, developmental, and financial needs. It is about getting to know the client and his/her family, where they are at, and understanding that many things can become obstacles in meetings their personal needs. This includes all aspects of an individual life such as: (e.g., self-advocacy, health and wellness, health care systems, social and recreation, independent living skills, education). Care Coordinators will continue to work with CSHCN and family to develop goals that meet their needs and help them grow and become proficient in all aspects for growth and development throughout the life span.

During the last two Title V needs assessment cycles, the Kansas Special Health Care (KS-SHCN) program selected medical home as their priority but has always considered transition skills a key component of a strong Action Plan and care coordination service delivery. While the KS-SHCN program will continue to work on the spread and scale of the holistic care coordination (HCC) work, it was determined that more work on transition supports were needed for all youth. Thus, based on the needs assessment findings, KS-SHCN staff discussion, a review of family needs and discussion with the Title V team the SHCN priority chosen for this grant cycle is transition.

In order to support adolescents, in their transition needs a multi-faceted approach is required that will be used as part of the HCC approach but can also be used as stand-alone components for all youth. Each phase of the transition work that will take place over the next year and beyond is listed below.

Transition Direct Assistance Program (TR-DAP)

The KS-SHCN team will be developing a Transition Direct Assistance Program (TR-DAP) to meet the needs of adolescent who qualify for the KS-SHCN program. The KS-SHCN team will begin with a review of the existing transition tools and resources currently shared with adolescents and their families, an external review of other transition tools and resources, and seek input from youth on what they think would be helpful.

The process will begin with an internal brainstorming session with the KS-SHCN team to list what transition needs are currently being identified through the HCC work. Care coordinators will engage adolescents and their families on the program in discussions around their thoughts and ideas regarding transition and document their feedback. Program staff will work in partnership with the Adolescent Health Consultant to hold focus groups and gather stories from adolescents and young adults both with and without disabilities on their transition experiences to help guide the work.

Many tools and resources were developed by the KS-SHCN program several years ago that might need to be updates or totally changes to reflect current needs. Once staff has made changes to these documents, they will be shared with adolescents to get feedback from them, so final changes can be made. Once these tools are refined the team will determine what format would be best to distribute them in (e.g., webinars, videos, electronically, paper).

The TR-DAP when complete will offer the following services:

- Coverage for pediatric to adult provider patient consultation (including specialty care providers) - This gives the medical providers an opportunity to be reimbursed when providing quality transfer of care information.
- Client consultation with new adult provider – this gives the KS-SHCN clients the opportunity to find the provider that they feel comfortable with by having an initial consultation to determine comfort level.
- Medical literacy education incentives for adolescent clients – this will be in the form of online videos, webinars, classes, and other formats still to be determined where, upon completion, the adolescent will receive a monetary stipend for completion.

The TR-DAP will be automatically available for all adolescents on the KS-SHCN program from 12 - 21 years of age. Care coordinators will assess clients regularly to determine progress on transition activities and health literacy improvement. While the primary focus of this DAP is health other components of transition will also be included such as: post-secondary education, work, independent living skills, budgeting and others identified during the development process. Quality Improvement procedures/tools will be used throughout the development process of this new DAP to monitor effectiveness once implemented. All KS-SHCN DAPs are reviewed annual and if determined that changes are needed, QI processes such as PDSA cycles are implemented.

During TR-DAP implementation planning, a need for better quality data was identified. Therefore, changes will be developed to the KS-SHCN data system to collect better quality data for transition, as well as other service components of the program. These changes will include quality improvement and quality assurance tools and processes to verify program data is accurate and reliable.

Systems Navigation for Adolescents

As part of the KS-SHCN staff discussion on transition, the idea of reconstructing the Systems Navigation Training for Families (SNTF) was identified as another way to strengthen support for transitioning adolescents. However, knowing that adolescents have unique transition needs and in view of Kansas Title V belief of "nothing about us without us", it was determined that this work should be driven by adolescent/young adults with program support and oversight. For this reason, the KS-SHCN program will partner with St. Louis University (SLU) internship program to host a summer intern to lead this work.

Expectations for the intern team will be to:

- Review current transition tools, resources, and SNTF;
- Development of a transition portfolio that could be used as part of the SNTA curriculum or as a stand-alone;
- Outline and develop the new SNTA curriculum;
- Develop a recruitment and training plan for Trainers – It is anticipated that these trainings will be done by young adults with support from the KS-SHCN staff and modeled from the current SNTF Trainer-of-Trainer process. The idea is to partner with local universities to have young adult trainers.

Once the SNTA is developed and implemented the KS-SHCN program will look to translate the curriculum and transition portfolio into Spanish to be able to offer adolescents whose primary language is Spanish. This work will be done over multi years and monitored for success using a variety of QI/QA tools and processes.

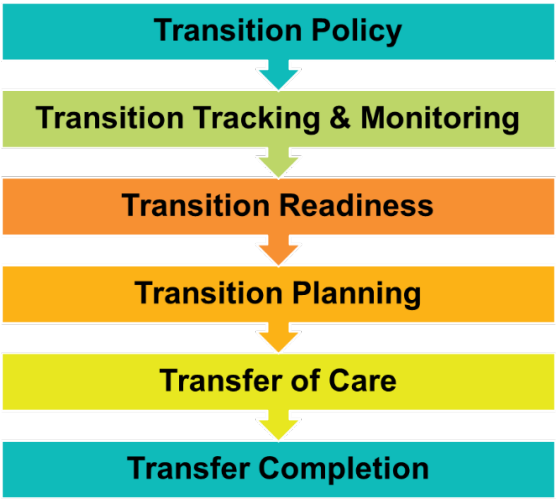
All SNTA will be offered Free to any Adolescent in the state of Kansas who would like to participate. Those that are part of the KS-SHCN program will be allowed to count this training as part of their medical literacy education incentive package and receive a stipend for attending once they complete the post assessment survey.

Additional KS-SHCN staff trainings for Satellite Offices (SO) will occur over the next year to strengthen their understand and ability to provide quality transition services to their care coordination clients and any youth who seek services at their agencies. They will also be closely monitored by the KS-SHCN Lead Care Coordinator (LCC) to make sure they are clearly documenting transition data within the system. Ongoing supports will be provided by the LCC to all staff around transition upon request or when there is an identified need.

Health Care Transition (HCT) Planning: To develop a comprehensive transition plan, providers must engage youth and their caregivers in the planning process. Transition discussions can be a sensitive subject, especially for youth with special health needs (YSHCN) entering unknown territory, and many challenges may present themselves. Some of the identified challenges include:

- YSHCN may be concerned about what more will be expected of them.
- Parents/caregivers can have trouble "letting go," as so much of their life has been focused on caring for the adolescent.
- Adult health care providers can be hard to find (particularly in rural areas) or lack experience in providing care to YSCHN or their specific medical needs.
- YSCHN may struggle to find flexibility in employment schedules and/or concerns about missing school.
- YSHCN transition planning takes additional time and resources for busy provider practices, where reimbursement for transition is not widely available.
- Pediatric and adult providers may need several consultation visits to support the YSHCN and their family.

KS-SHCN will be recommending evidence-based models, such as the Six Core Elements of Health Care Transition 2.0 through GotTransition.org (depicted to the right). These elements provide practical guidelines and recommendations to providers when developing their own transition planning protocols or curriculum. In addition, American Academy of Pediatrics (AAP)/Bright Futures has recently collaborated on new evidence-based resources to help healthcare providers implement transition practices and policies. This resource will be included in transition provider training and patient education efforts.



KS-SHCN Care Coordinators and staff will be available to offer technical support to providers of mutual clients, assisting them to problem solve challenges and barriers to creating transition plans for their CSHCN patients. Lunch & Learn presentations, short webinar presentations or videos that allow busy providers to partake in educational opportunities over their lunchtime, are a great way of providing guidance they can access, and revisit as needed. These presentations will provide valuable information on all ages and stages of transition, with a special focus on transitioning into adulthood.

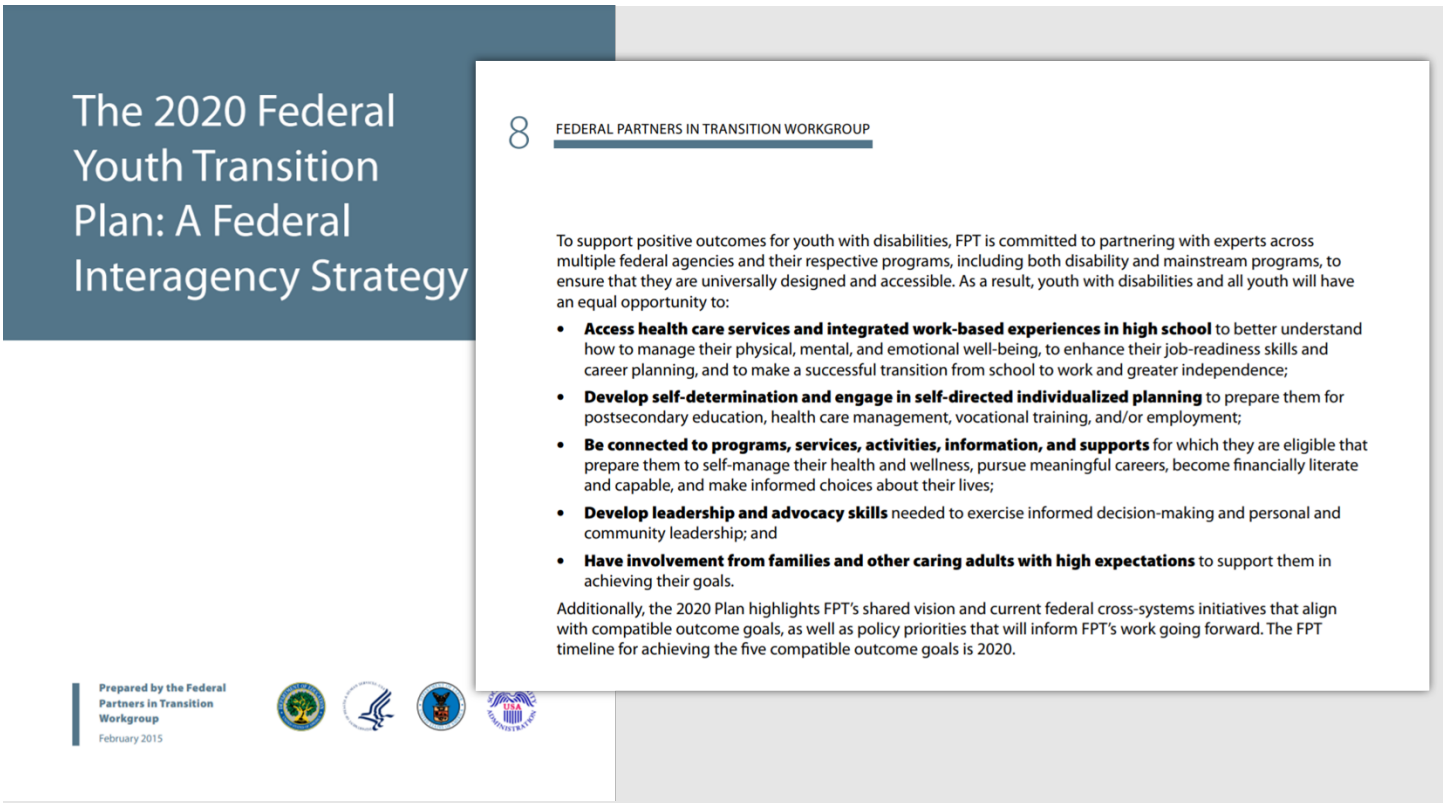
Title V staff will create and implement strategies to incorporate transition information to CSHCN educational tools using the Youth Health Guide and WHY (Whole Healthy You) campaign that was created and designed by Kansas youth. The team will reach out to Washburn University's Student Health Services and Diversity & Inclusion department to begin conversations regarding an interest in piloting monthly WHY conversations (using the Zoom platform with small group discussions) so youth and young adults can have conversations on topics related to transitioning from pediatric to adult health care. Additional topics might include insurance coverage, how to make doctor appointments, preparing for an appointment, medications/therapies prescribed, what to look for in a "good fit" patient-doctor relationship, confidentiality/consent laws, youth-friendly environments and practices (both positive and negative experiences).

Title V will continue to engage in state-level discussions around telemedicine for all populations. The KS-SHCN program will continue to encourage the use of telehealth services as it relates to the direct 1:1 Care Coordination supports for CSCHN and their families to support transition planning, as well as including to offer this as part of technical assistance to health care providers. It is the programs staff's belief that telehealth is a great way to reach adolescents and provide the transition assistance they may need in an easy and comprehensive manner. KS-SHCN will pursue technology advancements within the program, considering integrated telemedicine possibilities within the KS-SHCN electronic records system, Welligent.

HCT Systems of Care: Title V will continue to monitor insurance and financing needs related to HCT and work with both public and private insurers to support adequate reimbursement rates for transition. HCT practices require additional time during medical appointments and wrap around supports to help guide youth and families through this process. Providers have shared that without adequate reimbursement it is challenging to take the time to work on effective HCT planning. Recognizing effective transition planning must look holistically at the youth's needs (e.g., family needs, education, social, housing, employment), KS-SHCN will work with YSHCN and their families to discuss the importance of transition and to set holistic goals to help them reach their full potential and ensure a smooth transition into adult living.

This holistic approach will take alignment with many other systems and agencies. Utilizing *The 2020 Federal Youth Transition Plan: A Federal Interagency Strategy* as a guide, Title V will engage in efforts across systems to support the vision outlined in this plan. It should be noted that this plan is presented by the Federal Partners in Transition (FPT) Workgroup and is reflective of a cross-systems approach to provide supports and services to youth with disabilities. Several federal departments and agencies were involved, including the Departments of Education, Health and Human Services, Labor, and the Social Security Administration. While Title V is not named specifically in this plan, there is clear alignment to the Kansas Title V vision for supporting transition through the population health/system of care lens.

Excerpt from Federal Plan Executive Summary



Transfer of Care: Once an adult provider is identified, the pediatric provider should begin the transfer of client information, including up-to-date medical records, to ensure a smooth transition of care. For clients with special health care needs, there may be multiple specialists on the care team, making consistent and frequent communication between all providers a critical part of the care team's service delivery. The HCC provided through KS-SHCN can support these communication efforts by utilizing strategies and tools identified through GotTransition.org. KS-SHCN and the HCC project staff will continue to review evidence-based transition tools and resources to be shared with providers, health agencies, families and especially adolescents.

The more a youth can assess where they are in the transition journey and have resources to help guide them as they move through this process, the higher their success rate. Program staff feel the addition of a transition portfolio would be a valuable tool to help guide youth and their families to transition readiness and success. The portfolio would include a transition checklist, a list of members on the care team with contact information, medications, the patient's challenges and strengths, a current copy of their Action Plan or SPoC and their dreams and hopes for their future. The portfolio will also have a resource section that lists SSI or disability contact information, legal resources, career options and training, support groups, housing, and other items of need for the youth. A question/concern form will be included that can be completed prior to medical appointments to share with providers and facilitate open dialog during visits. Training webinars will be developed for care coordinators, providers and families, that focus on all stages of transition and will be tailored to all levels of abilities, with the focus to support all youth in becoming their best adult self and to reach their maximum potential. The Transition Portfolio with be embedded as part of the Adolescent/Young Adult Systems Navigation Training curriculum and added to the Systems Navigation Training for Families.

Local MCH Agencies: Local agencies will provide guidance to children with special health care needs and their families/support people in navigating through transition from adolescence into adulthood. A few examples include:

- *Neosho County:* will assist all CSHCN and their families in assuring that they are able to live as independently as possible as adults. They partner with TRI-Valley which works with clients and youth with special needs to build confidence and skills to help enter the workforce.
- *Saline County:* is establishing a direct collaboration with their local Independent Connection Inc. Independent Connection provides youth transition services for individuals with disabilities to live independently to include helping with financial planning, accessing community services for disabled youth/adults, find accessible housing, strengthen communication skills with family and providers, pre-

employment transition services, ADA Assessments, Independent Living Assessments, and Disability Etiquette Training. A focus of this collaboration will be a peer support group as a resource to provide mothers of children with disabilities, a layer of social support along with local/state resources for transitional services for their children.

- *Nemaha County:* KS-SHCN program participants receiving MCH services, with and without special health care needs, will receive a transition readiness assessment to begin a discussion about health-related skills and prepare to transition into the adult health care system. Staff will utilize tools, materials and timelines from the Got Transition National Resource Center and adopt a Transition Readiness Assessment for adolescents to support conversations with the adolescent, parent/caregiver, and medical provider about moving into adult health care. Local MCH staff will collaborate with the KS Special Health Care Needs Program to help that program's participants better transition into adult health care. Adolescents receiving MCH services and having a smart phone will be encouraged to set up the medical id portion of their individual health app.

Objective: Increase the proportion of families who receive care coordination supports through cross-system collaboration by 25% by 2025.

Holistic Care Coordination: The KS-SHCN program will continue to provide HCC services as described in the CSHCN Report. These services continue to evolve based on input from clients and families and other members of their care team. Many lessons have been learned from the COVID-19 pandemic that will be utilized moving forward to support efforts to maintain a high level of care. More information about program expansion efforts for KS-SHCN can be found below and information about the HCC statewide expansion, replicating the KS-SHCN model in other programs, can be found in the Cross-Cutting Plan.

As the HCC work continues to develop and evolve to support the CSHCN population and providers who care for them, the KS-SHCN team will provide guidance, training and support for the HCC work as expansion occurs based on their skills and knowledge from doing this work for many years. They will be working closely, as will the CSHCN Director, to provide support for the HCC Consultant and doctor's offices across that state who will be participating in the HCC pilots.

Bridges Care Coordination Pilot: As outlined in the CSHCN Report, KS-SHCN will continue to implement and refine the Bridges Pilot Program to provide HCC to transitioning children exiting early intervention services (Part C of IDEA). Bridges is designed to assist families as they navigating the complex systems of care. Any child exiting services through Infant Toddler Services (ITS) will be eligible to receive care coordination through the KS-SHCN program until 8 years of age, as long as they remain active in the program. r
The program will be expanding over the coming year to add 3 new pilot communities (Miami, Crawford, and Barton)., These new satellite offices added to the already existing 5 will add greater capacity to refine the program, so that it will be able to transition from a pilot to a subcomponent of the KS-SHCN program in the coming year. The Bridges program is one more step to move towards providing services and supports to the larger CSHCN population in Kansas. Over the next year, the tools and process will be refined, family survey data gathered and reviewed, on-line parent trainings developed and offered, new partnerships developed with ITS providers in the new regions, and staff training for new care coordinators will occur. Training will occur for a Bridges Lead Care Coordinator over the next year. This individual will lead the Bridges program with oversight from the CSHCN Director moving forward.

CSHCN Systems Alignment and Integration: Title V CSHCN Leadership, including the Title V Directors, and when hired the new KS-SHCN Program Manager will continue to focus efforts over the next year on partnerships building with a variety of state and local partners to improve the systems of care for the CSHCN population. The first area of focus is building a collaborative relationship with the Department of Children and Families (DCF). Title V intends for this relationship to be widespread, covering children with SHCN in foster, adoptive, or kinship placement, including families who are engaging in DCF prevention, reintegration, and/or permanency.

Further, partnerships need to be forged to improve the referral process for CYSHCN in the child welfare system to the KS-SHCN program. Programmatic changes have been made to waive financial eligibility requirements, work in partnership with social workers and caregivers, and to support the caregivers and child

through any care transition they may experience. KS-SHCN care coordinators are in a unique role to help monitor and support care for these vulnerable children. Over the next year information about the KS-SHCN program will be shared with a variety of DCF service providers. The KS-SHCN will offer the Systems Navigation Trainings for Families for all populations involved with DCF. The KS-SHCN program desires to enter an MOA with DCF to offer the SNTF and develop a formal referral process.

During SFY21 KS-SHCN and the Newborn Screening programs (blood, hearing, and heart screening) collaborated to restructure a referral process to increase referrals between the programs and streamline services and supports for families. However, after reviewing data it was determined that the process needs to be refined to be more effective and additional staff training needs to occur. Over the next year, this process will be improved and closely monitored by the KS-SHCN program Manage and CSHCN Director. The first step will be to develop introductory referral postcards that can be sent to families. Upon reviewing data it was determined that cold calling families was not affective as many did not answer since they did not know who might be calling. By sending an introductory postcard letting families know their child Medically qualifies for the KS-SHCN program and that a care coordinator will be calling to answer questions about this free program families will be more likely to answer and engage in conversation about the program. A follow-up postcard will also be developed to go out to those who were not able to be reach by phone following the Introductory postcard. Postcards will be folded over and sealed to maintain confidentiality. Data tracking will also be improved and monitored monthly to identify additional gaps and barriers. Target goals have been set by the KS-SHCN team to be achieved within one year/five years.

Family Systems Navigation Trainings: A train-the-trainer curriculum was developed prior to the pandemic with training almost concluded for two new trainers, however this was halted due to the pandemic and not being able to hold in-person trainings. Over the next year, this training will be completed, and new Train-the-Trainer sessions offered. The goal is to train a total of 6 English speaking and 3 Spanish speaking trainers. New trainers will be recruited first from the FAC for those interested in conducting these trainings for families. Trainers are provided training, tools, resources, compensation and on-going support from KS-SHCN. This further extends the capacity of the KS-SHCN program while supporting family professional development and allowing a peer-to-peer model to learning. KS-SHCN bi-lingual staff will complete the translation of all materials, tools and the PowerPoint presentation modules into Spanish during the next year, so trainings can begin to be offered to Spanish speaking families in 2023. See above in the Transition section about the Systems Navigation Training for Adolescents being planned.

KS-SHCN plans to offer quarterly trainings across the state once families of CSHCN are comfortable returning to in-person events, as this intensive in-person training does not lend itself to a virtual model. However, if in-person trainings are not able to begin during the next year, virtual platforms will be relooked at and considered. KS-SHCN will work with community partners, grantees, and SO staff to plan and implement these trainings at different locations across that state in both English and Spanish.

Local MCH Agencies: Local agencies will provide care coordination supports. A few examples include:

- *Barton County:* will train their staff to use the IRIS referral system connect families to needed services or assist in connecting them to schedule these services. Our agency will also educate families on information needed in successfully bridging the gap between them, their families and services/providers. Barton County Health Department provides Care Coordination Supports in their role as a CSHCN satellite office, where they are responsible for CSHCN applications, renewals, and care coordination for 14 counties in Central and South-Central Kansas.
- *Community Health Center of Southeast Kansas*: Will provide care coordination for every family we serve especially our low-income families and single parents who struggle to manage their child's needs. *Provide education for our own staff, as well as private providers, on best practices in meeting the needs of this population; forge closer relationships with the service providers (e.g. sheltered workshops, mental health centers, etc.) to ensure their clients have access to all medical, dental and behavioral health resources available; *Continue to develop internal resources to better meet the needs of the children and their families (e.g. recruitment of additional professionals); *Through a Needs Assessment of this special population, develop a list of priorities for consideration by public and private entities; *Continue to foster a close working relationship/referral network with Children's Mercy in Kansas City; *Expand the availability of handicapped accessible transportation; improve the quality now available;

*Work with the care coordinators now providing services on improved communication with the families ensuring a clear understanding of what is expected and needed; facilitate if needed.

- *Leavenworth County:* Will ensure 100 percent of the patients seen for special needs get care coordination to help them get the care they need for their child. They will identify needs at the well child visit and assist with care coordination through a social worker. They will assist with insurance access if needed.
- *Neosho County:* Will assist all families with CSHCN in navigating the healthcare system. They will provide resources based on individual needs, assist with applying for special healthcare needs, Medicaid, and/or private insurance. Assist with scheduling medical appointments and any Individual Education Plans.
- *Miami County:* Is rebuilding their CSHCN satellite office program with new staff. Their goal is to serve 25 clients during the year. They will 1) Introduce and establish working relationship with MCH SHCN program staff at the state-level 2) Determine the onboarding and training processes for new coordinators and undergo evidence-based training and explore relevant curriculum 3) Explore and obtain resources and collaborative partnerships throughout each geographical area served 4) Explore internal processes for referrals and resource support 5) Ensure follow-up and appropriate processes are in place to best serve clients and families 6) Determine next steps for program evaluation and enhancement.

Other CSHCN Health Objectives

Objective: Increase the proportion of families of children with special health care needs who report their child received care in a well-functioning system.

The KS-SHCN program will continue to align with the National Standards for Children with Special Health Care Needs. The Bureau realignment will increase capacity (see Workforce Development and Capacity section) for the Title V Directors to engage in higher system level discussions to advance systems of care work and better support the KS-SHCN program. This will allow the program to focus on state mandated work and align with federally mandated expectations. Throughout the 2021-2025 reporting period, the State Plan will be reviewed annually with the FAC and priority areas will be identified for the program to work on. In FFY23, the focus will be on identifying gaps in the plan, specifically those noted within the insurance and financing domain, and will build a collaborative network of programs, providers, partners and families dedicated to advancing the systems of care to best meet the needs of the CSHCN population. The current state plan is viewed as a road map to strengthen services and supports for CSHCN and their families.

Educating families on the definition of a “well-functioning system” will continue to be key to accurate reporting from families on the services and supports they receive. The KS-SHCN program will continue to work to educate families on what they can and should expect from their care team and monitor their responses. Information gathered will be used to strengthen supports and services provided to clients and their families.

KS-SHCN and Medicaid Partnership: The general partnership between KS-SHCN and Medicaid is outlined in the Title V and Medicaid Partnership narrative. However, formal partnerships with the MCOs are desired to support inclusion and expectation of KS-SHCN partnership during MCH Case Manager training and onboarding procedures. KS-SHCN will continue to offer educational presentations to MCO staff upon request, to provide a better understanding of the program and how complimentary the programs can be to each other, while reducing duplication.

Division of Health Care Finance (DHCF) and KS-SHCN staff have begun discussions around improving support services for clients with cleft lip/cleft palate. Lack of in-network orthodontic providers is the largest barrier in putting timely orthodontic services in place. Through discussion with multiple orthodontic providers, low reimbursement rates, extremely slow payment turn around and burdensome application processes are deterrents to becoming a Medicaid provider. Prior to COVID, Medicaid partners stated that they would do a fiscal review to determine if the current reimbursement rate is enough to cover the services provided by dental and orthodontic providers. Due to Medicaid staff turnover and COVID-19 this did not occur; KS-SHCN will pursue this again in the coming year. KS-SHCN also hope to begin open discussion with Medicaid to consider a carve out for these children that could be administered by KS-SHCN and eliminate long waits for approval

and repeated appeal processes for families, especially as the managed care contracts will be up for procurement in 2023.

Another partnership area of interest is reimbursement for care coordination services. Research across care coordination financing models will take place in the coming year and will drive discussions with DHCF and private insurers. Data collected through the primary care HCC expansion pilot (described in the Cross-Cutting Plan) will also be utilized to identify needs and adequate reimbursement rates to support these services across the state. It is believed the adequate reimbursement will help providers bring in the revenue to support having a Care Coordinator on staff to work with families and assist in their goals of establishing a comprehensive medical home. Under the OneCare Kansas approach to service coordination, it is believed that this same model could be established for the general child population.

Insurance and Financing Systems of Care for CSHCN: The Title V MCH Director, CSHCN Director and the HCC Consultant will be working to implement a three-phase approach to identifying gaps and barriers in the financing of systems of care for the SHCN population in Kansas. This process will include an environmental scan & service assessment; review of what insurance financing looks like in other states; and face-to-face meetings to gain more concrete information. All phases will build from one another to lead to the development of a state plan to address identified needs.

1. Phase 1: Will focus on holistic care coordination billing, insurance, and sustainability.
2. Phase 2: Will focus more specifically on the children and youth with special health care needs (CSHCN) population and their access to adequate care and insurance coverage.
3. Phase 3: Will look more specifically at population health needs of the CSHCN population and their families. We plan to build each phase with the knowledge we have learned from the previous.

Other KS-SHCN Program Activities

The KS-SHCN program will continue to: provide HCC services to those with medically eligible conditions; financial assistance through the Direct Assistance Programs (DAPs) and Special Bequest, meeting eligibility requirements; program strategic planning; staff workforce development; data system enhancements; quality improvement activities; peer supports; and family and consumer engagement efforts. DAPs are reviewed annually for necessary revisions – no changes were identified in SFY21, however the team recognizes the COVID-19 pandemic may have impacted the review, as there was a clear reduction in requests for services. The team plans to closely monitor the need and will determine if changes are needed mid-year. An additional diagnosis was added to the medical eligibility list (under the craniofacial anomalies umbrella) as the treatment for plagiocephaly has been a long-identified service gap, with treatment not routinely covered by either public or private insurance. Treatment can be expensive, and if left untreated can lead to serious complications including head deformities and possible severe and permanent pressure inside the head.

Peer Supports for CSHCN: KS-SHCN will continue to engage as a Supporting You Network Program. The KS-SHCN program has been a participate in the Supporting You program for the last few years but has not made the progress desired due in part to the pandemic. Program staff felt that with the move from only state status specific condition to expansion of conditions for all special health care needs populations it would be easier to grow the program while helping a larger number of families across Kansas. The program will continue to promote these services to families who may benefit from additional peer support. The KS-SHCN program continues to identify parents who have become experts in navigating the various systems of care for recruitment as a Support Peer. The KS-SHCN Program Manager will work with the Peer Support Administrator to determine other recruitment strategies and conduct ongoing monitoring of support matches. Read more about Supporting You in the Cross-Cutting Report and Plan. Additional shifts will be occurring in SFY23 to include:

1. Diversification of dedicated KS-SHCN program staff to support and promote Supporting you;
2. Addition of Supporting You as a core component of the KS-SHCN program in brochures/materials, presentation, media promotion and informational booths;
3. Development and implementation of a dedicated outreach plan that includes goals and monitoring;
4. Development of additional 200 (program required) & 300 (optional) level training series for Supporting Peers; and

5. Research, plan and development of Supporting You for Spanish speaking families.

Per interest and recommendation from the FAC, KS-SHCN plans to partner with the Kansas Chapter of the National Alliance for Mental Illness (NAMI) to provide the *Ending the Silence* training for adolescents experiencing mental health needs. Currently, NAMI provides trainings in school settings to support adolescents in understanding the importance of taking care of their mental health needs, when to seek help, and resources/tools to respond in a positive manner to those experiencing a mental health situation. This will help to decrease stigma associated with mental health conditions, providing an outlet for adolescents needing supports to reach out. Additionally, youth may be more likely to provide support for their peers when they feel more equipped or have a better understanding of where they are coming from.

From NAMI Kansas Offering Brochure about the Ending the Silence Presentation

NAMI Ending the Silence Presentation is a 50-minute in-school interactive presentation that helps teens, ages 13-18, learn about the warning signs of mental health conditions and what steps they can take to find support for themselves or their friends.

Who can participate?

NAMI Ending the Silence is designed for middle and high school-age youth. The program is typically presented in a health, science or psychology class, but may also be provided to youth groups, clubs and after-school programs.

Care Coordinator Training and Workforce Development: The KS-SHCN program leads va and understand the importance of a strong and informed workforce, therefore this will continue to be an ongoing process where additional training opportunities will be identified and offered to KS-SHCN staff (including SO Staff) regularly. Not only will the SHCN team have a one-day in-person training event with designated training curriculum, but they will continue to have bi-monthly webinars and brain trust calls. Daily support will continue to be available to all SO staff via the Lead Care Coordinator (LCC) but beginning in SFY23 a new mentorship support will be introduced. The peer-to-peer mentorship support will be set up and monitored in collaboration between the SHCN Program Manager and the LCC to support new staff and SO staff while lessoning the burden on the LCC of being the only one currently providing support to SO.

Program Policy & Service Delivery Changes: Remaining relevant among ongoing shifts to the health care industry and changing needs of communities is critical for a program like KS-SHCN. The program reviews program data annually to adapt and provide meaningful and coordinated supports to families. This generally includes: HCC data review; a determination of statewide or local clinical support needs; DAP service utilization; and policy revisions.

- *New HCC Eligibility:* KS-SHCN will continue to offer HCC service to applicants who qualify medically, removing financial eligibility requirements. Prospective clients will still be required to complete the full application, to provide opportunity for the Care Coordinators to determine if they are eligible for other supports too, however this is expected to increase the number of families the program can reach. Careful monitoring will assure program staffing capacity is assessed regularly to meet the needs of the additional clients.
- *SO Changes:* Data is reviewed annually around the reach and impact of each SO, to determine if a shift in staffing, regional boundaries, or resources is needed. The number of SOs was decreased by one, Saline County, in SFY22, which required a shift in the regional boundaries. Two SO's (Ellis and Neosho) agreed to add additional counties to their region, with the Topeka office absorbing the remaining counties, to ensure the continuation of care and promotional efforts for that region. In the upcoming year, efforts will be made to identify new satellite office partners for this region and other areas as needed. The newest satellite office, located in Neosho County began providing services July 1, 2020, and quickly became a much-valued partner of the KS-SHCN program team. Their true dedication to serving those in their community has not only led them to becoming part of our team, but

has also led to an exploration of additional MCH initiatives and trainings to incorporate these services into their health department. Upon assessment of the population served, including geographical location and language(s) spoken, Neosho County is providing an additional bi-lingual staff to serve the roughly 20% Spanish-speaking clientele, improving service delivery and reducing burden for state bilingual Care Coordinators. Due to the need to reach a larger client base the KS-SHCN program will require SO's to begin improving their outreach capacity by adding specific outreach expectations, providing them with new marketing materials, monthly electronic newsletter and increasing the programs social media exposure.

- *Enhanced Data Capacity.* KS-SHCN will work with the data vendor to enhance data reporting and evaluation capacity, specifically tracking and monitoring direct and indirect care coordination activities, referral sources, outcome measures and other data elements. Additionally, the program plans to develop a family portal for the system, so families can access key program information and documents (e.g., action plans, service authorizations), update their application, and send secure messages directly to their Care Coordinator. During FY23, the KS-SHCN program will conduct a comprehensive review of the income guidelines and governing regulation to identify the possibility of increasing the income guidelines and implementing the sliding fee scale for all clients. Moving from a 100%, 50% and 25% scale to a 100% and 50%, but with higher Federal Poverty criteria.

Expansion of Newborn Screening Conditions: The KS-SHCN program continues to expand services to support a wider variety of children with special needs beyond the specified conditions as noted in the state statuses. As new conditions are added to the newborn screening panel for the state thoses conditions are automatically added. With the XLD being the newest condition to be added soon. The CSHCN Director or SHCN Program Manager will continue to participate on the newborn screen work group for this condition. Information will continue to be shared with the KS-SHCN team about services and supports clients with this condition need. A review of current Direct Assistance Programs (DAPs) will be done to identify if changes need to occur to accommodate for this and other new conditions a they are added. If changes need to occur to DAP's these are made, tracked, and monitored using QI/QA tools until they are refined and meet the needs of children and families.

While state statues dictate what financial support the SHCN program can provide though DAP's, program staff will continue to identify ways to provide support to other special health care needs populations. As the KS-SHCN workforce continues to strengthen it is the hope of program staff to begin offering care coordination services to additional populations. Currently, any family with a child with any type of special health care need is able to participate in the Systems Navigation Trainings for Families and the KS-SHCN Supporting You components for the program.

Local MCH Agencies: Local agencies will improve systems of care for CSHCN. A few examples include:

- *Barton County:* Will be knowledgeable of internal and external services provided regarding care of our CSHCN population, through staff training at our staff in-service on Sept 9, 2022. Barton County Health Department will use the IRIS referral system to connect families to needed services or assist in connecting them to schedule these services. Their agency will also educate families on information needed in successfully bridging the gap between them, their families and services/providers.
- *Community Health Center of Southeast Kansas:* Plan to continue to be a resource for all of our special needs children and an advocate for them and their families within other systems of care. Activities that will be completed to move closer to this goal include.... *Provide and advocate for care that creates a positive experience for children and their families (e.g. sensory rooms, sedation dentistry, etc.); *Continue to work with specialty centers (e.g. KU) in the provision of services via televideo or on-site that reduces the logistics burden on families; *Connect families to all available services; facilitate enrollments/participation in state-funded initiatives (e.g. Systems of care survey). *Develop a local resource guide for families with updated contact information and participation requirements; *Create a peer support group for family members of special needs children; offer educational sessions of interest; *Complete a Comprehensive Needs Assessment for Special Needs Children in Southeast Kansas; disseminate findings.

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

Domain: Cross Cutting - Workforce Development

SPM 3: Workforce Development (Percent of participants reporting increased self-efficacy in translating knowledge into practice after attending a state sponsored workforce development event)

ESM: Percent of participants reporting increased knowledge after attending a state sponsored workforce development event

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SPM 3: Percent of participants reporting increased self-efficacy in translating knowledge into practice after attending a state sponsored workforce development event

ESM: Percent of participants reporting increased knowledge after attending a state sponsored workforce development event

MCH Local Agency Technical Assistance Webinars: State MCH staff provide technical assistance and training webinars throughout the year to local MCH agencies. Topics are identified based on emerging issues identified by state or local staff; identified need for reporting changes in the health care/public health system; need for increased collaboration with other partners; and/or identified need for assistance with screening, intervention, education, referral or other services or supports provided at the local level. A variety of topics were presented during FFY21 (see table below).

Date	Title/Topic	Attendees
10/25/2021	BaM Technical Assistance Webinar	23
10/21/2021	MCH Lunch and Learn: Perinatal Behavioral Health Services and Resources	39
9/19/2021	MCH Lunch and Learn: Youth in Crisis: Adolescent Suicide Prevention	34
8/19/2021	MCH Lunch and Learn: Maternal Warning Signs	58
7/29/2021	1-800-CHILDREN Supporting Parents	21
7/22/2021	1-800-CHILDREN Supporting Parents	23
7/7/2021	MCH Opportunity Project Kickoff	7
6/28/2021	BaM Quarterly Webinar	35
6/8/2021	Maternal Warning Signs Initiative Kick Off Webinar	97
5/12/2021	KDHE LARC Lunch and Learn	15
4/26/2021	BaM Quarterly Webinar	29
4/15/2021	KDHE Black Maternal Health Week Webinar	81

In August 2021, KS Title V launched a *Maternal & Child Health: Third Thursday Webinar Series*. Local MCH programs, community providers, and system partners are invited to participate in these monthly learning opportunities. Sessions focused on providing information on initiatives and resources that can be applied to maternal and child health work across the state. Session presentations, recordings, and resources are shared with all registrants following the live webinar. FFY2021 webinars include: Maternal Warning Signs and Youth in Crisis: Adolescent Suicide Prevention.

Maternal & Child Health:
Third Thursday Webinar Series

Join the Kansas Department of Health and Environment's Maternal and Child Health Team, along with subject matter experts from across the state, for monthly learning opportunities! These sessions will focus on providing information about initiatives and resources that can be applied to maternal and child health work in your community. Attend them all or join as your schedule allows! Register for individual sessions by clicking on the links, below. **All sessions will be held on the third Thursday of the month from noon – 1 p.m. CT.**

Maternal Warning Signs
August 19, 2021 - Register here

Youth in Crisis: Adolescent Suicide Prevention
September 16, 2021 - Register here

Perinatal Behavioral Health Services and Resources
October 21, 2021 - Register here

Adolescent SBIRT: Resource Guide and Toolkit Overview
November 18, 2021 - Register here

Tobacco Cessation During Pregnancy and Postpartum
December 16, 2021 - Register here

How to Build and Sustain a Perinatal Community Collaborative
January 20, 2022 - Register here

Supporting Kansas Families Through School-Based Health and Population-Based Approaches to Serving Children with Special Health Care Needs
February 17, 2022 - Register here

Women's Health Resources: Addressing Barriers to Preventive Care
March 17, 2022 - Register here

Month of the Young Child: Increasing Literacy While Reducing Screen Time
April 21, 2022 - Register here

KSKidsMAP: A Resource for Responding to the Pediatric Mental Health Crisis
May 19, 2022 - Register here

Consumer and Family Engagement: Essential for Maternal and Child Health
June 16, 2022 - Register here

MCH Opportunity Project: Health Equity Outcomes and Takeaways
July 21, 2022 - Register here

Objective: Increase the proportion of providers with increased comfort to address the behavioral health needs of MCH populations.

Mental Health First Aid Training: In partnership with the Labette Center for Mental Health Services, KDHE and KS Title V offered virtual Mental Health First Aid trainings to MCH providers. Mental Health First Aid is a skills-based training course that teaches participants about mental health and substance use disorders. Trainings are intended to also help participants build skills they need to reach out, provide initial support, and help connect individuals to appropriate care. Participants must complete a two-hour self-paced online training prior

to attending the 5.5-hour instructor-led online training. Two versions of the training were made available to providers:

- Adult: This training is for adults and focuses on adult mental health issues
- Youth: This training is for adults who work with youth and focuses on youth mental health issues

From December 2020 through April 2021, 14 Mental Health First Aid Training sessions were offered (11 Adult; three Youth), certifying 123 Kansas providers in Mental Health First Aid (94 Adult; 29 Youth).

Increasing Early Identification by Expanding Universal Screening Practices: Identifying needs is a critical first step to connecting individuals and families with appropriate services. Universal screening is a quick and effective strategy for identifying signs and symptoms of health risks. Screening for mental illness and substance use should be a part of comprehensive care provided across the lifespan. As such, KS Title V published behavioral health screening tools guidance and added screening forms to DAISEY in July 2021. These tools cover a variety of health risk areas and have been validated for use for different age ranges. KS Title V intends for this guidance to be used by local programs seeking to implement or enhance their behavioral health screening practices. Programs should follow the best practice guidelines referenced throughout the guidance and are strongly encouraged to follow the U.S. Preventive Services Task Force's recommendation for screening to be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow up for all health screens for all populations. A Plan of Action form will be populated in DAISEY for moderate or high-risk screening results. This form allows for local MCH staff to document that a brief intervention was conducted, the type of brief intervention provided, indicate referral(s) made, and summarize any emergency or support services initiated for a client experiencing a crisis.

Table 1: Behavioral Health Screening Forms Available in DAISEY, effective July 2021

Acronym	Screening Tool	Risk Assessment
ASSIST	Alcohol, Smoking and Substance Involvement Screening Test	Adult substance use
CRAFFT 2.1+N	Car, Relax, Alone, Forget, Families/Friends, Trouble + Nicotine	Adolescent substance use
EPDS	Edinburgh Postnatal Depression Scale	Perinatal anxiety and depression
GAD-7	General Anxiety Disorder	Anxiety
PHQ-9	Patient Health Questionnaire	Depression
PHQ-A	Patient Health Questionnaire Modified for Teens	Adolescent depression
PSC-17	Pediatric Symptom Checklist	Child and adolescent mental health

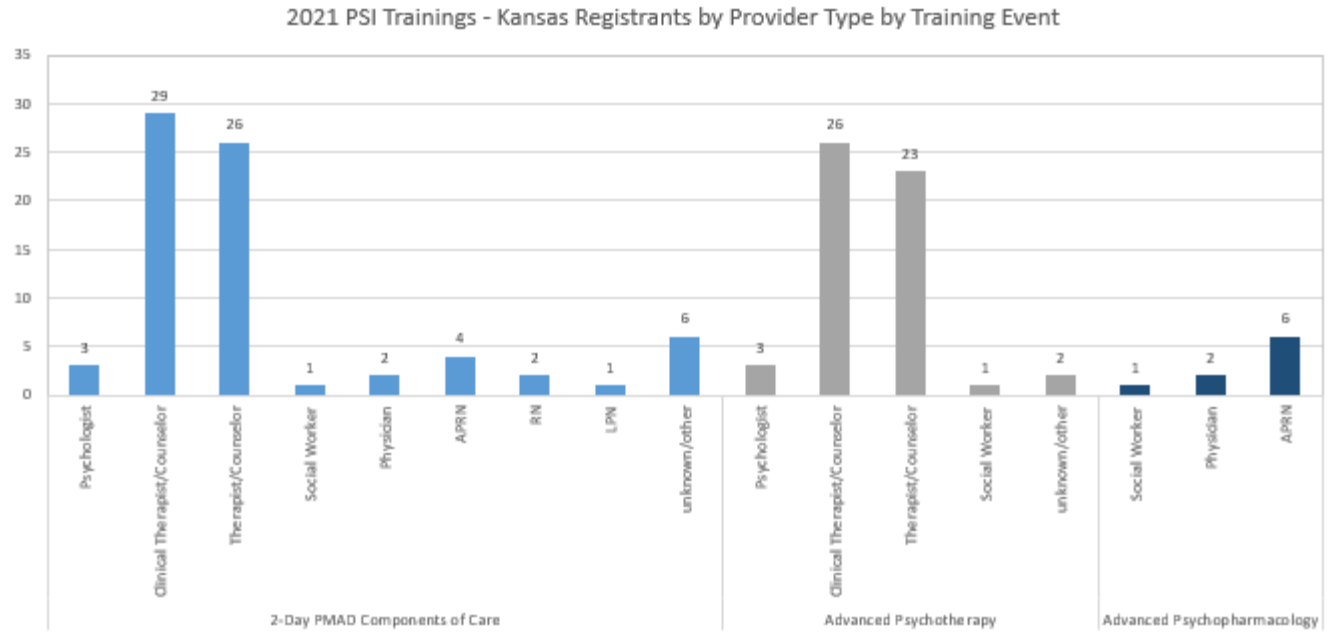
The Guidance includes framework for administering behavioral health screenings (e.g., selecting a validated screening tool for the population, preparing your agency, establishing and formalizing a local system of care), support resources, and a one-page overview of each behavioral health screening tool available in DAISEY. Examples of the screening tool overview sheets are included, below. Feedback received from the November 2020 COVID Listening Sessions indicated the need for electronically fillable data collection and screening forms. English and Spanish screening forms were created as fillable PDFs and published on the DAISEY Solutions webpage in January 2022. Title V utilized validated Spanish forms, when available, and solicited feedback from providers that work with Spanish-speaking clients to ensure the translated documents were dialectically appropriate.

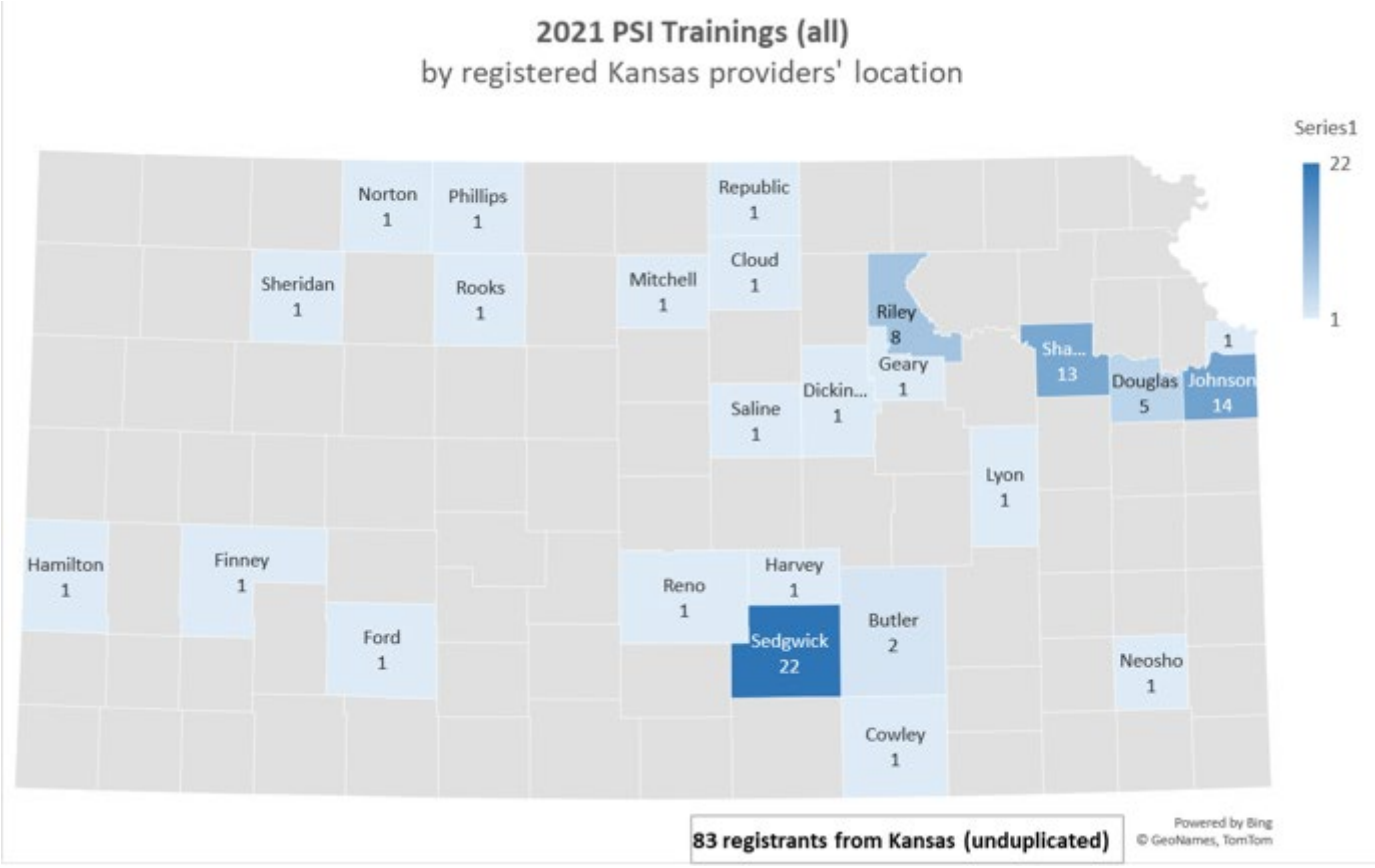
Perinatal Behavioral Health: BFH was awarded the HRSA *Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program* Cooperative Agreement funding in October 2018. The project provides the opportunity to increase health care providers' capacity to screen, assess, treat, and refer pregnant and postpartum women for depression, anxiety, and substance use disorders. Title V leads the vision for this project (from application to implementation) titled Kansas Connecting Communities (KCC), which is managed by the Behavioral Health Consultant. Through this alignment, several KCC workforce capacity opportunities were made available to local MCH agencies:

- Access to the *Perinatal Provider Consultation Line* for resource and referral support and case consultations at no cost. KCC announced Dr. Erin Bider, M.D., a peripartum psychiatrist, was joining their team effective September 20, 2021. Dr. Bider is the only peripartum psychiatrist in Kansas; practitioners can now receive clinical case consultations with Dr. Bider via the Consultation Line.
- *Project Extension for Community Healthcare Outcomes (ECHO) Series:* In April 2021, KCC held its third ECHO series in partnership with KU Medical Center. The series included four, 1-hour sessions on

various topics related to perinatal behavioral health: *Frontline Medical Providers' Role in Treating Perinatal Behavioral Health Disorders, Medication Therapy for Maternal Behavioral Health, When Rx Isn't Enough: Care Coordination and Referrals,* and *A Post-Pandemic Outlook and Response to Perinatal Behavioral Health Conditions*. A total of 104 providers registered to participate with an average of 47 providers attending each session.

- *Maternal Mental Health 101*: This 1-hour introductory training focused on maternal mental health and its wide-reaching impacts on individuals, families, and communities. Facilitated by Melissa Hoffman – a provider and someone with lived experience – emphasized the importance of using non-stigmatizing language, being non-judgmental, and conveying empathy when working with someone experiencing a mental health condition. The training included conversation starters, referral planning, and promoted available resources, including the Perinatal Provider Consultation Line, Perinatal Mental Health Toolkit, and Perinatal Substance Use Toolkit. Total participants included 8 staff from local MCH programs.
- *Identifying Postpartum Depression During the Well-Child Visit: Resources for Screening, Referral, and Treatment*: KCC partnered with the Kansas Chapter of the American Academy of Pediatrics (KAAP) to offer two sessions of this 1-hour training. While aimed at pediatricians and family practice physicians, any Kansas provider could participate. The training featured the *Clinical Guidelines for Implementing Universal Postpartum Depression Screening in Well-Child Checks*, which is included in the Perinatal Mental Health Toolkit. A total of 44 Kansas providers attended the virtual trainings.
- *Postpartum Support International's Perinatal Mood and Anxiety Disorder Components of Care Training*: This 2-day evidence-based training is designed for nurses, physicians, social workers, mental health providers, childbirth professionals, social support providers, or anyone interested in learning skills and knowledge for assessment and treatment of perinatal mood disorders. A total of 74 Kansas providers attended the virtual training.
- *Postpartum Support International's Advanced Psychotherapy Training*: This 6-hour training is designed for mental health and psychotherapy providers and covers: differential diagnosis, evidence-based psychotherapeutic approaches, and advanced therapeutic issues. A total of 55 Kansas providers attended the virtual training.
- *Postpartum Support International's Advanced Psychopharmacology training*: This 6-hour training is designed for prescribing providers, focuses on psychiatric pharmacology during pregnancy and lactation, and covers: differential diagnosis, medication challenges, case examples, and research on medication safety. A total of 9 Kansas providers attended the virtual training.





- KCC provided technical support and guidance in implementing substance use disorder (SUD) screening to the Kansas Perinatal Collaborative Communities (KPCC) implementing the Becoming a Mom© (BaM) prenatal education series. Utilizing the NIDA Quick Screen, a new question was added to the participant completed Initial Survey. Positive responses to the NIDA elicit follow up, via a one-on-one interview with BaM staff utilizing the full ASSIST tool. KCC also assisted Title V staff with updating the BaM Perinatal Mental Health Integration guidance and algorithms to reflect these changes.

Other KCC Activities:

- In partnership with Wichita State University (WSU), prepared a *Perinatal Support Group Guidebook*, with contributions from the Kansas Chapter of Postpartum Support International, including from their members with lived experience. The Guidebook was developed to provide information and guidance to local programs looking to start a perinatal support group. It provides practical tips and ideas for creating and maintaining a support group, including information on recruitment and promotion, establishing group agreements, group structure and environment, choosing a group's location (e.g., in-person and virtual meeting place considerations), facilitator roles and responsibilities, and how to keep a support group going. To support implementation of this guidance, KCC/WSU partnered with two Kansas Perinatal Community Collaborative participants: Delivering Change (Geary County) and Saline County Health Department as part of a Perinatal Peer Support Group Technical Assistance Project. The project launched in September 2021 and will conclude in June 2022.
- KCC facilitated a rapid five-month technical assistance project with six family practice/midwifery clinics from May-September 2021. Participating clinics received implementation technical assistance and case consultations led by the KCC Expert Team to support screening and treatment best practices during pregnancy.
- KCC continued publishing its E-Newsletter, the *Perinatal Press*. The newsletter includes information about KCC activities (e.g., Consultation Line, upcoming trainings, program updates) and perinatal behavioral health resources, like the integration toolkits. The newsletter is released on a quarterly basis and shared with MCH partners. Each newsletter edition includes a "spotlight." In one edition, KCC featured information on the positive impact of peer support and maternal mental health:

SPOTLIGHT

Peer Support and Maternal Mental Health

"I was absolutely convinced- with every fiber of my being- that I was alone, that no one could possibly understand, that there was no way out and no way to find support in this struggle. I am happy to tell you that I was wrong."

This feeling of helplessness, submitted by an anonymous participant of a peer support group, reflects how the experience of pregnancy and postpartum can be a difficult time on its own. Add that to the mental health and/or substance use challenges during this time, and it can be overwhelming. Connecting moms with peers who have faced similar challenges is one way to effectively support them. Support groups and individual peer support have been shown to foster resiliency, give hope, and enhance treatment that may be happening simultaneously. Peer support impacts lives, and supports, not replaces, medical and psychiatric treatment. Peers are experts on recovery because they are living it; the healing and hope contained within the peer relationship cannot be found elsewhere. It is a gift to be celebrated and shared!

Are you or your organization passionate about supporting moms in this way? For information and resources related to finding, starting, or maintaining a perinatal peer support group, contact Kansas Support Group Services at supportgroups@wichita.edu. The Support Group Toolbox is also a valuable resource in guiding local peer support group development.

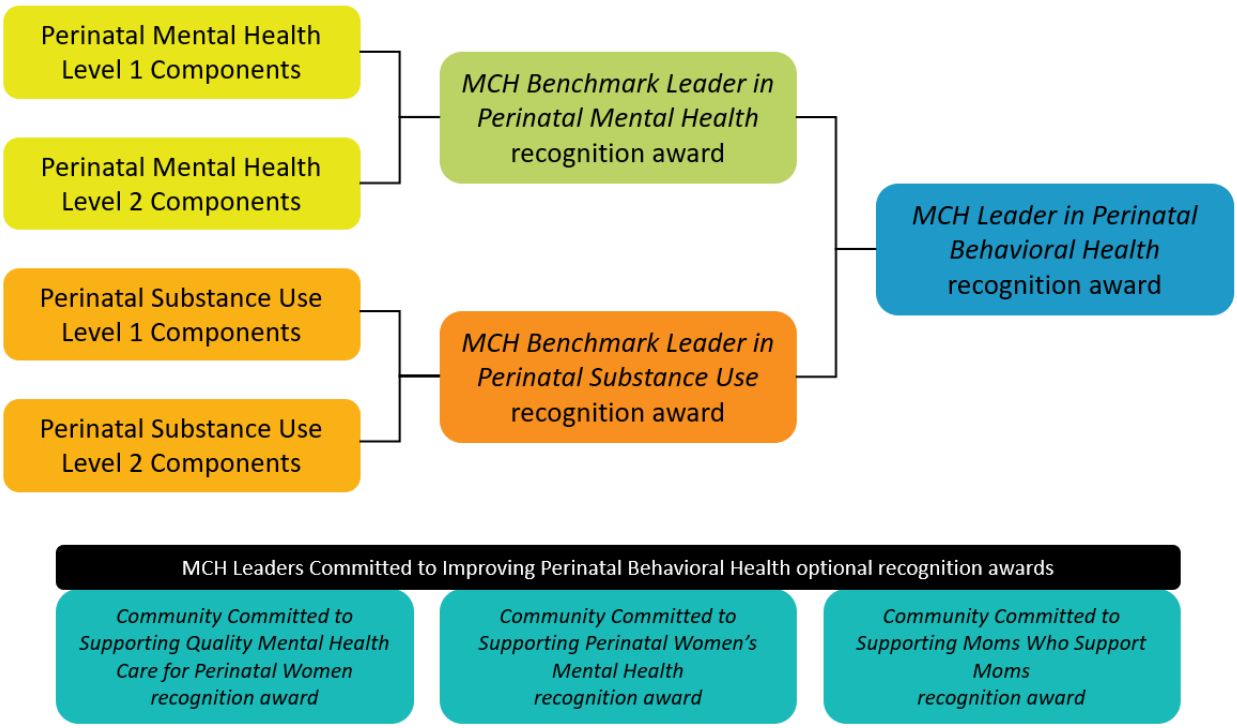
Kansas Support Group Services is developing a Perinatal Peer Support Guidebook in coordination with KCC and other state and local perinatal behavioral health stakeholders. It is tentatively scheduled to be published by Fall 2021. If you or your organization are interested in more information on funding opportunities related to local perinatal peer support group development through the KCC grant, email kcc@ku.edu.

Other KCC Updates and Announcements:

- KCC was featured by HRSA's Division of MCH Workforce Development in their *Partnerships in Action* highlight (September 2021). The information shared via HRSA listserv included two of KCC's community focused partnerships with Kansas Perinatal Quality Collaborative and CKF Addiction Treatment to improve maternal health outcomes.
- Kansas and KCC was featured in the AMCHP/NASADAD *Screening, Brief Intervention, and Referral to Treatment for Pregnant and Postpartum Women* October 2020 Issue Brief. The program summary featured key workforce development activities, including trainings, technical assistance, consultations, and resource development, highlighting the Perinatal Substance Use Toolkit.

Communities Supporting Perinatal Behavioral Health Community Collaborative: There is great interest in the expansion of KCC, and BFH is seeing a demand for additional perinatal behavioral health trainings from local MCH programs. To meet this need, a Collaborative launched in July 2020. The opportunity provided five local MCH programs to partner with the BFH to receive targeted technical assistance, 1:1 interaction, and networking across programs on a quarterly basis to gain ideas and guidance. The goal is for MCH programs to implement perinatal behavioral health screenings, brief interventions, and referrals to treatment into their practice that meets the benchmark standards recently established. These "standards" can be used as a guide by local programs to strengthen their perinatal behavioral health practices. Once a participant completes both benchmarks, they are recognized as an *MCH Leader in Perinatal Behavioral Health*.

Framework for the Community Collaborative & Recognition Awards



Addressing perinatal behavioral health and improving health outcomes is much broader in scope than screening alone. BFH developed a list of components to serve as guidance for local agencies to enhance their programs. Becoming an "MCH Benchmark Leader in Perinatal Mental Health," includes screenings, brief interventions, and referrals to treatment for perinatal mood and anxiety disorders. Similarly, becoming an *MCH Benchmark Leader in Perinatal Substance Use* requires implementation of perinatal substance use screenings, brief interventions, and referrals to treatment. Examples of these components are included below.

MCH Benchmark Leader in Perinatal Mental Health: Implement perinatal mood and anxiety disorders (PMADs) screenings, brief interventions, and referrals to treatment into clinical practice that includes both level one and level two components.

MCH Benchmark Leader in Perinatal Substance Use: Implement perinatal substance use screenings, brief interventions, and referrals to treatment into clinical practice that includes both level one and level two components.

Level 1 Components:

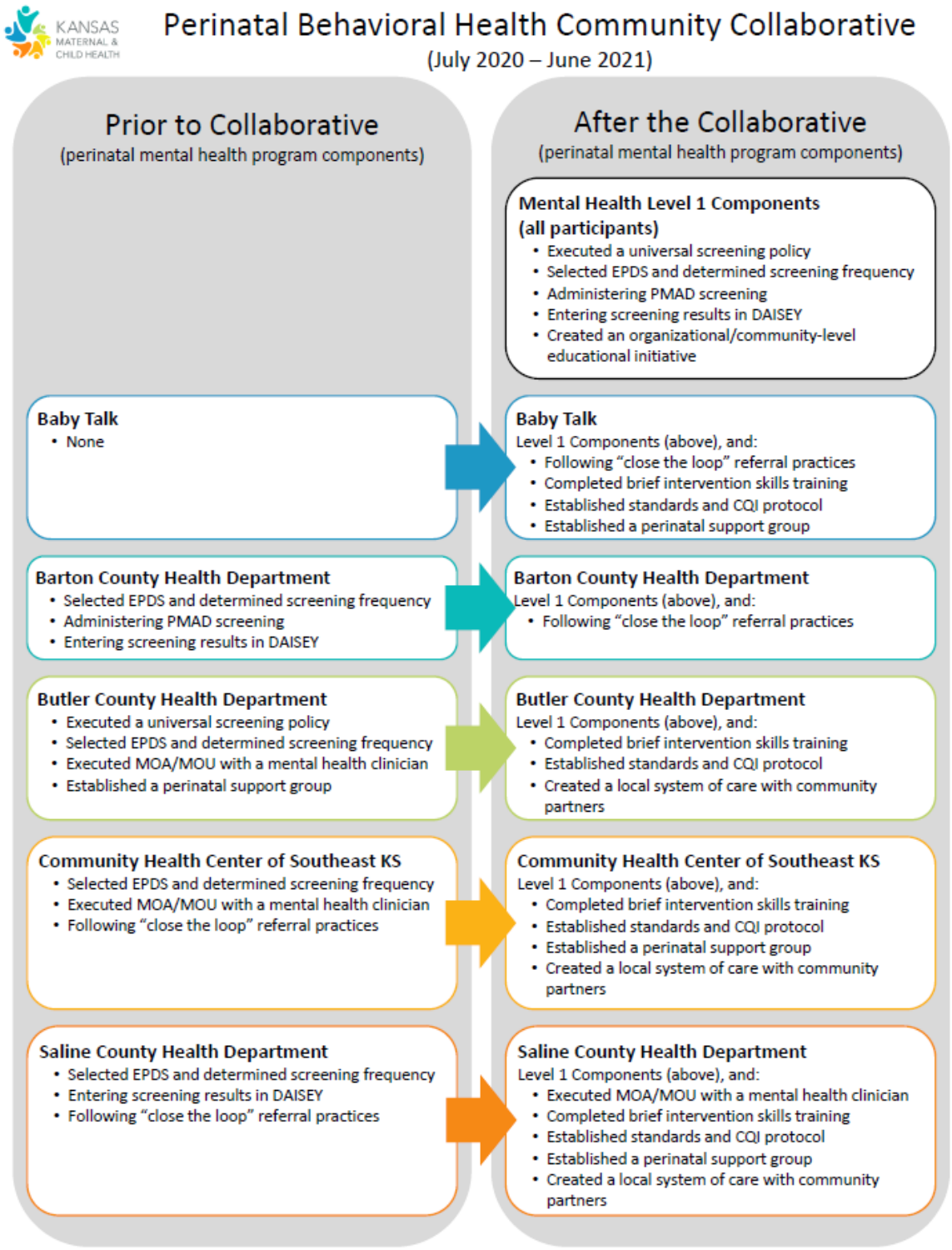
- Create, inform staff, and adhere to a universal PMAD screening policy for pregnant and postpartum women. The policy should include a response protocol for positive screens and crisis intervention. Individual(s) with lived experience of PMADs should be engaged in this process.
- Adopt the Edinburgh Postnatal Depression Scale (EPDS) as the validated PMAD screening tool used in practice.
- Determine screening frequency.
- Conduct validated PMAD screening during the established timed patient encounters. Provide brief interventions and referrals to treatment, when indicated. Screenings, brief interventions, and referrals to treatment should meet compliance with the adopted policy.
- 100% of all screens and action plans are entered into DAISEY.
- Utilization of the Perinatal Provider Behavioral Health Consultation Line, as needed.
- Establish at least one organization-level educational initiative (e.g., class, brochures/handouts, posters, etc.) aimed at increasing awareness, decreasing bias, and providing information to perinatal women and their families about PMADs.

Level 2 Components:

- Establish a Memorandum of Agreement/Understanding (MOA/MOU) with a local substance use treatment provider for substance use assessments and/or with a substance use treatment provider who will conduct assessments using telehealth.
- Follow the established IRIS Community Standards for making referrals and "closing the loop" communication practices. For non-IRIS communities, make referrals for treatment, when indicated, and follow up to ensure patient was able to access treatment services.
- Participate in a training focused on brief intervention skills-building.
- Establish local standards for recognition and response to measure compliance, understand individual performance, and track outcomes. Use DAISEY reports to guide quality improvement projects.
- Establish and/or promote a community perinatal support group. The group should be registered on http://SupportGroupsInKansas.org.
- Establish at least one community-level educational initiative (e.g., social media campaign, multi-media advertisements, etc.) aimed at increasing awareness, decreasing bias, and providing information to perinatal women and their families about perinatal substance use.
- Establish a local system of care for perinatal women and their families, which should include (where available), but is not limited to, MCH programs, an obstetrician/gynecologist, a pediatrician/family physician, a substance use treatment provider, and a person with lived experience of perinatal substance use. Members of the local system of care should establish community standards that include building and maintaining a non-judgmental culture of safety and care.

Throughout the 12-month Collaborative, numerous engagement modalities were used for resource-sharing, networking, and providing technical assistance: all-participant webinar and virtual meetings, 1:1 virtual meetings (phone and video), and participant-to-participant virtual information exchange. All five Collaborative participants (Baby Talk: KU-W, Barton County HD, Butler County HD, Community Health Center of Southeast

Kansas (CHCSEK), and Saline County HD) focused on the perinatal mental health components, while only two (Barton County HD and CHCSEK) focused on the perinatal substance use components.



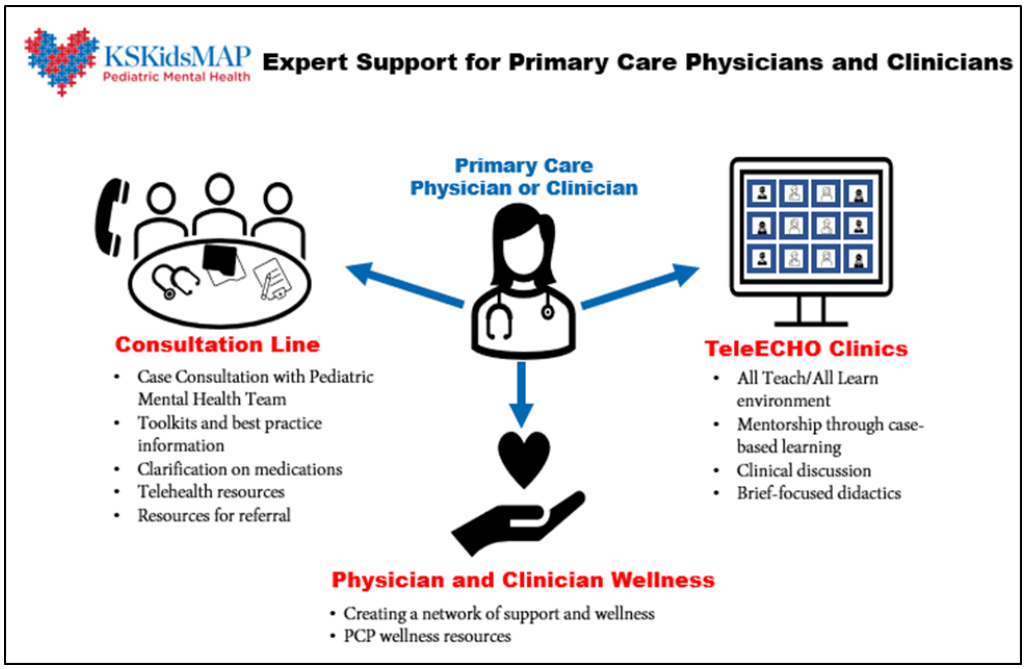
Paternal Postpartum Depression (PPD): Postpartum depression affects about 1:7 women (with 14.3% of Kansans with a recent live birth in 2020 reporting postpartum depressive symptoms, according to Kansas PRAMS data). However, many are surprised to learn that 10% of fathers experience PPD, and prevalence can increase up to 50% when the mother is also experiencing perinatal depression. It is important for providers to understand the signs, symptoms, and onset differences between paternal and maternal depression to increase identification and early interventions. For example, women experience stress, crying, sleep problems, and loss of interest or pleasure in things they usually enjoy at significantly greater rates than men. Alternatively, men

experience anger attacks/aggression, substance abuse, and risk-taking behavior due to depressive symptoms at significantly higher rates than woman. Preliminary research suggests the onset of paternal depression occurs much later in the postpartum period than maternal depression. In fact, findings suggest the rate decreases from birth to six-weeks post-delivery, but then steadily increases throughout the postpartum period. As with maternal depression, paternal depression is a treatable condition and men do recover.

BFH developed a Paternal PPD Package that was used in conjunction with the Perinatal Mental Health Toolkit. BFH promoted this in recognition of International Father's Mental Health Awareness Day (June 22, 2021). Components of the package is used to further increase provider awareness about the prevalence of paternal PPD, educate about the symptoms and how they differ from perinatal depression, serve as guidance for implementing paternal screenings into their clinic workflow, and offer programming considerations. In addition, the toolkit includes resources for fathers who might be experiencing PPD. An infographic was created for fathers to help increase awareness and offer guidance on how and where to access treatment services and supports. The infographic was reviewed by Geared Up Dads, a fatherhood initiative in Geary County. Using feedback received from Geared Up Dads, the infographic was modified into a tri-fold brochure.

Plans are in development for integration of a PPD component into the KPCC BaM curriculum and group support environment during sessions 6 and session 7, which is slated for a phased implementation period of July 2021-July 2022.

Pediatric Mental Health: As of September 30, 2021, more than 67.3% of Kansans lived with unmet mental health needs, based on the percent of the population living in mental health professional shortage areas.[1] With rising behavioral health concerns and shortage of mental health professionals in Kansas, more individuals are seeking treatment in primary care and emergency department settings. KDHE BFH was awarded HRSA's *Pediatric Mental Health Care Access Program* Cooperative Agreement funding in July 2019. The program provides the opportunity to promote behavioral health integration into pediatric primary care by supporting mental health care telehealth access programs. The project, KSKidsMAP, is a partnership between KDHE, KS Title V, and the University of Kansas School of Medicine-Wichita Departments of Pediatrics and Psychiatry and Behavioral Sciences. The program established a pediatric mental health care team to support enrolled primary care physicians and clinicians (PCPs) in treating behavioral health issues in their clinical practice. The Team includes board-certified: child and adolescent psychiatrists, child and adolescent psychologists, and pediatrician, as well as a social worker with expertise in pediatric mental health. The three main program components are led by the Team: Consultation Line, ongoing TeleECHO Clinic, and Physician and Clinician Wellness.

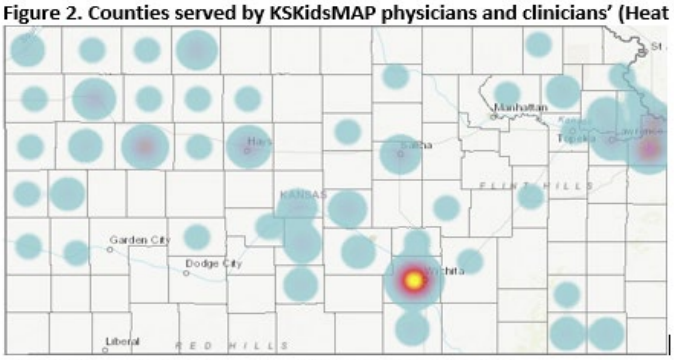


Through these activities, the KSKidsMAP Team equips PCPs with education, skills, and support to increase confidence and comfort in delivering evidence-based mental health care to youth in their clinical practice. In the first two years of the program (July 2019-June 2021), multimodality outreach activities (e.g., email/mail, in-person/virtual meetings and presentations, e-newsletter, media releases) resulted in the enrollment of 126 PCPs, who indicate serving pediatric patients in 62/105 Kansas counties (59%).

Table 1. KSKidsMAP Network

Physician/clinician Type	N (%)
Physician	77 (61.1%)
Nurse Practitioner	27 (21.4%)
Behavioral Health Clinician	7 (5.6%)
Social Worker	7 (5.6%)
Physician Assistant	2 (1.6%)
Registered Nurse	3 (2.4%)
Other	3 (2.4%)
Total	126 (100.0%)

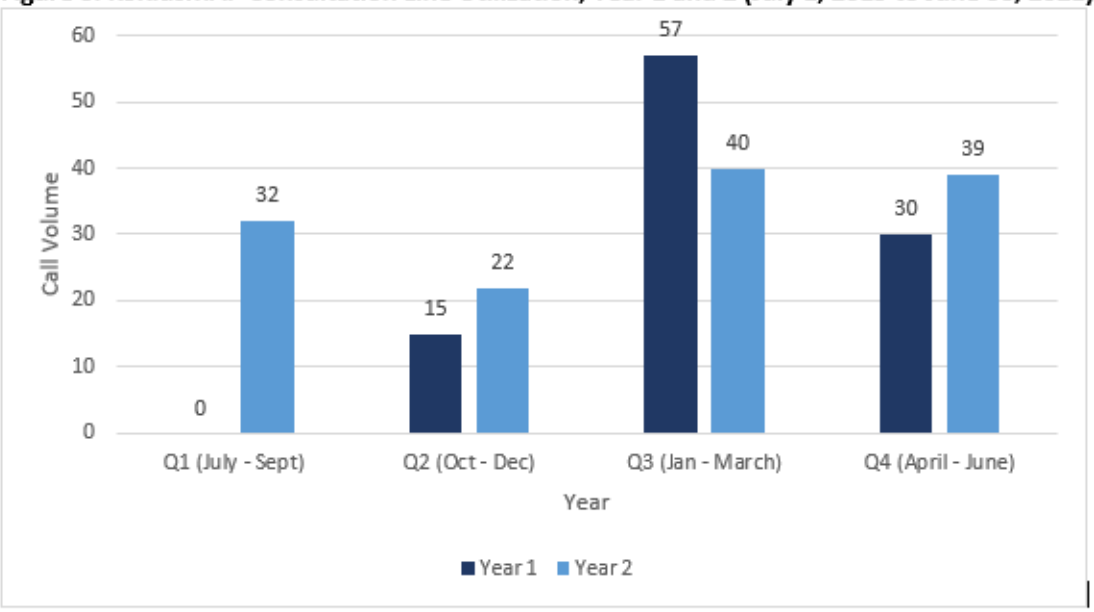
Figure 2. Counties served by KSKidsMAP physicians and clinicians' (Heat Map)



***Note:** Large circles denote high numbers in the given area

KSKidsMAP Consultation Line is staffed weekdays from 8 am-5 pm by the Social Worker/Care Coordinator, who assists PCPs by providing mental health and community resources, toolkits, best practice guidelines, referral information, and physician wellness resources. The social worker is also responsible for coordinating case consultations with the pediatric mental health team When a case consultation is requested, the Team reviews available behavioral health and psychiatric symptoms/concerns and makes recommendation for intervention treatment strategies. The Team works directly with the PCP during the case consultation. The PCP then provides care and treatment to the child/adolescent within their clinical practice. Enrolled PCPs can contact the Consultation Line for more than one reason at a time; from the soft-launch in December 2019 through June 2021, PCPs utilized the Consultation Line 242 times, resulting in 331 inquiries (averaging 4 inquiries a week).

Figure 3. KSKidsMAP Consultation Line Utilization, Year 1 and 2 (July 1, 2019 to June 30, 2021)



***Note**: The first quarter of year 1 focused on program development and building tracking tools and resource network. The Consultation Line soft launch in December 2019 until February 2020 when it fully launched.

Figure 4. KSKidsMAP Consultation Line Inquiries (July 1, 2019 to June 30, 2021)

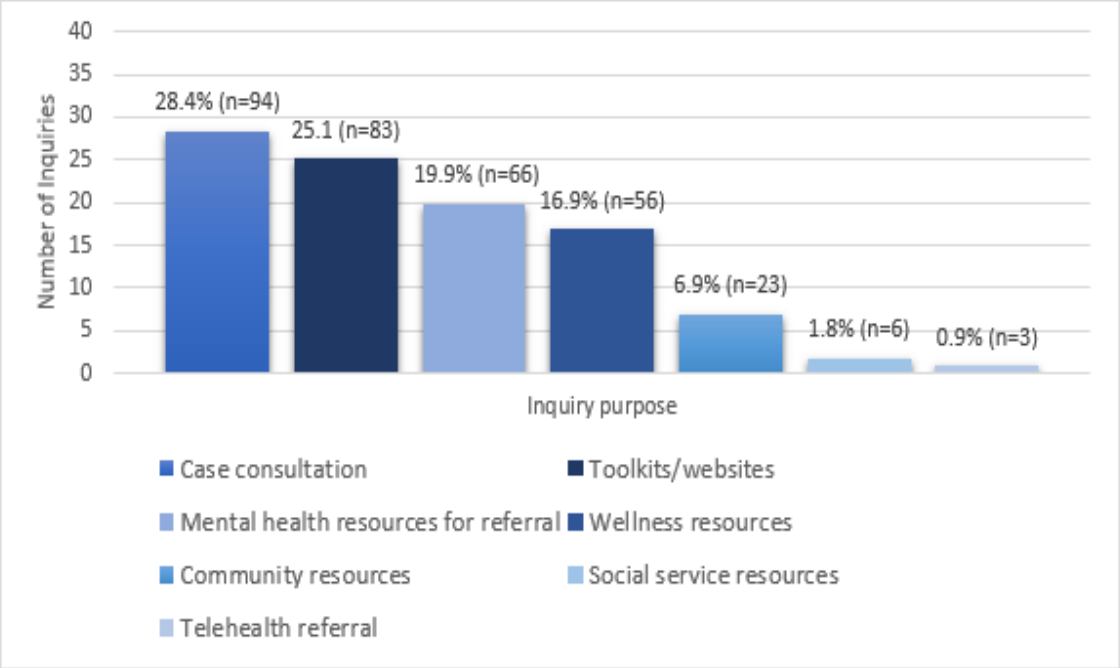
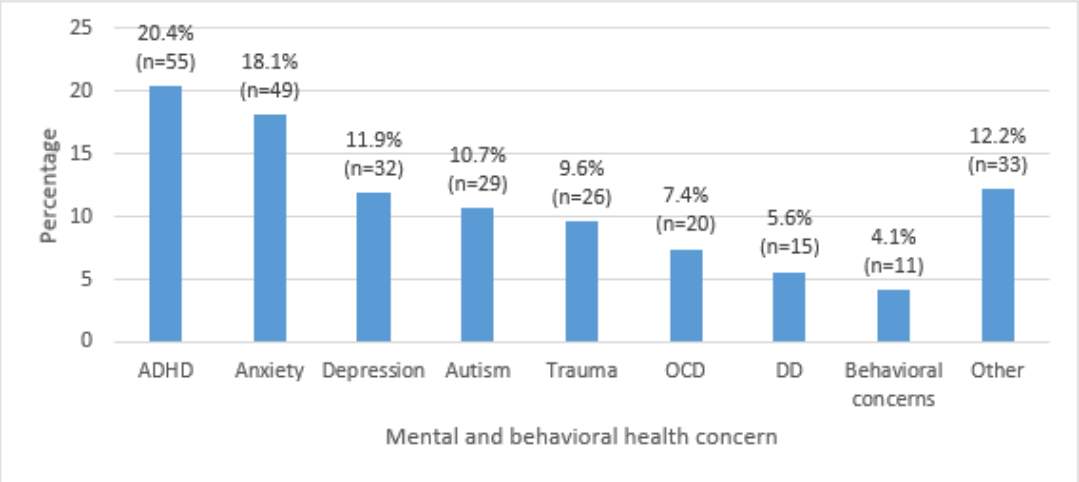


Figure 5. Specific Mental Health Disorders for Consults (N=270)

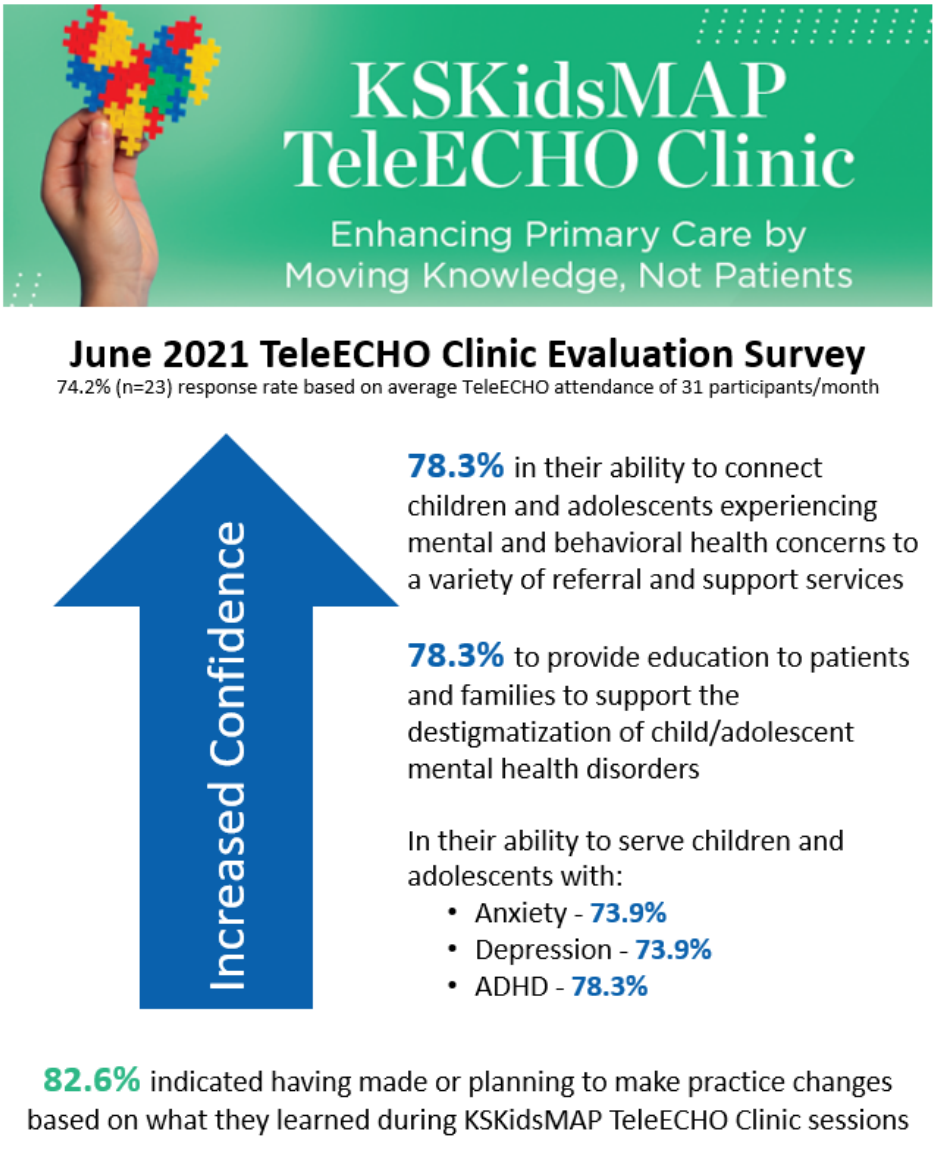


*OCD = obsessive-compulsive disorder
*DD= developmental delay
*Disorders categories under other include adjustment disorder (0.4%, n=1), bipolar disorder (0.7%, n=2), disruptive mood dysregulation disorder (1.5%, n=4), oppositional defiant disorder (1.5%, n=4), substance use disorder (3.0%. n=8), suicidal ideation (2.2%, n=6), eating disorders (1.5%, n=4), sleep concerns (0.7%, n=2), and self-harm (0.7%, n=2).

KSKidsMAP ongoing TeleECHO Clinic was launched in April 2020 following the Project ECHO model. This virtual clinic meets twice a month for case consultation and didactic learning on childhood/adolescent mental health needs in primary care settings. The TeleECHO Clinic philosophy is “enhancing primary care by moving knowledge, not patients,” and aims to create an “all teach/all learn” environment for PCPs to learn how to provide the best care for children and adolescents with behavioral health concerns. The Team facilitates the TeleECHO Clinic sessions and offers mentorship to support knowledge in practice. Each participant can present a case and receive feedback and recommendations from other PCP participants, as well as from the Team. Following each TeleECHO Clinic session, the recommendations are summarized, and additional resources are compiled and emailed to all session participants. As this is an ongoing virtual learning opportunity, practitioners commit to participating for six months, which has contributed to highly interactive clinic sessions and connection between practitioners in different areas of the state. Topics covered during sessions include how to use screening tools and make diagnosis, first line treatment and interventions, monitoring, following up, and when to refer for mental health concerns such as anxiety, depression, attention

deficit hyperactive disorder, and anxiety. Other topics discussed were sleep hygiene, physician wellness, COVID-19 implications to mental health relating to return to school. From the launch in April 2020 to June 2021, 86 PCPs have been trained through the KSKidsMAP TeleECHO Clinic, with an average of 12 practitioners attending each TeleECHO Clinic session.

TeleECHO Evaluation Surveys were administered in December 2020 and June 2021 to PCPs who participated in the Clinic sessions within the previous 6-months. There was a 48.4% (n=15) response rate based on average TeleECHO attendance of 31 participants each month for the December 2020 survey. Statewide access to specialist in the field of child psychiatry and collaboration across disciplines were noted as a strength of the KSKidsMAP TeleECHO Clinic. PCPs also noted the focus on best practices, variety of cases, discussion, and accessibility of the clinic sessions as strengths. One PCP shared, “the opportunity to interact with colleagues has helped a lot to lessen isolation.” PCPs shared an interest in learning more about self-care strategies during the COVID-19 pandemic, setting limits and saying no and preventing provider burn-out. In response to the feedback received from PCPs, KSKidsMAP continues conducting physician wellness sessions during TeleECHO and further explore how to best support their wellness. There was a 74.2% (n=23) response rate based on average TeleECHO attendance of 31 participants each month for the June 2021 survey. Of those who participated in the survey, 78.3% (n=18) indicated being somewhat (n=9; 50%) to very comfortable (n=9; 50%) addressing child and adolescent behavioral health concerns with families. Additionally, most PCPs indicated an increase in confidence in several areas, outlined on the graphic, below. Lastly, 82.6% (n=19) indicated having made or planning to make practice changes based on what they learned during the KSKidsMAP TeleECHO Clinic sessions thus far.



KSKidsMAP Physician Wellness activities were held throughout this report period. NIHCM published a *Physician Burnout & Moral Injury: The Hidden Health Care Crisis* infographic in March 2021, highlighting that 76% of health care workers reported feeling exhaustion and burnout, an increase from 35-54% in 2019. Recognizing that when PCPs have the tools and support mechanisms in place to increase or maintain their own positive personal wellness, the quality of care they provide within their practice is also enhanced, KSKidsMAP offered the following opportunities to enrolled PCPs:

- *Wellness Boxes* in recognition of Mental Health Awareness Month (May 2021): The Team distributed boxes to all enrollees to encourage them to prioritize their personal wellbeing. In response to receiving the wellness box, one PCP said, "I received [the box] on a particularly challenging day of clinic and it really meant a lot. I very much appreciate that you took the time to do that." Another PCP said, "What a great surprise and wonderful mood-lifter on a day when I really needed something."
- WorkWell Kansas' *Worksite Wellness Training* was delivered to six primary care clinics (32 attendees). The training focused strategies to increase productivity, decrease rates of illness, injuries, absenteeism, improve employee relations and morale, and enhance recruitment and retention of employees.
- A *Physician Wellness Retreat* was attended by six PCPs in May 2021 Retreat topics included: time management and the art of saying no; self-coaching strategies every physician should know; self-compassion exercises; overcoming imposter syndrome and quieting the inner critic; and secondary trauma and post-traumatic growth. Following participation in the retreat, one PCP shared, "I found the [retreat] refreshing. It was a blessing to know that I was not alone in my feelings. Listening to others help me understand my feelings and how to better deal with them."
- *Wellness Coaching Calls* were facilitated by the Institute of Physician Wellness.1-hour calls were facilitated for 4-weeks in June 2021 and focused on a different topic including giving ourselves permission for self-care; anxiety and the mind: staying grounded in uncertain times; setting healthy boundaries at work and home; and care alignment: values and interests across the lifespan. The goal of the physician coaching calls was to provide a safe space for PCPs to share, learn from each other, and be able to apply the concepts discussed to their personal and professional lives. A total of 13 PCPs participated in coaching calls. Following the final coaching call, a feedback survey was sent out to all participants; responses included the following comments:
    - "I wish I could have been exposed to these much earlier in my career."
    - "I would love to have another month of these sessions taking the topics to a deeper level. Would sign up again if available."
    - "I absolutely love the program. I wasn't always available at the session time due to meetings or emergencies, but I love the program and hope that it will receive ongoing funding to continue."
    - "Would love to see more wellness coaching sessions like the ones facilitated by Dr. Stepien. I have already started applying some of the tools she gave to my life and feel that my mental state has benefited greatly already."

Child Resilience/Preventing Adverse Childhood Experiences (ACEs): MCH staff continue its partnerships with other state agencies and local grantees to prevent adverse childhood experiences and provide training opportunities on not only the impact that trauma and toxic stress has on a developing child's brain but to shine a light on how small, everyday encounters can build resiliency skills and create an environment where children can thrive.

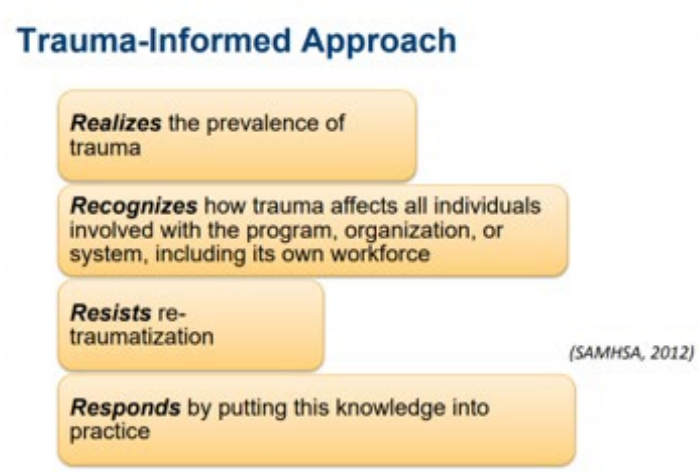
Community Partnerships: Universal behavioral health screening is most effective when providers work collaboratively to ensure adequate systems of care are in place supporting accurate diagnostic assessments, appropriate treatment, and essential follow-up. Having effective partnerships or collaboration is critical when creating and sustaining a local community of care. Title V developed a *Creating Effective Partnerships to Improve Behavioral Health* Outcomes guide for local MCH programs. The guide includes steps for developing effective partnerships (e.g., determine your needs, create new relationships), creating new relationships, enhancing existing relationships, and determining levels of involvement. Title V will develop a marketing strategy to promote use of the report by local MCH programs.

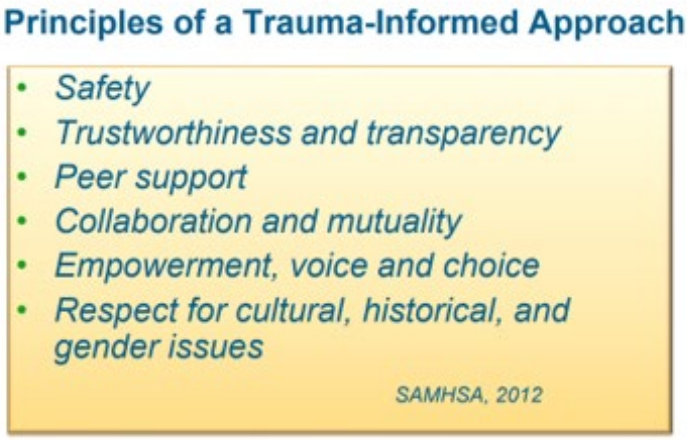
Objective: Increase the proportion of MCH local agencies implementing trauma-informed approaches that support increased staff satisfaction and healthier work environments.

Now more than ever it is essential that the MCH workforce recognize how trauma and stress impact their own wellbeing, just as much as of those they serve, related to both "normal" practices and the short- and long-term impacts of COVID-19 to their community. To be successful in addressing the needs of the MCH populations within their community, they must be well. Title V promotes the SAMHSA Culture of Wellness Organizational Self-Assessment (COW-OSA) to assist programs in gathering baseline information about their organization's strengths and shortcomings related to fostering a culture of wellness and resiliency. The COW-OSA includes ten domains and related standards that are characteristic of an organizational culture of wellness. MCH agencies are encouraged to use this self-assessment to identify wellness-related strengths and areas requiring further exploration and development. Title V provides support to local agencies accordingly, as well as identify support opportunities for the entire MCH network.

Title V is currently finalizing a resource guide, *Building and Maintaining a Resilient Team: Tools for the Public Health Workforce*, that includes vetted resources including: leadership and management during a public health crisis, building a resilient team, trauma-informed human resources best practices, and referral resources. The guide was distributed to local partners and one-on-one technical assistance is available upon request.

As healthcare providers begin to move beyond pressing needs of the pandemic, we continue to provide additional resources and tools on how to provide patient-facing trauma-informed care. Being "trauma informed" is much more than being sensitive or emphatic during an office visit. Addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment (SAMHSA, July 2014). SAMHSA has outlined the trauma-informed approach, as well as established principles:





In 2017, FAC families developed the a Trauma-Informed Approach Fact Sheet specifically to address the importance of providers utilizing trauma-informed approaches when working with families. When the AMP Team is convened, this will be reviewed to determine current relevancy and to inquire about recommendations for revision, expansion, or proposed strategies to implement into other workforce development efforts written in this narrative. The following from a presentation about the fact sheet.

Behavioral Health During the COVID-19 Pandemic: In response to the COVID-19 pandemic and in partnership with the Division of Emergency Management and Department for Aging and Disability Services, a *Kansas: Stronger Together* resource guide was developed.

- Resource Guide (print)
- Media Toolkit (print)

Through the partnership, Kansas was successful in its application for crisis counseling assistance and training program funding, receiving both the Immediate Services Program and the Regular Services Program awards to increase access and availability of crisis services.

Objective: Increase the proportion of MCH-led activities that address social determinants of health (SDOH) to reduce disparities and improve health outcomes for MCH populations.

MCH (Health Equity) Opportunity Project (MCHOP): Addressing health equity requires identifying and removing obstacles to health (e.g., lack of access to good jobs, quality education, safe housing and environments, fresh food, health care) to assure everyone has a fair and just opportunity to be healthy. In 2019, Title V partnered with the University of Kansas Center for Community Health & Development (KU-CCHD) to implement the first MCHOP with seven local MCH agencies to advance local efforts to assure equal opportunities for MCH populations regardless of income, education, age, race/ethnicity, or where people live. The 2nd cohort of the MCHOP was launched in July 1, 2021, utilizing the Kansas Healthy Communities Action Toolkit to encourage action in building communities with equal opportunities for healthy living and well-being. The toolkit provides questions to consider, recommended actions, and examples (resources and links to tools) to support filling out the application as well as learning about action in community work. Local agency participation was limited due to the demands of the pandemic on local health partners. Two agencies participated as MCH Opportunity Project partners, participating in monthly trainings and carrying out work related to health disparities. Sumner County Health Department focused work on increasing vaccinations among the pregnant and postpartum population while Barton County Health Department worked to increase the number of children who had blood lead tests. Final reports that outline the successes and lessons learned from this project will be completed in spring of 2022.

Birth Defects Prevention Campaign: The Centers for Disease Control and Prevention states that one in 33 children are born with a birth defect each year. Kansas is no exception; in 2018, Kansas recorded 36,247 births to resident mothers with a reported 1,021 of the 47 most common, reportable birth defects. The goal is to lower the incidence rate of birth defects in children born to Kansas families by increasing awareness, education and information going to families about birth defects.

To reach MCH populations, a large social media presence was implemented January 2022, aligned with the National Birth Defects Prevention Month. Each day of January will highlight new information targeted towards MCH populations using KDHE-generated materials, data, and other pre-developed materials provided by the Centers for Disease Control and Prevention, the National Birth Defects Prevention Network, and March of Dimes. To further reach populations, hard-copy brochures are provided to Kansas birthing providers for distribution to those without access to social media. Included in the materials will be information about programs offered for families that may help pay for things such as prenatal vitamins and healthcare provider visits. The remainder of the year, the Birth Defects Surveillance (BDS) program provide content for Screening and Surveillance Unit social media campaigns.

Other MCH Workforce Development Activities

The MCH Navigator and online MCH Assessment continue to be utilized in the professional development planning and performance reviews for all staff. All MCH program staff and supervisors must complete two MCH courses (MCH 101 and MCH Orientation) via the online MCH Navigator, within three months of grant award or hire, whichever applies. Other courses selected for professional development must be identified on the "personalized learning plan" as a result of completing the online MCH Navigator Self-Assessment. In addition to basic training and orientation, local program staff are required to complete training (e.g., tobacco, breastfeeding, safe sleep, care coordination). Ongoing training requirements for all local MCH staff include technical assistance calls/webinars and may include trainings on the various integration toolkits outlined through this narrative. The annual Governor's Public Health Conference serves as another opportunity to engage the MCH workforce.

Governor's Public Health Conference: The 2021 Governor's Public Health Conference was held virtually. The Conference featured nationally-recognized keynote speakers on topics including: The current COVID-19 pandemic; Improving school and community cultures to prevent school violence and suicides; Lessons learned from disaster response around the world; Strategies to ensure governmental public health is well-prepared for present and future health challenges. Breakout sessions included: Fourth Trimester Initiatives; Beyond ACEs Training: What's Next; Behavioral Health 101; Addressing Marijuana Use with Pregnant Women; and Esperanza: Immigration in 2021 and Beyond.

Annual Home Visitor Training: Kansas Title V provides an annual workforce development event for all MCH Universal Home Visitors and MIECHV Home Visitors. For SFY21, this training occurred virtually due to the COVID-19 pandemic. Home Visitors were required to take all five training sessions through KS-Train. Session topics included Well-Woman Integration Toolkit; KPQC Maternal Quality Initiative; Maternal Warning Signs; Reproductive Life Plan; and Behavioral Health. Sessions were self-paced so home visiting staff could spread the trainings to fit their schedule. Over 60 home visitors participated in the trainings.

Maternal Warning Signs Initiative: Based on findings from the Kansas Maternal Mortality Review Committee, the *Maternal Warning Signs Initiative*, launched in July 2021, was created to raise awareness and educate providers, perinatal persons and their support systems, on the Maternal Warning Signs and the need to take appropriate action on these warning signs. The Initiative includes an 18-page Patient Education Guide, utilizing National resources such as the CDC's Hear Her campaign resources and the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) POST-BIRTH Warning Signs initiative resources, as well state adapted resources in partnership with organizations such as the Eunice Kennedy Shriver National Institute of Child Health and Human Development. In July 2021 - following the initiative kick-off webinar - bound, laminated and tabbed copies of the Patient Education Guide, as well as a start-up supply of patient education magnets included in the initiative, were mailed to 88 local MCH, KPCC, MIECHV, TPTCM, and PMI agencies, and 28 birth facilities across the state. The first two pages of the Patient Education Guide are intended to guide providers through use of the initiative resources, identifying which resource/s best suits which setting, population, education opportunity, etc. Feedback received from locals expressed much appreciation for the resources and guidance, and eagerness to implement them.

Additionally, Title V invested in the POST-BIRTH Warning Signs training developed by Association of Women's Health Obstetrics and Neonatal Nursing (AWHONN). All local MCH programs, including KPCC's, TPTCM, PMI, MICEHV sites received training seats. Once the local program completed the POST-BIRTH online training, access to the AWHONN POST-BIRTH Implementation Toolkit, which provides guidance in establishing policies and protocols to embed maternal warning signs education and awareness in their entity, was provided.

Covid-19 Resources: Throughout the pandemic Title V staff have developed resources related to COVID-19 which are available for download via the Kansas COVID-19 Resource Center. These resources are available in both English and Spanish and are updated regularly based on guidance from the Centers for Disease Control, American College of Obstetricians and Gynecologists, etc. and are aimed at helping consumers and providers navigate their healthcare, including pregnancy, during these difficult times.

In addition, Title V staff worked closely with Kansas' CDC's Surveillance of Emerging Threats to Mothers and Babies Network (SET-NET) epidemiologists to stay abreast of emerging trends related to pregnant and postpartum women and infants. When the delta variant began to emerge as a potentially more serious threat to pregnant women and infants, Title V staff worked to share information in real time with providers about the importance of COVID-19 vaccination prior to, or during pregnancy.

Awareness Month Action Alerts and Social Media Graphics: Kansas Title V has developed Action Alerts and social media graphics which are disseminated to local MCH agencies and state partners to inform, educate and raise awareness on a variety of health topics, in connection with nationally recognized Awareness Months/Weeks/Days. Action Alert dissemination is targeted for the first day of the month of the associated Awareness Month and reaches a wide partner network, including our Aid-to-Local grantees. Title V staff work collaboratively with other KDHE bureaus and state partners who have focused interest on the particular topic

area (i.e. the Kansas Breastfeeding Coalition, the Kansas Infant Death and SIDS Network) to join forces and not duplicate efforts. Action Alerts and social media graphics can be accessed here.

2023 CROSS-CUTTING / MCH WORKFORCE DEVELOPMENT APPLICATION PLANS

PRIORITY: Professionals have the knowledge, skills, and comfort to address the needs of maternal and child health populations

SPM 3: Percent of participants reporting increased self-efficacy in translating knowledge into practice after attending a state sponsored workforce development event

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Objective: Increase the proportion of providers with increased comfort to address the behavioral health needs of MCH populations.

Pediatric Behavioral Health: The Title V Behavioral Health Consultant serves as the project director for Kansas' Pediatric Mental Health Access Program, KSKidsMAP to Mental Wellness (KSKidsMAP). The program has established a centralized telehealth network with an expert pediatric mental health team that supports primary care physicians (PCPs) and clinicians in treating behavioral health conditions within their clinical practice.

The KSKidsMAP team facilitates TeleECHO Clinic sessions (virtual, twice monthly) and offers mentorship to support knowledge in practice for case consultation and didactic learning on childhood/adolescent mental health needs. The TeleECHO Clinic philosophy is "enhancing primary care by moving knowledge, not patients," and aims to create an "all teach/all learn" environment for PCPs to learn how to provide the best care for children and adolescents with behavioral health concerns. Each participant has the opportunity to present a case and receive feedback and recommendations from other TeleECHO Clinic participants as well as the KSKidsMAP team. Following each TeleECHO Clinic session, the recommendations are summarized, and additional resources are compiled and emailed to all session participants.

The KSKidsMAP Provider Consultation Line will continue to be staffed to assist PCPs by providing mental health and community resources, toolkits, best practice guidelines, referral information, and physician wellness recommendations. KSKidsMAP will continue to identify innovative outreach methods to increase provider enrollment, including presenting at conferences geared towards PCP engagement (e.g., American Academy of Pediatrics). Further, KSKidsMAP will continue development of subsequent sections to the Pediatric Mental Health Toolkit prioritizing new topic sections based on emerging needs identified via case consultation requests and TeleECHO Clinic sessions.

Perinatal Behavioral Health: There are four key initiatives planned to help increase workforce capacity to screen, facilitate brief interventions, make referrals to treatment, and provide education and resources to their perinatal patients at risk of behavioral health conditions:

- *Pediatrics Supporting Parents (PSP) Workgroup*: A new maternal depression screening payment policy has been adopted by Kansas Medicaid, effective January 2021. The policy supports reimbursement for up to three screenings during the prenatal period under the mother's Medicaid plan, and up to five screenings during the 12-month postpartum period under the child's Medicaid plan supporting child social and emotional development and healthy family functioning. BFH will continue to support implementation by assisting with any necessary guidance to providers, developing any needed training materials and analyzing Medicaid claims data to determine provider or clinic training or technical assistance needs.
- *Kansas Connecting Communities (KCC):* Through KCC, a Perinatal Provider Consultation Line was established to support perinatal providers through case consultations, providing best-practices information, and offering multiple training opportunities. The line is accessible weekdays from 8 a.m. to 5 p.m. to assist providers with their perinatal behavioral health questions. Consultation line staff can help with diagnosis, medication, treatment, patient resources, identifying local referral options, and connecting the calling provider with a clinical psychiatrist for case consultations. This effort directly

supports increasing health care providers' capacity to screen, assess, treat, and refer pregnant and postpartum women for depression, anxiety, and substance use disorders.

- *Paternal Postpartum Depression (PPD):* Title V will continue to promote the PPD package to: increase provider awareness about prevalence; educate about symptoms; inform on the difference of PPD and maternal depression; guide implementation of paternal screenings into clinic workflow; offer programming considerations; and provide resources for fathers who might be experiencing postpartum depression.
- *Perinatal Behavioral Health Toolkits:* Title V will continue promotion activities to increase awareness and utilization of the Perinatal Mental Health and Perinatal Substance Use toolkits. The toolkits are intended to provide education, guidance, and resources to providers in support of their perinatal behavioral health screening practices. Each toolkit includes an overview of screening integration, screening tools, workflows and algorithms, templates for local use (e.g., sample policy, MOA/MOU template to execute with treating providers), provider resources, and resources providers can use with their clients. Title V will review toolkit content and make updates, as needed, on an annual basis.

More information about these initiatives are available in the Woman/Maternal Plan.

Child Resilience/Preventing Adverse Childhood Experiences (ACEs): MCH staff will continue its partnerships with other state agencies and local grantees to prevent adverse childhood experiences and provide training opportunities on not only the impact that trauma and toxic stress has on a developing child's brain but to shine a light on how small, everyday encounters can build resiliency skills and create an environment where children can thrive. KCSL presented to the Family Advisory Council (FAC) in April 2021 regarding the Connections Matter curriculum and will be working with the Title V Family and Consumer Partnership (FCP) Consultant to integrate the teachings of this curriculum into training offerings for FAC Members and Support Peers through the Supporting You: Peer to Peer Network. This will be discussed with the Alumni, Mentorship, and Policy (AMP) Team when it is convened in the coming year.

Community Partnerships: Universal behavioral health screening is most effective when providers work collaboratively to ensure adequate systems of care are in place supporting accurate diagnostic assessments, appropriate treatment, and essential follow-up. Having effective partnerships or collaboration is critical when creating and sustaining a local community of care. Title V developed a *Creating Effective Partnerships to Improve Behavioral Health* Outcomes guide for local MCH programs. The guide includes steps for developing effective partnerships (e.g., determine your needs, create new relationships), enhancing existing relationships, and determining levels of involvement. Title V will develop a marketing strategy to promote use of the report by local MCH programs.

Objective: Increase the proportion of MCH local agencies implementing trauma-informed approaches that support increased staff satisfaction and healthier work environments.

Now more than ever it is essential that the MCH workforce recognize how trauma and stress impact their own wellbeing, just as much as of those they serve, related to both "normal" practices and the short- and long-term impacts of COVID-19 to their community. To be successful in addressing the needs of the MCH populations within their community, they must be well. Title V will promote the SAMHSA Culture of Wellness Organizational Self-Assessment (COW-OSA) to assist programs in gathering baseline information about their organization's strengths and shortcomings related to fostering a culture of wellness and resiliency. The COW-OSA includes ten domains and related standards that are characteristic of an organizational culture of wellness. MCH agencies will be encouraged to use this self-assessment to identify wellness-related strengths and areas requiring further exploration and development. Title V will provide support to local agencies accordingly, as well as identify support opportunities for the entire MCH network.

Title V will continue to promote the *Building and Maintaining a Resilient Team Resource Guide: Tools for the Public Heath Workforce.* The Resource Guide includes vetted resources on: leadership and management during a public health crisis, building a resilient team, trauma-informed human resources best practices, and referral resources. The guide will be distributed to local partners and one-on-one technical assistance will be available upon request.

As healthcare providers begin to move beyond pressing needs of the pandemic, we will continue to provide additional resources and tools on how to provide patient-facing trauma-informed care. Being "trauma informed" is much more than being sensitive or emphatic during an office visit. Addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment (SAMHSA, July 2014). SAMHSA has outlined the trauma-informed approach, as well as established principles:

Lemonade for Life: Lemonade for Life (LFL) is a promising approach developed by the University of Kansas Center for Public Partnerships & Research (KU-CPPR) around ACEs prevention and intervention. LFL trains professionals on using the ACEs Questionnaire to prevent future exposure to ACEs, while promoting resiliency and hope. The program helps individuals understand how early life experiences have a long-lasting effect on interactions in future relationships. LFL training conveys that individuals "cannot rewrite the beginning of their story, *but they can change how it ends*," instilling hope and responsibility for change and an important factor in individuals building self-sufficiency.

Title V, in partnership with the Bureau of Health Promotion (BHP) and KU-CPPR, plan to host LFL training for MCH Universal Home Visitors and invest in a pilot LFL Learning Collaborative delivered through home visiting programs. This pilot will allow Title V to assess and measure the impact prior to integrating LFL into more MCH communities. The requirements for a community to participate include:

- Complete two online ACEs learning modules
- Attend a full-day in-person training and one group coaching call (45-60 days post training)
- Participate in evaluation of Lemonade for Life Curriculum
- Commit to showing the Brain Builder video during the first three months (before the 6th visit) to all prenatal clients and clients with children birth to 3
- Commit to introducing ACEs Questionnaire (following video completion)
- Download video to Home Visitor cell phone or device and allow parents to hold the phone or device at the home visit while watching the video
- Introduce a discussion about parenting and the parent's experience as a child, ACEs, stress/toxic stress, and how trauma can affect parenting
- Serve and return as a way to discuss the importance of interactions and building pathways in the brain especially reading and talking with baby
- Use YouTube videos of parents interacting with their babies as a closing for the visit
- Collect data on training, ACEs Questionnaire, referrals, parental motivation, and more

Objective: Increase the proportion of MCH-led activities that address social determinants of health (SDOH) to reduce disparities and improve health outcomes for MCH populations.

Identifying Social Determinants of Health Needs by Expanding Universal Screening Practices: Identifying needs is a critical first step to connecting individuals and families with appropriate services. Non-medical social needs, or social determinates of health (SDOH) have a large influence on an individual's health outcomes. As

such, Title V is adding the American Academy of Family Physician's EveryONE Project's SDOH screening tool to DAISEY effective July 2022. This screening tool includes questions related to housing, food, transportation, utilities, child care, employment, education, finances, and personal safety. Title V is working with the contracted DAISEY development team to score and prompt providers on intervention necessary based on responses received. The prompt will direct providers to contact the statewide access line, 1-800-CHILDREN. Title V will also make English and Spanish fillable PDFs of the screening tool available on DAISEY Solutions for local MCH programs' use. Title V will also develop and publish integration, administration, and interventions required based on participant responses guidance for local programs.

MCH (Health Equity) Opportunity Project (MCHOP): Addressing health equity requires identifying and removing obstacles to health (e.g., lack of access to good jobs, quality education, safe housing and environments, fresh food, health care) to assure everyone has a fair and just opportunity to be healthy. In 2019, Title V partnered with the University of Kansas Center for Community Health & Development (KU-CCHD) to implement the first MCHOP with seven local MCH agencies to advance local efforts to assure equal opportunities for MCH populations regardless of income, education, age, race/ethnicity, or where people live. The 2nd cohort of the MCHOP was launched in July 1, 2021, utilizing the Kansas Healthy Communities Action Toolkit to encourage action in building communities with equal opportunities for healthy living and well-being. The toolkit provides questions to consider, recommended actions, and examples (resources and links to tools) to support filling out the application as well as learning about action in community work.

As a spin-off of this work, planning will begin in FY2023 for a BaM/KPCC model-focused Health Equity Opportunity Project. As written to within the Women/Maternal Domain, this project will provide mini-grant opportunities for KPCCs and BaM programs who are interested in targeting high risk disparity populations with service provision through unique cross-sector partnerships, as well as developing and implementing a unique approach to decreasing risks associated with chronic disease processes associated with pregnancy.

Black Infant Mortality: Title V recognizes that stark disparities exist between rates of infant mortality for black infants and those of other races. Black infants in Kansas are nearly three times more likely to die than white or Hispanic infants. To strategically address this issue in an informed and meaningful way. In April 2021, Title V created a webinar presentation focused on black maternal health disparities in the state, and projects that are underway to further explore and address these issues. The resulting webinar include data from the 2019 Pregnancy Risk Assessment and Monitoring (PRAMS) report and the Kansas Maternal Mortality Review Committee. In addition, the webinar included presentations from Title V partners and highlighted past MCH Opportunity grant awardees and upcoming collaborations to facilitate conversations with black mothers across the state. The presentations can be viewed in their entirety on the KDHE Integration Toolkits website and will continue to be shared with MCH, Title X, and WIC professionals. A final report with recommended strategies to address disparities for Black mothers and infants will be utilized by KDHE to help inform ongoing approaches, including special projects, technical assistance and ATL education.

Birth Defects Prevention Campaign: To reach MCH populations, a large social media presence was implemented in January 2022, and will continue in subsequent years, to align with the National Birth Defects Prevention Month. Each day in the month of January will highlight new information targeted towards MCH populations using KDHE-generated materials, data, and other pre-developed materials provided by the Centers for Disease Control and Prevention, the National Birth Defects Prevention Network, and March of Dimes. To further reach populations, hard-copy brochures will be provided to Kansas birthing providers for distribution to those without access to social media. Included in the materials will be information about programs offered for families that may help pay for things such as prenatal vitamins and healthcare provider visits. The remainder of the year, the Birth Defects Surveillance (BDS) program will provide content for Screening and Surveillance Unit social media campaigns. Materials will be posted in both Spanish and English, as shown below.

Other MCH Workforce Development Activities

The MCH Navigator and online MCH Assessment will continue to be utilized in the professional development planning and performance reviews for all staff. All MCH program staff and supervisors must complete two MCH courses (MCH 101 and MCH Orientation) via the online MCH Navigator, within three months of grant award or hire, whichever applies. Other courses selected for professional development must be identified on the "personalized learning plan" as a result of completing the online MCH Navigator Self-Assessment. In addition to basic training and orientation, local program staff are required to complete training (e.g., tobacco, breastfeeding, safe sleep, care coordination). Ongoing training requirements for all local MCH staff include technical assistance calls/webinars and may include trainings on the various integration toolkits outlined through this narrative. The annual Governor's Public Health Conference serves as another opportunity to engage the MCH workforce.

Annual Home Visitor Training: Kansas Title V staff partner with the Maternal, Infant and Early Childhood Home Visiting (MIECHV) staff to provide an annual Kansas Home Visiting Conference for MCH Universal Home Visitors and MIECHV Home Visitors. For the FY23 grant year, staff will survey home visitors to select the most requested topic for the upcoming training to be held in September 2022. National speakers will be recruited to do the opening and closing presentation for this conference, while state experts will be asked to do breakout sessions. The training may need to be delivered virtually this year if in-person is not allowed.

DAISEY Learning Collaborative: This project encourages utilization and application of MCH data at the local level with up to 5 local MCH agencies to collaborate and explore ways to impact their programs and practices with DAISEY data. Each of participating agencies will be awarded a mini grant of $1,000 to support time on the project. Due to the high demand of COVID-19 responsibilities of Local MCH Agencies, the DAISEY Learning Collaborative was put on hold during SFY2021. This opportunity will be offered in the coming year. Participating agencies will receive expert technical assistance and support from Title V as well as the University of Kansas Center for Public Partnership and Research (KU-CPPR) DAISEY team. Each agency will use their local DAISEY data to identify an area of opportunity for improvement within their practice. Participants will:

- Implement Plan-Do-Study-Act (PDSA) cycles to make small-scale changes
- Use DAISEY data to measure impact
- Participate in a kick-off event (preferably in-person) to identify their project
- Technical assistance webinars (a total of three)
- Participate in a wrap-up session (teams summarize their project/impact)

The local MCH agencies will be asked to present a summary of their project, primary impact, lessons learned, and the challenges they encountered during the 2023 Governor's Public Health Conference Pre-session. Information about the Collaborative can be found in the Supporting Documents as part of this application.

Local Public Health Program (LPHP) Partnership: Kansas Title V will continue to partner with the LPHP to provide professional development events to the MCH network. In the coming year the LPHP will provide the following activities:

- Produce and disseminate MCH articles, news, resources and training opportunities through the Public Health Connections electronic newsletter
- Link MCH priorities to the Foundational Services
- Provide sessions related to cross cutting/life course issues at the Governor's Public Health Conference, Regional Public Health meetings and other venues
- Conduct monthly webinars for local health department staff and other public health system partners
- Plan and deliver the 2023 Governor's Public Health Conference to meet the workforce needs of Kansas local health departments, including MCH workforce
- Address workforce needs for well woman visits and reproductive life plans
- Facilitate regional public health meetings and other events for local public health administrators as an avenue for providing workforce development
- Organize KanBeHealthy (EPSDT) trainings for public health staff
- Collaborate with the KS Public Health Workforce Development Coordinating Council
- Develop/provide quality improvement training for KDHE staff and local health departments

Title V University: During the FY23 the Title V team in partnership with KU-CCHD will develop the Title V University to provide training opportunities for Title V staff, partners, and families. This will be a web-based platform where individuals will have access to a wide variety of Title V core trainings designed for all and more customized trainings to meet their individual needs. Some components will be added to Title V onboarding training for new staff and can be used as continuing education for existing staff.

PRIORITY 7: Strengths-based supports and services are available to promote healthy families and relationships.

Domain: Cross Cutting - Family and Consumer Partnership

SPM 4: Family Strengths (Percent of children whose family members know all of the time they have strengths to draw on when the family faces problems)

ESM: Number of MCH participants receiving holistic care coordination

ESM: Percent of families enrolled in Special Health Care Needs Care Coordination Program that have increased their ability to independently navigate the systems of care

2021 CROSS-CUTTING / FAMILY SUPPORTS ANNUAL REPORT

SPM 4: Percent of children whose family members know all the time they have strengths to draw on when the family faces problems

ESM: Number of MCH participants receiving holistic care coordination

ESM: Percent of families enrolled in Special Health Care Needs Care Coordination Program that have increased their ability to independently navigate the systems of care

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Kansas selected this new priority focused on family engagement and supporting families from a strengths-based perspective. This further solidifies the long-standing priority that Kansas has had on family engagement and consumer partnership. It is well known that when families are strong, connected, and healthy, the family

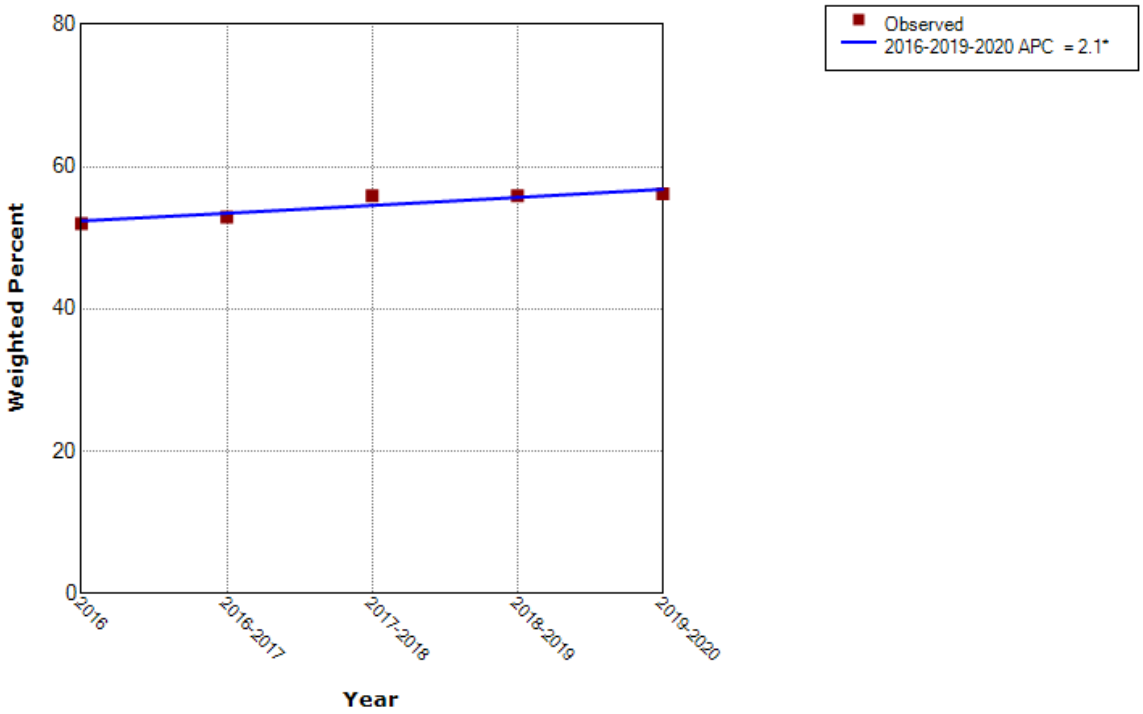
members and their surrounding community thrive. Title V is distinctly poised to strengthening self-efficacy and self-determination among families by assuring: MCH-led activities and services (informed by family needs and desires, centered on the family voice, and representative of diverse values and ideals); family/consumer peer support opportunities; family/consumer leadership activities; and expansion of holistic care coordination services across Title V populations. These things collectively will provide multiple areas where families can be supported and feel like they have strengths to draw on when faced with challenges.

According to the 2019-2020 NSCH (two years of data combined), for 56.2% of Kansas children, their family members reported that they themselves were likely to know “all of the time” that they have strengths to draw on when the family faces problems (95% confidence interval [CI]: 52.4%-60.0%). Among Kansas children with special health care needs, the estimate was 49.3% (95% CI: 41.2%-57.5%), which was not significantly different from those without special health care needs (58.1%; 95% CI: 53.8%-62.3%).

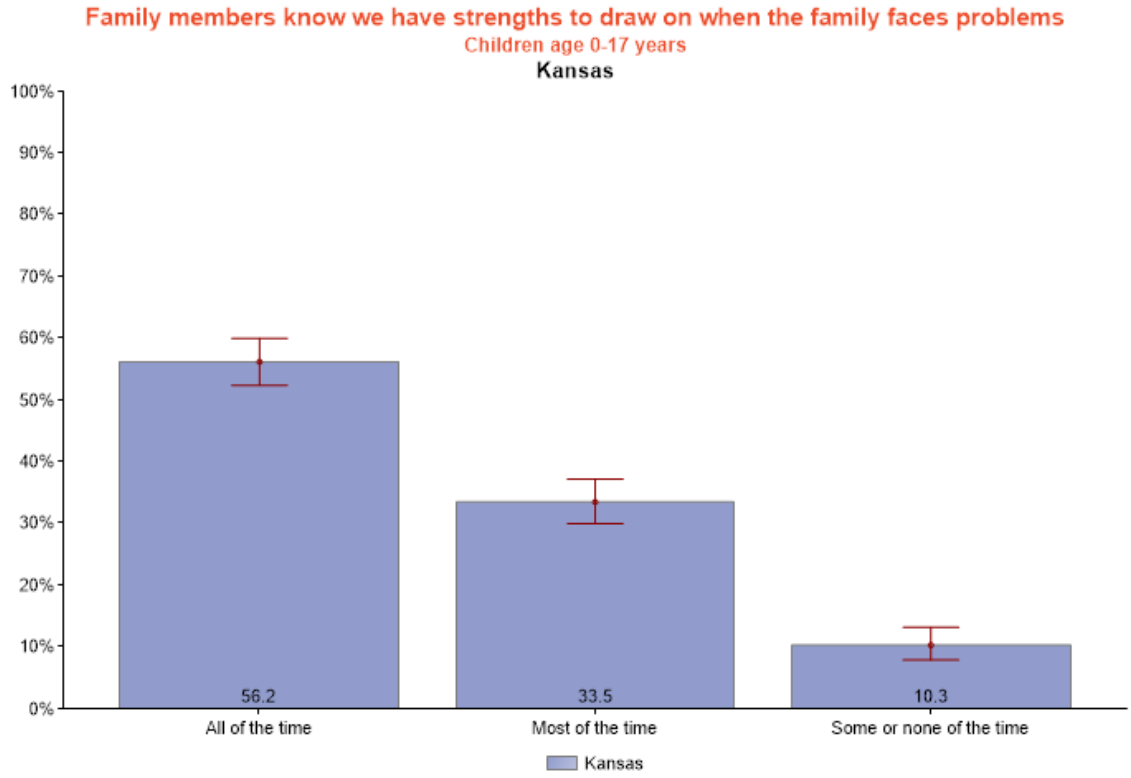
The percentage of Kansas children with this indicator decreased with increasing levels of ACEs. For around three in five children with no ACEs (61.1%), a family member reported that they themselves were likely to know “all of the time” that they have strengths to draw on when the family faces problems (95% CI: 56.4%-65.5%). This was significantly higher than among children with two or more ACEs (43.9%; 95% CI: 35.1%-53.2%).

From 2016 (one-year estimate) to 2019-2020 (two-year estimate), the percentage of Kansas children whose family members know all of the time that they have strengths to draw on when the family faces problems increased significantly, with an annual percent change of 2.1% (95% CI: 0.3%-3.8%).

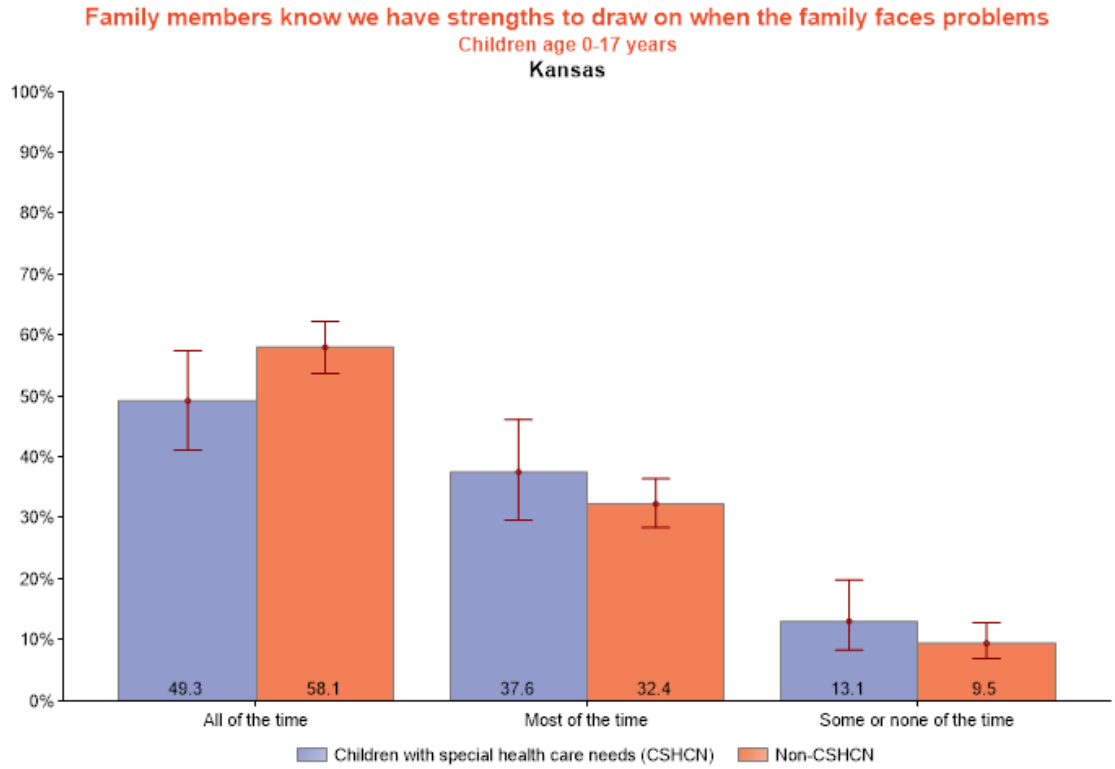
Weighted Percent of Kansas Children Whose Family Members Know All of the Time They Have Strengths to Draw on When the Family Faces Problems, 2016-2020†



* Indicates that the Annual Percent Change (APC) is significantly different from zero at the alpha = 0.05 level.
† Note: After 2016, state-level estimates were produced using two-year combined data.
Source: U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), National Survey of Children’s Health (NSCH)



Source: Child and Adolescent Health Measurement Initiative. 2019-2020 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved 04/26/22 from [www.childhealthdata.org].



Source: Child and Adolescent Health Measurement Initiative. 2019-2020 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved 04/26/22 from [www.childhealthdata.org].

Objective: Increase the proportion of MCH-led activities with a defined program plan for family and consumer partnership (FCP).

MCHB defines family partnership as “patients, families, their representatives, and health professionals working in active partnership at various levels across the health care system – direct care, organizational design and governance, and policy-making -to improve health and health care.” While the Kansas vision has always included family-centered approaches and the assurance of family engagement at various levels, statewide and local programs have struggled with operationalizing family and consumer engagement opportunities, outside of the CSHCN program/population. With the adoption of this priority, the Title V Family and Consumer Partnership (FCP) Program has been established, housed in the System of Supports Section, to provide capacity and support to Title V staff/partners. The focus is on understanding the need for FCP and supporting programs and services to engage with families and consumers in their daily work and fully embrace the “nothing about and for us, without us” philosophy.

The FCP Program builds strong partnerships with families through peer supports, advisory opportunities, leadership and development, and technical assistance. More information about the four program areas can be found in the Family Partnership narrative. This dedicated program provides a framework for family engagement, and technical assistance for local and state Title V programs, to assure families are engaged at the level they desire and assure families are provided opportunities to assist with planning, implementation, and evaluation of the services and programs they engage with, as well as policy at the local, state, and national levels.

Title V began working with the FAC on developing the Family and Consumer Engagement Implementation Toolkit. The Toolkit was designed with the intent to share information about state and national frameworks that guide the Title V approach to engagement and partnership with the families and consumers served. The goal is to assist local or state programs are supported to, and feel confident, engaging families or consumers in a variety of ways. The toolkit was developed with input from families around the “levels of engagement” as outlined by AMCHP (engaging families for input, feedback, or buy-in; as advisors; in leadership and support roles). The goals of the toolkit are to assure:

- families or consumers are engaged in meaningful and mutually beneficial ways;
- family or consumer engagement practices are supported at both community and state program levels;
- evaluation activities consider family voice, choice, and experience related to services provided; and
- opportunities exist to partner with those with lived experiences and served by programs to inform and advance policy at the local, state, and national levels.

These goals were presented to, and approved by, the FAC in 2020. As the FAC expanded through 2020/2021, so did the conversation about the toolkit. The July 2021 and October 2021 meetings were completely focused on the content for the toolkit, engaging families. The toolkit was developed with cross-system and cross-sector implementation in mind and when complete will be available for all Kansas organizations and communities to utilize.

Objective: Increase the number of individuals receiving peer supports through Title V-sponsored programs.

Pregnancy and Postpartum Peer & Social Networks: Title V staff support pregnant and new mothers through the KPCC model, which allows mothers to connect with one another during this important time and share lived experiences in an authentic and supportive environment. Plans to extend the program past birth are underway, which provides an opportunity for mothers to share birth stories as well as postpartum struggles – reinforcing a network that can reduce isolation and promote healing and resilience. For women not participating in BaM, Title V staff vet and promote secure and safe peer support options through social media, training and marketing including those offered through Postpartum Support International (PSI).

In partnership with Wichita State University’s Community Engagement Institute (CEI), health care practitioners/organizations and interested groups can receive support in the development of peer support groups within their community. CEI manages the Kansas Support Groups website. Individuals can search for support groups by type of group and/or location of group meetings. Support groups can register on the site, so individuals can find and participate in their groups. CEI joined the Southeast Kansas IRIS Community; providers can refer patients to CEI who can help identify support groups in their area, as well as help establish

groups, if that is the request. CEI also developed a *Perinatal Support Group Guidebook*, a resource for local communities wanting to start or revamp a perinatal support group.

Supporting You: Since peer-to-peer support is identified as one of the strongest measures of individual/family support, the Title V goal is to assure that every individual/family has the opportunity to connect with a trained peer who can provide emotional support, referrals to resources, and a listening ear – by others who have experienced similar situations where they can express their grief, concerns and questions, without feeling judged. In a collaborative partnership, BFH programs (KS-SHCN and the Early Hearing Detection and Intervention) worked together with the FAC to develop a family support network called Supporting You: A Peer to Peer Support Network. The peers provide space for individuals to express their grief, concerns and questions with someone who can share their own personal story – helping them know they are not alone in this journey. This is an important component that can lead to improved mental health and development of the skills needed to navigate systems of care.

The Network officially launched with the ability to connect peers in January 2020 with two "Network Programs," KS-SHCN and the KS School for the Deaf. Since Network Programs serve targeted populations, Title V contracts with one FAC member to serve as a Peer Support Administrator (PSA) to catch anyone that might sign up that wouldn't be filtered to one of the existing Network Programs. The Network was developed with the opportunity for expansion and inclusion of other community or state programs, with the intent and desire to expand beyond the CSHCN population. The Network has the partnership capabilities to engage multiple organizations to "administer" their own peer support program, with the potential to connect with supporting parents across the overall network. Read more about this in the Cross-Cutting Plan narrative.

Connected peers are matched to support peers (parents, caregivers, individuals, or siblings) who have similar experiences or needs. A web-based questionnaire supports matching peers about their experiences and desired supports. The system can match on any criteria asked on the questionnaire. Since the program began, extensive work has been done to develop the data system, trainings, promotion, protocols, policies and onboarding criteria, providing a framework and recognizing the supports needed for broader utilization across MCH populations, such as the creating of peer-support programs for pregnant women, adolescents, foster children/parents, etc.

In September 2020 the part-time staff serving as the Network Administrator was reallocated to a full-time position as the Family and Consumer Partnership Coordinator, responsible for the Supporting You and FAC expanded efforts. This Coordinator monitors all aspects of the Network, including program onboarding; technical assistance and trainings; marketing and recruitment efforts; network and data system updates; guidance and protocols for Network Programs; and evaluation and fidelity monitoring. Ultimately, there are three key responsibilities: Network Administration (KDHE), Program Administration (partnering organization/program), and Peer Support Administration (partnering organization/program). An Administrator Handbook is being developed to support onboarding of additional programs.

Key activities for Supporting You have revolved around the initial development of the model, evaluation and performance measures to monitor the fidelity and impact of the network, and marketing/branding. These materials can be found in the Supporting Documents as part of this application. A promotional video was developed and can be found online at www.supportingyoukansas.org.

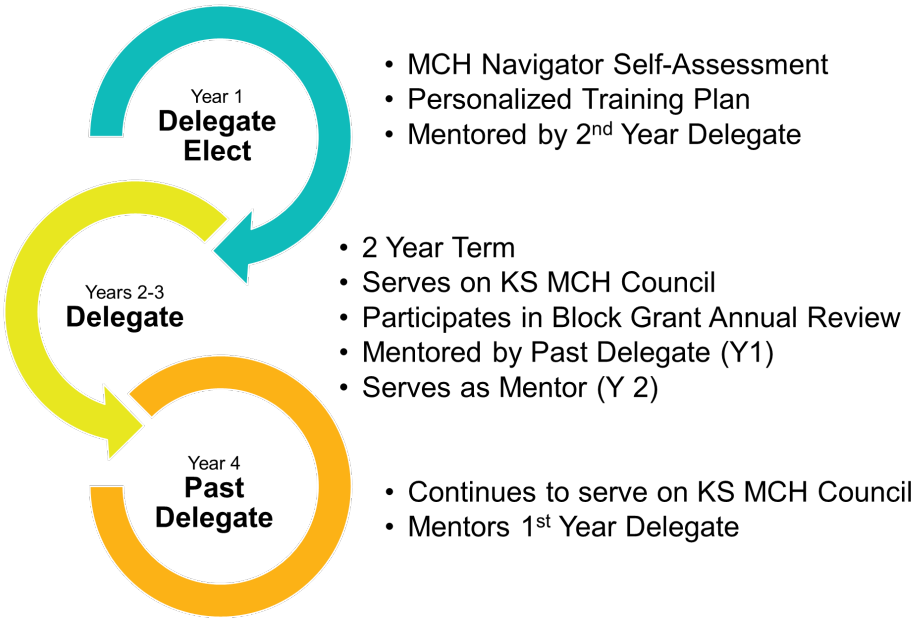
Ongoing enhancements and expansion efforts continue for the Network, Including creating a new and easier way for Support Peers to access trainings directly on the Supporting You website, finalizing the onboarding plan for new Network Programs, and submitting the website user dashboard encasements. Conversations with two new programs to join the network are ongoing and moving towards the onboarding process. First to be onboarded will be *Foster, Adopt, Connect* which may look at the idea of creating two separate programs for families, one for families who are a part of the foster care system in Kanas and a sperate one for families with adoptive children.

Objective: Increase the number of families and consumers engaging as leadership partners with the MCH workforce through the FCP Program.

Family Delegate Program: Expanding family leadership efforts across Title V programs is a high priority and supporting stronger efforts to equip and empower families to engage as partners with the MCH workforce. As part of this effort, there is continued focus on the Kansas AMCHP Family Delegate program, under the FCP Program. During the July 2020 FAC meeting, Council members were engaged in some planning/discusison about the Family Delegate Program and began to formalize a structure for this program. Under discussion included: the application process, eligibility or qualifications of the family delegate, training and leadership development needs, and annual expectations of the Delegate. From this discussion, a new program was formed and a progressive succession and transition plan for incoming and outgoing Delegates was established, shifting from a single-family leader involved at any given time, to three (e.g., Past-Delegate, Delegate, Delegate-Elect).

The Family Delegate now serves a four-year term which allows for progressive and more intensive training and mentorship opportunities. This also supports continuity among the family leader representing Title V. Formal supports continue to be available to family leaders engaged in this program, including stipends for meetings, travel supports and assistance, trainings, and professional coaching models. The Delegate program is open to any or all family leaders, regardless of Title V affiliation at the time of application, however it is a competitive application process with recruitment occurring every two years (next recruitment period will be in 2022).

- *Delegate Elect.* The family leader will engage in specific trainings and discussions with Title V staff to build foundational knowledge of Title V that will assist them during their term as the Delegate. The Delegate Elect will be encouraged to participate in KMCHC Council activities; it is an optional engagement during this first year.
- *Delegate.* The family leader will identify an area they'd like to build their skills and competency within Title V and will work closely with the Title V Domain Consultant or program staff to learn more and assist them with expanding family and consumer engagement efforts within those programs.
- *Past Delegate.* The family leader will remain on the KMCHC Council and represent the family/consumer voice on the KMCHC Council Executive Committee.



In October 2020, Kansas selected a new Delegate Elect, Kate Roggenbaum. Kate is a mother to three amazing kids - Lilah, Ella, and Carter. She and her husband fostered and adopted their two oldest children and the girls have significant special healthcare needs and trauma which has led Kate into advocacy for the children of Kansas. She currently serves on the BFH Family Advisory Council, the Family Advisory Board for Children's Mercy Hospital, the Special Bequest Board for the KS-SHCN Program, and is also the FAC Peer Support Administrator for the gap-filling Supporting You program, run by KDHE.

Family Advisory Council (FAC): As outlined in previous sections of this application, the FAC expanded not only in population domain focus, but also as an opportunity to more strategically align with the Kansas MCH Council (KMCHC), comprised primarily of professional organizations and providers. The FAC and KMCHC meet at similar schedules (e.g., 3rd week of January, April, July, and October) to support timely discussion of similar

topics and shared learning opportunities. This will also offer additional opportunities for MCH programs to engage families and consumer with lived experiences at all levels: as program evaluators, co-trainers, interns, paid staff or consultants, mentors, grant reviewer, active participants in assessment processes, and more.

Throughout 2020, the FAC provided input in development of the FCP Program, but also the expansion of the FAC itself. In FFY21, the FAC spent October finalizing the new structure of the FAC, December preparing the Children with Special Health Care Needs Work Group to transition and what would come in 2021. The goal was to expand the Council, beginning in January 2021 with the Women/Maternal work group, April 2021 with the Child work group, July with the Adolescent work group, and October with the Early Childhood work group. In each meeting, it was planned that the work groups would orient to Title V/MCH work, the aligned priorities within the State Action Plan, and learn about existing and planned work for that population. Numerous challenges presented within this expansion plan and after the April meeting it was determined that the focus needed to be placed on recruitment to build membership among the new groups. Thus, the remaining 2021 meetings were adapted to gather input on the FCP Implementation Toolkit. Brief summaries of each meeting during this reporting period are outlined below. More information about these can be found in the Supporting Documents included with this report.

While the FAC finished out FFY21 with a focus on the implementation toolkit, the FCP Program staff spent most of FFY21 focused on establishing protocols and guidance for the work group co-chairs and staff supports. The following processes, forms, and guidance were established to support the co-chairs and members, and BFH staff supports. All of these allowed for adequate preparation for the January 2022 launch of all five work groups and expanded partnership with internal and external staff and programs.

- Revised the FAC Bylaws
- Established the FAC Structure, Guidance, and Oversight document
- Updated FAC applications, selection protocols, and a formal interview/acceptance process
- Updated FAC reimbursement policy
- Expanded the Executive Committee
- Established the partnership with the Family Leadership Team
- Developed position descriptions for the EC Chair and the Work Group Co-Chairs
- Developed the Work Group Charter & Development Guide

The groups' Charter identify their priority objective and outline what they hope to accomplish, and by when. This serves as their "AIM" statement and guide their work. Groups are also asked to discuss the specific membership diversity they need to advance the work, and are supported to identify ways to engage diverse populations not currently represented (e.g., recruit new members, engage a professional subject matter expert, conduct interviews/research to gain insight and the views of those populations). The Charters also outline their groups' communication preferences and plans, to assure all members are able to actively participate and engage in the outcomes, deliverables, or recommendations that come from the group. Lastly, this allows opportunity for all Council members to discuss their roles and responsibilities as a group member, as compared to the roles of the Co-Chairs.

Objective: Increase the number of MCH-affiliated programs providing holistic care coordination through cross-system collaboration.

Title V recognizes the HCC model established and implemented by KS-SHCN, adapted in partnership from the Boston Children's Hospital, has shown to be effective in meeting the needs of those engaged in care coordination. Title V desires to expand this model across Title V/MCH programs, and beyond, through the provision of resources, information, and targeted technical assistance. Building from the established KS-SHCN model, and aligned with the National Care Coordination Standards for CYSHCN. Title V is partnering with the early childhood system efforts to expand this into primary care. The All in for Kansas Kids strategic plan has identified this as a strategy under Goal 2: Community-Level Coordination.

The expansion for HCC within primary care settings is being led by the System of Care (SOC) Consultant, a position established in November 2020 to support this expanded effort and work closely with similar public health programs, such as the KS Special Health Care Needs Program, where the public health HCC model originated in Kansas, and the Bridges Program, a pilot program to implement HCC for children who have

received early intervention services (Part C of IDEA) and are transitioning out of those services and into community-based services or school-based educational interventions (Part B of IDEA). More information about Bridges can be found in the CSHCN Plan narrative. While these expansion efforts are happening in parallel, the synergy between all of these initiatives is complimentary and collaborative.

Holistic Care Coordination (HCC) Implementation Toolkit: An implementation toolkit is under development. This toolkit is intended to support providers, practices, and programs interested in establishing a care coordination model at different stages, both in public health and primary care settings. The toolkit includes foundational context, resources and tools for planning/implementation, evaluation and sustainability, sample job descriptions and training plans for care coordinators, and other resources to support needed technical assistance.

Throughout the implementation toolkit development, the SOC Consultant focused on outreach and promotion, provider input, and quality improvement focused development activities. Key activities include:

- HCC Video Series: Title V contracted with Trozzolo, a local marketing firm who created the first video series (completed in June 2020) to develop six additional videos, aligned with each of the domains within the National Care Coordination Standards.
- Primary Care Provider Survey: Conducted a survey to assess knowledge, attitudes, and practices in holistic approaches to care coordination. Questions were aligned with the National Care Coordination Standards, and responses provided valuable information to help advance the development of the HCC Implementation Toolkit.
- Focus-groups/Roundtable input sessions: Hosted four sessions to learn about interest in the Standard domains. Through the four sessions, we had XX participants and learned…
- National Standards Presentations: Partners with the Kansas early literacy program, Turn a Page, Touch a Mind, to present at eight sessions to XX providers regarding the National Care Coordination Standards, and engage in a discussion with primary care practices about what HCC means to them and how they would utilize care coordinators in their practice.

Phase 2 includes the development of tools and resources to support Title V in providing technical assistance to primary care, public health, or other sector partners interested in engaging in a holistic approach to serving families through care coordination. This work began XX 2021 and is ongoing. To date, the following tools have been established:

- Domain-specific Standards Checklists: A series of six checklists for practices to help identify how well their practices or organization is positioned to meet the standards within that domain. Each checklist is one-page and includes between 8 to 12 “yes/no” questions that is intended to support the provider in reflecting on their current practices or care coordination efforts, while providing some insight into possible resource or technical assistance needs. These checklists will be utilized during initial TA conversations with practices.
- Tools/resource list per domain: Tools and resources for each domains have been collected from various care coordination programs across the nation that align with the Standards. The tools are paired with a cover form that provides information such as where the tool was developed and the best practices for implementing the tool. The resources for each domain have been gathered for a one-page document per domain with a list of resources and a brief description of the use and purposes of the resource.

HCC Technical Assistance and Supports: Over the past year, the feedback from the provider input activities was utilized to guide additional projects to establish supports for providers interested in establishing a HCC program or engaging in a more holistic approach to their existing care coordination efforts. To provide opportunities to engage with primary care providers, Title V partnered with the American Academy of Pediatrics, Kansas Chapter (KAAP) to host a series of Project ECHO webinars to provide more information to primary care providers on how pieces of care coordination can be implemented in their practice along with ways that care coordination can benefit the practice. The “Setting New Standards for Coordinating Care of Pediatric Patients and their Families” ECHO series was originally established and planned for Fall 2021, however due to a variety of circumstances was cancelled and rescheduled for Spring 2022.

Throughout Summer 2021, plans for a short-term quality improvement project began, as part of the technical assistance offerings. Based upon feedback from KAAP, and the FDA approvals for the COVID-19 vaccine for adolescents 12 and up and the projection of the approval for children 5 to 11 later in the fall, It was determined to shift this project from the originally planned 12 month project to a focus on supporting providers in responding to the influx of education and testing needs associated with the pandemic.

Long-term technical assistance supports for primary care, and eventually public health, has continued throughout the reporting period. All activities to date are designed to establish a HCC Technical Assistance Center within the System of Supports Team at KDHE. The goal of TA will be to continue to provide supports to public health and primary care settings interested in providing HCC, utilization and navigation of the implementation toolkit, and provide training and educational opportunities to care coordinators across the state. These are efforts to continue to spread and scale the model of a holisitic approach to care coordination across systems and sectors. It is acknowledged that many care coordinators already take a more holistic approach to providing care coordination and the intent is not for them to do anything different. Our hope it so also engage those providers as partners in our efforts and highlight their work. The toolkit and TA offerings are there to continue to support continuity across systems for high-risk patients and families. The TA Center will be lead by the SOC Consultant, in partnership with the Title V MCH and CSHCN Directors, as well as the KS-SHCN Program Care Coordination Team. Technical assistance has been organized by domain of the National Standards and follows a "readiness assessment." The assessment will be used in the *"COVID Support through Care Coordination"* project and transcend into a broader Community of Practice, to be established as TA is provided.

Practices will engage in a "readiness assessment" to determine what they already provide as it relates to care coordination. Then, based on the readiness assessment, the SOC consultant will be able to assign each practice to a technical assistance provider with the most experience/knowledge in the needed area. Through this assessment, an individualized technical assistance plan will be developed. This may include one or more of the following: assisting with development of policy; establishing a job description and hiring a care coordinator; engaging in community-level conversations to support cross-system referrals and partnership development for the practice; training and support for the care coordinator (to be supported by the KS Special Health Care Needs Program); establishing evaluation strategies or plans; developing sustainability plans; recommendations for policy advocacy; or any other activity deemed of interest and within scope from the practice. Dependent on the assessment and where the practice is in terms of planning, implementing, or evaluating their care coordination efforts and their individual interest, they will be assigned to a 3, 6, or 12-month cohort. Just like HCC programs meet the family where they are, this approach will meet the providers and practices where they are and assure success. Those practices placed in the 3-month cohort will have already established some level of care coordination in their practice and already employ a care coordinator. Those placed in the 6-month cohort will have already established protocols and practices they intend to implement, however do not have the resources or supports to effectively hire or train a care coordinator. Those placed in the 12-month cohort will have a willingness to establish a program, however they have not yet begun planning.

Care Coordination Training Curriculum: Title V reviewed the curriculums developed by the KS-SHCN Program for their care coordinators, and the Community Health Worker (CHW) Curriculum utilized by several entities in the state. The KS-SHCN Program trainings provide a strong holistic approach to care coordination it was identified it was too specific to use as the complete training curriculum for the public health and primary care settings. The CHW Curriculum offers a robust training aligned with the scope of practice adopted by the Kansas CHW Coalition. Additionally, this training fully aligns with the holistic approach to coordinating care through a whole person/family lens, and fits well with the National Standards. The Community of Practice will offer scholarships to programs that work with the HCC TA team if they would like to have their care coordinator become a certified CHW (more information about CHW certifications can be found in the MCH Workforce Development narrative).

In addition to promoting the CHW trainings to any provider engaged with the HCC TA Team, additional trainings will be offered to those interested in continuing their learning, but not interested in CHW certification. This will provide an in-depth review of established protocols and tools used in providing HCC to families, a detailed overview of the KS-SHCN HCC Structure and processes, and strategies and techniques to support

practices in providing holistic services to families, aligned with the National Standards. Providers who are interested in replicating this model are given these resources to structure their own care coordination process. At a minimum, the training modules cover the following topics, and will be adapted and expanded throughout the development phase with input from patients and providers:

- *Building Patient/Family-centered Care Coordination Through Ongoing Delivery System Design.* Describe key components of a high performing care coordination model; compare existing care coordination models or efforts; assist learners in recognizing opportunities for improvement; and encourage learners to develop action steps for improving collaboration and teamwork
- *Care Coordination as a Continuous Partnership:* Explore the nature and dynamics of different kinds of "care coordination partnership relationships; define the core components of building partnerships with families; and inform practices going forward
- *Integrating Care Coordination into our Everyday Work:* Focus on longitudinal care; improve communication and accountability among providers; embrace the role of Care Coordinator as an agent of change; recognize patients/families as members of the medical home; and integrate patient/family input, appreciating that family satisfaction is central to successful care coordination
- *Strategies to Assess and Address in the Family-Centered Medical Home:* Social determinants of health; social service systems, supports, and common needs; barriers to assessing unmet needs; and strategies to address unmet needs

Alumni & Mentorship Program (AMP) Activities: Described in the Family Partnership narrative, AMP provides opportunity for family leaders to engage beyond their formal Council membership roles, either through extended engagement with Title V or as a mentor for others. There are currently ten Family Advisory Council (FAC) Alumni members. The AMP members did not meet formally during the reporting period, however two members did particiapte in FAC meetings. All of these members remain connected to Title V in some fashion and are kept informed of Title V and BFH initiatives with opportunity to engage at any time. Two of the Alumni members are now serving as family representatives on the Kansas Council for Developmental Disabilities and are partnering to support alignment and bring more focus to early intervention, health, and systems navigation for families of children with medical complexities and intellectual/developmental disabilities.

Other Cross-Cutting Activities

Family Empowerment Among MCH-Affiliated Programs:

- *MCH Universal Home Visiting*: The Title V Home Visiting Program engages with families with trained family support staff who answer questions, provide information and resources and offer guidance. Home Visitors play an important role in empowering families to make educated choices for themselves and their families health and well-being by employing a strengths-based approach to home visiting, which helps families focus on their strengths and build goals around those strengths.
- *TPTCM and PMI: C*ase management provided through the TPTCM/PMI programs allow the opportunity to provide health information education to clients. Case managers work to empower their clients to be strong MCH advocates by fostering leadership opportunities, offering a platform to be positive role models to peers, and giving clients the opportunity to provide feedback on program evaluation. An example of this at work is seen in the following story.
    - Catholic Charities of Northeast Kansas enrolled a refugee woman in the PMI program. A client we will name Clara was diagnosed with gestational diabetes, while this is a fairly common diagnosis during pregnancy, it is always scary, and it is even harder to navigate when you cannot speak English, do not possess a working knowledge of diabetes, and have never been taught how to advocate for yourself in a health care environment. During a monthly visit with the case manager, the client shared this diagnosis, revealing her feelings of confusion and powerlessness regarding it. Together, along with an interpreter, they called the client's doctor and connected with a nurse practitioner who thoroughly explained the diagnosis. The interpreter translated so that the client had a full understanding of the medical condition and her treatment protocol. After the phone call with the nurse, Clara felt much more confident in her abilities to confidently navigate the rest of her pregnancy with gestational diabetes. Having the supports emotional, practical, and linguistical to get her questions answered was just the beginning of Clara's journey. One of the tasks associated with a diagnosis of gestational diabetes is to test

your glucose level using a special machine available only at specific pharmacies. Because Clara has Medicaid, the case manager needed to locate a pharmacy that a) had the machine in stock, b) would accept Medicaid, and c) was accessible by public transportation. After several phone calls and some research, Clara and her case manager located a pharmacy that met all their criteria. Now, Clara feels much more positive about this diagnosis and confident in her ability to advocate for herself and her growing family. Because of the PMI program, this client had the support she needed to get her questions answered and make the best choices she can for her baby.

- *Holistic Care Coordination:* Building strong MCH advocates and empowering families is also a goal of the KS SHCN Holistic Care Coordination program. By working one on one with families, Care Coordinators help families learn to navigate the health system on their own and provides the family with skills on how to be an advocate for themselves and their children. An example of this includes a young, single mother and her special needs child that the program worked with. In speaking with the mother, it became apparent that she had become overwhelmed with all those that were working with her daughter and was hesitant to bring in another party. She did agree to try the care coordination services. The regional care coordinator worked with the mother to set up times to talk that would fit in her work schedule, or to take place before or after. After the first few contacts with this mother, the care coordinator had already began building a relationship of trust and mutual respect. Within the first year of care coordination services, the barriers to attending appointments had been resolved. This mother became a wonderful promoter of the KS-SHCN Program with other parents she met in service provider's waiting rooms. In her second year of care coordination she began a Facebook group for other parents with special needs children.
- *Kansas Perinatal Community Collaboratives:* The KPCCs continue to empower families to be strong MCH advocates. KPCCs provide in depth education and resources to pregnant moms and their support systems - arming moms with knowledge empowers them and their support persons to advocate for their own health and the health of those in their community. Providers in both the clinical and inpatient settings, in KPCC communities, have indicated that there is a clear difference between patients that have participated in the Becoming a Mom Prenatal Education classes and those who have not. Participants (as reported by their providers) are more engaged in their healthcare – by asking thoughtful, informed questions and following up on content discussed in the class setting.

The Kansas Home Visiting Conference was held virtually on September 27th and 28th. In attendance were home visitors, supervisors, and various support staff (including agency directors) from all home visiting models across the state. With 349 attendees, 90.4% of respondents rating the conference overall as either "Outstanding" or "Good", which were the two highest ratings available. The focus of the conference was not only on the critical aspects of home visiting such as the sessions "Rethinking Safe Infant Sleep Education: Utilizing a Conversational Approach", "Using the Period of PURPLE Crying to Support Families and Prevent Infant Abuse", and "Perinatal Behavioral Health: Screening, Referrals, and Resources", but specifically on the impact of COVID-19 in Kansas homes and communities, as well as a focus on cultural competency and equity in home visiting.

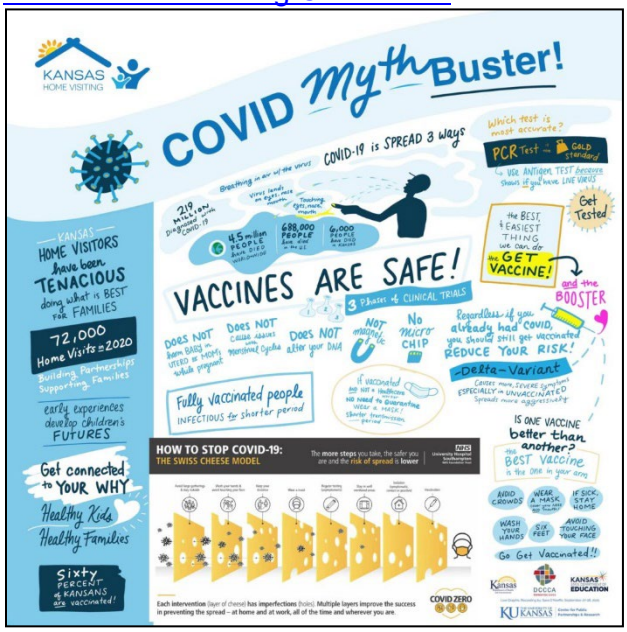
On day one, the keynote speaker was Dr. Joan Duwve, Kansas Department of Health and Environment (KDHE) Deputy State Health Officer. Presenting on "COVID MythBusters", Dr. Duwve focused on ensuring all attendees were clear on state and federal guidance, understood the development of and reason for the vaccine and resources for use when discussing COVID-19 related issues with families, while also presenting popular myths and the reality behind where they came from or the reasons for their inaccuracy. Focusing specifically on home visiting, her session also included a chance for questions and answers and received praise from attendees as one remarked in their evaluation of the session, "I enjoyed her enthusiasm for what we do. I will implement new strategies on how to talk to families about informing them on the COVID vaccine." Another remarked that they learned how to, "Provide families with research-based information regarding COVID-19 and the COVID-19 vaccine to help them make an informed decision about getting vaccinated."

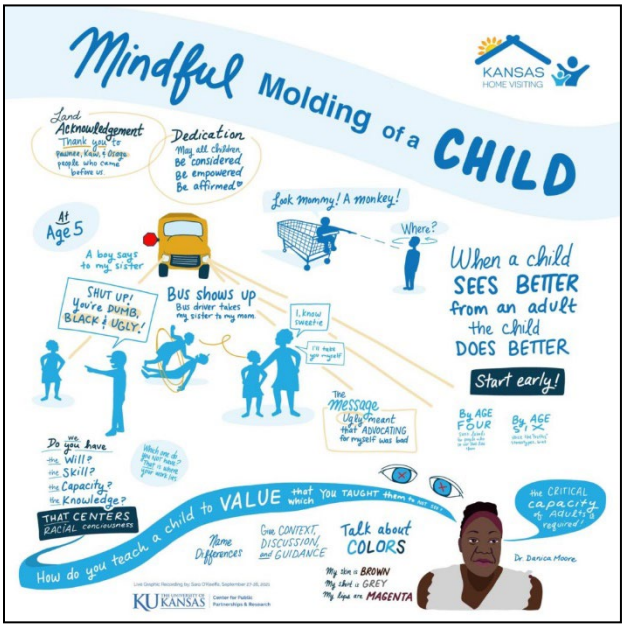
The second day of the conference featured keynote speaker Dr. Danica Moore, a national trainer focused on diversity, equity, and inclusion. Her session, "The Mindful Molding of a Child: The Critical Capacity of an Adult" received incredible responses on evaluations. Using brain research, Dr. Moore explained how quickly opinions of self and others are formed based upon interactions with others, and specifically from adults and those seen

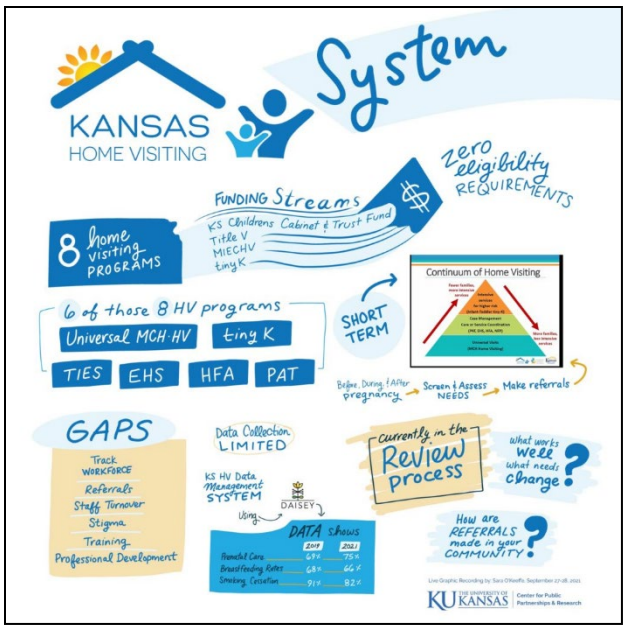
as influential, such as friends. Giving specific ways to engage in conversations about race in home visiting, such as discussing the different skin tones in a book, or asking how someone identifies racially rather than assuming, this keynote session was a hit. From praise such as, “Dr. Moore was fantastic! We need more from her or others like her in working toward more DEI awareness and practical application!”. Dr. Moore truly helped many attendees gain understanding about how to approach a subject that can be difficult for some to grasp and practice. Through her additional session in the form of a breakout, Dr. Moore focused on “Discussing Race in the Space: Am I Ready to Engage? Did I Miss Something?” as a means to start a conversation with home visitors who may be approaching this topic for the first time.

A total of two keynote speakers and 17 breakout sessions offered between the two afternoons, attendees had a wide variety of topics to bolster their professional development.

Sessions such as “Breastfeeding Support During COVID-19: The Powerful Role of the Home Visitor”, “Mindfully Managing Stress and Supporting Others”, “Recruitment of Families” which also discussed specific ways to engage families during COVID, and “Cultural Humility as an Everyday Practice”. Below are the whiteboard summaries of the featured keynote sessions and breakout sessions. For larger images, visit Kansas Home Visiting Conference.







Kansas Home Visiting (KSHV): has worked to engage as many key groups as possible in the continued work to get *all* pregnant women access to information and resources about home visiting. With the engagement of state leaders across several programs, KSHV hosted monthly State Home Visiting Leadership (SHVL) Group collaborative meetings and worked within the mission statement, "To elevate and sustain the early childhood home visitation system assuring lifelong benefits and values for all Kansas children and families." Members include Kansas home visiting models: Parents as Teachers, Early and Head Start, Healthy Families American, Nurse Family Partnerships, as well as leaders from the Kansas Department of Education, the Kansas Department of Children and Families, the Kansas Children's Cabinet and Trust Fund, the University of Kansas Center for Public Partnerships and Research (KU-CPPR), the Kansas Department of Health and Environment in programs of tiny-k and home visiting (MIECHV and Universal MCH), for a total of 28 members. Using this group to plan for ways to: pivot service delivery for safety and efficacy during the COVID-19 pandemic, address and remove barriers for families to receive quality home visiting services, incorporate data from annual evaluations of home visiting programs into practice, and broaden our approach to effectively promote programs across the state. While there are several parents who have participated in home visiting services at one time, they are filling roles associated with their programs. Going forward, the SHVL Group is recruiting new membership from parents currently receiving home visiting services for this collaboration, as this is a critical voice in the work we do.

Always working to ensure programs are progressing and meeting the needs of Kansas families, an Early Childhood Needs Assessment was conducted in 2019 in line with the Preschool Development Grant. Information gained from this assessment incorporating 6,100 voices from various key groups across all 105 counties in the state, a strategic plan for the state, All in for Kansas Kids was developed. The following year, a Needs Assessment was conducted specifically for the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, and gathered new and updated data that the KSHV team found important to incorporate into *all* home visiting practice across the state.

The 2020 Kansas Home Visiting Needs Assessment found many aspects of home visiting that were looking to be updated and some of those changes were implemented in FY2021. Three of the more specific findings that were addressed by KSHV in FY21 include:

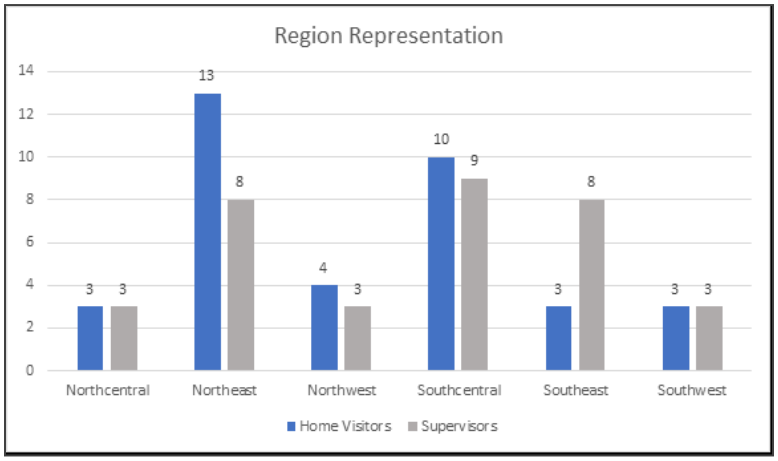
1) Assure that efforts to strengthen the Kansas early childhood infrastructure and create greater systems alignment at state and local levels reflect a commitment to home visiting with the broader early childhood care and education system. Examples include opportunities identified in this needs assessment to create support systems for cross sector screening and referrals, fully realize the early childhood integrated data system, continue implementation of a common funding application, and set funding priorities.
2) Many of the high-need counties in Kansas have diverse populations with multiple languages spoken and a combination of immigrant and refugee experiences. Gaps exist in providing appropriate materials and translations, but also in earning the trust of a family who may be fearful of deportation or whose cultural customs do not align with early childhood services, particularly in the home. Concerns about privacy were frequently referenced regarding enrolling and retaining families in programs.
3) Develop a large-scale public awareness campaign to help Kansans know what home visiting is, what it is not, and why it is important for pregnant women and families with small children to be supported for a strong start in life. Engage the early childhood education community, K-12 system, and medical professionals statewide in helping to spread the message.

With these three priorities for home visiting statewide, KSHV made moves to tackle these obstacles in many ways. For the first listed priority, we worked within the SHVL Group as well as with local agencies and our contracted data team to solicit feedback regarding ways to streamline reporting within our Data Application and Integration Solutions for the Early Years (DAISEY) system.

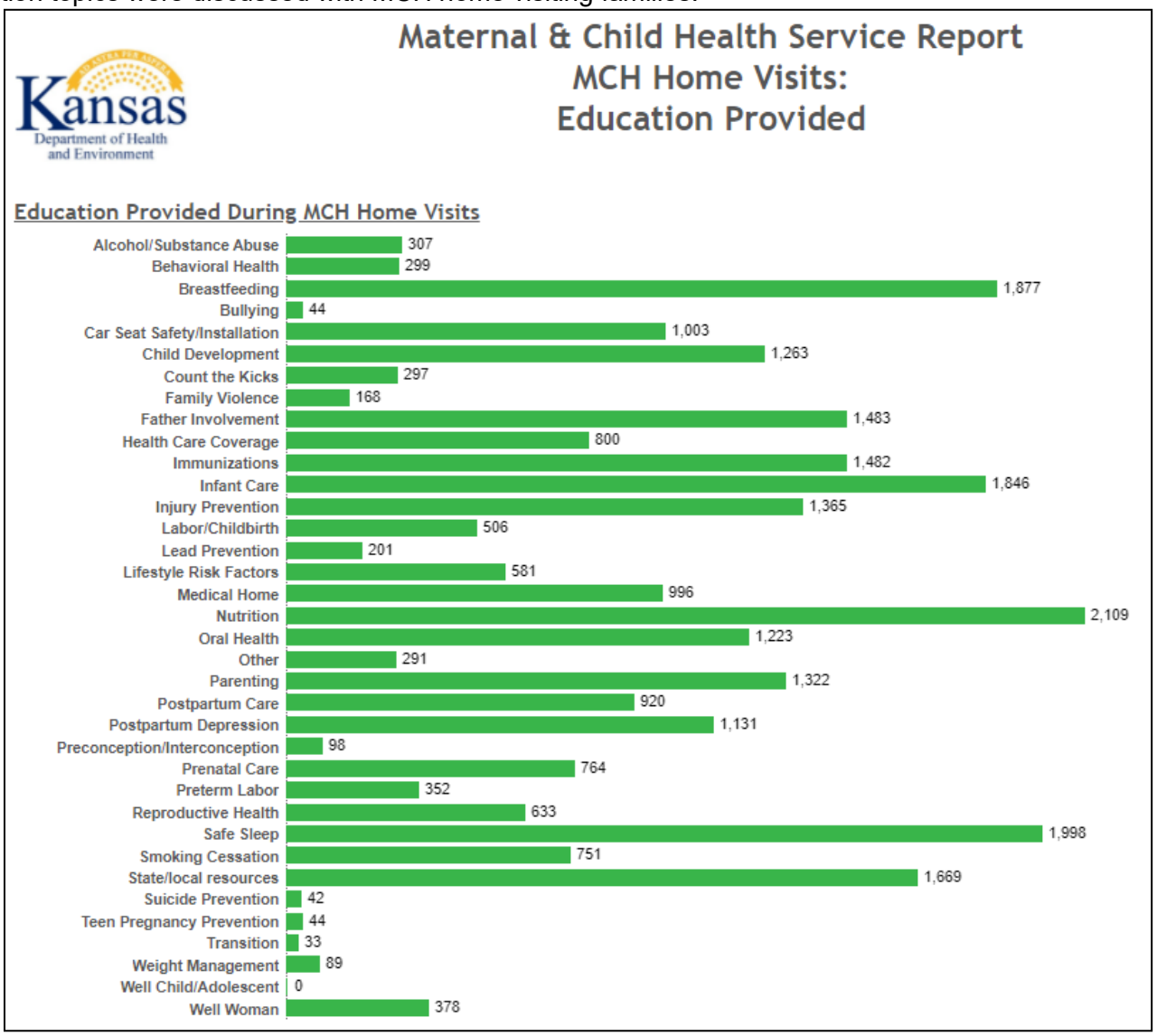
For priority two, several home visiting agencies made targeted hiring moves to onboard bilingual home visitors and support staff, as well as increased translation services to incorporate languages other than Spanish. With regards to both this priority and priority three, all materials used for promoting the KSHV program were developed in both English and Spanish for increased accessibility.

Priority three worked to collaborate across early childhood groups in the state. KSHV worked to promote home visiting programs to a broader audience with the assistance of the Douglas County Citizens' Committee on Alcoholism, Inc. (DCCCA), a local agency that works to promote essential community services in Kansas. With input from the SHVL Group, local agencies, and other key groups, KSHV and DCCCA worked in tandem to design and place billboards, social media and radio campaigns, and developed a brochure for targeted communities. While the campaign did not effectively take place until early summer 2021, the purpose of these materials was to provide quick and easy information for parents to find an agency that suited their specific needs, and with these campaigns, KSHV was able to continue adding new families to our home visiting programs, even during a pandemic. The metrics show that from June 6, 2021 to July 31, 2021 our Facebook campaign reached 91,845 users, Instagram 17,602 during the same period, we reached an estimated 524,919 people with 10 billboards across the state with one digital billboard in Southeast Kansas scheduled for 6 months reaching an estimated 38,500 people weekly and 9,400 people with 30 radio spots in the Kansas City area along with an estimation of two-thirds of the state with radio ads covering Central and Western Kansas with 20 radio spots. Finally, the KSHV website, kshomevisiting.org, saw 10,263 views, an increase of 4,166 users, a total of 5,259 sessions, with the most traffic being at the beginning of April 2021 and May 2021, then a steady increase as our outreach campaign launched mid-June 2021.

During FY21, in tandem with the KU-CPPR, an evaluation was conducted of the MCH universal home visiting model beginning in June 2021 which concluded with a report in September 2021. This allowed for feedback directly from service providers and from families receiving services. According to the report, this assessment included demographic data on 101 MCH home visitors as of July 1, 2019. The majority of Kansas MCH Home Visitors are in their 30's to 50's (76.5%), non-Hispanic (87.7%), white (96.3%), do not speak Spanish (84.1%), and all are female (100%). To collect additional data on the Kansas MCH universal home visiting workforce, online surveys were sent to home visitors as well as supervisors, and covered varying topics related to their work experience and model fidelity. In total, 37 home visitors and 34 supervisors completed the survey and represented all six regions in Kansas.



Using client-level data in DAISEY, 1,574 MCH home visiting clients were served during SFY2021. There were 1 100 prenatal/pregnant women, 1,444 postpartum women. Throughout this time period, the following education topics were discussed with MCH home visiting families.



With evaluation done in several areas of home visiting including workforce inquiry, delivery of service, program content, and reporting and evaluation, the overall summary findings were similar to those found in the 2020 Needs Assessment. In summary, the single theme of connection has repeatedly emerged as a top priority and value. We recommend that strengthening the relationships across and between every level of the home visiting structure will be the most important key to long-term success. As we approach the next stage of design, decision-making, and implementation, keeping connectedness and effective communication at the forefront of each step will be essential. Reflecting along the way should help continually refine and improve the process. With this continued message from those surveyed, KSHV continued to increase collaboration not only between early childhood programs within KDHE by creating internal meetings, documents, and listservs to better address alignment. We also held collaborative webinars to address continued efforts to align services and resources.

An additional priority came out of this FY21 report from KU-CPPR, which was geared toward our home visiting workforce, was to solicit local-level staff input on training needs and offer trainings designed to meet the needs of staff rather than a one-size fits all approach to ongoing professional development. Implementing the Kansas Learning Management System (KS-LMS) for MCH home visitors and develop new modules and digital badges for professional development needs not currently offered on the platform. The KSHV team worked to launch the KS-LMS. Trainings include: how to deliver effective home visiting services virtually; where to find MCH resources; substance use and child abuse/neglect screening; and Maternal Warning Signs. Additional topics focused on home visitor and family safety, trauma-informed care, cultural competency, and links to the MCH Navigator for targeted trainings (as needed). The launch of the KS-LMS allows for flexibility in training for home visiting staff across the state and intends to incorporate other early childhood programs, such as tiny-k (infant toddler services), as the system continues to grow. With the ability to track specific program models of users, level of experience and education, as well as specific role within the home visiting community, KSHV is able to track trends and respond in ways that will address the concern for more local level influence in training plans.

Finally, a report for SFY21 without specific mention of COVID-19 is impossible. KSHV made it their mission to ensure quality information and resources were distributed and easily accessed by the home visiting community. As mentioned from the State Home Visiting Conference with day one keynote speaker presenting on COVID MythBusters, guidance was both in the form of live trainings and webinars, recordings, and continually updated guidance sent via email, listservs, or through newsletters to home visiting staff. KDHE staff have developed and keep updated the KDHE Home Visiting Services Guidance; FAQs* for Pregnant, Postpartum and Infant Populations, and the Interim Guidance for Maternal and Child Health Service Providers documents. Continued guidance from the CDC: How I recommend was also sent to home visiting sites to ensure staff were prepared and comfortable discussing various aspects of the pandemic with their families served. Feedback from locals giving thanks and appreciation for this guidance in an atmosphere that was and is ever-changing was helpful.

References

1. Kaiser Family Foundation. Mental Health Care Health Professional Shortage Areas (HPSAs). https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas. Accessed May 25, 2022.

2023 CROSS-CUTTING / FAMILY SUPPORTS APPLICATION PLANS

PRIORITY: Strengths-based supports and services are available to promote healthy families and relationships.

SPM 4: Percent of children whose family members know all the time they have strengths to draw on when the family faces problems

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Kansas selected this new priority focused on family engagement and supporting families from a strengths-based perspective. This further solidifies the long-standing priority that Kansas has had on family engagement

and consumer partnership. It is well known that when families are strong, connected, and healthy, the family members and their surrounding community thrive. Title V is distinctly poised to strengthening self-efficacy and self-determination among families by assuring: MCH-led activities and services (informed by family needs and desires, centered on the family voice, and representative of diverse values and ideals); family/consumer peer support opportunities; family/consumer leadership activities; and expansion of holistic care coordination services across Title V populations. These things collectively will provide multiple areas where families can be supported and feel like they have strengths to draw on when faced with challenges.

Objective: Increase the proportion of MCH-led activities with a defined program plan for family and consumer partnership (FCP).

MCHB defines family partnership as "patients, families, their representatives, and health professionals working in active partnership at various levels across the health care system – direct care, organizational design and governance, and policy-making -to improve health and health care." While the Kansas vision has always included family-centered approaches and the assurance of family engagement at various levels, statewide and local programs have struggled with operationalizing family and consumer engagement opportunities, outside of the CSHCN program/population. The Family and Consumer Partnership (FCP) Program, housed within the System of Supports Team provides capacity and support to Title V staff/partners with a focus on understanding the need for FCP and supporting programs and services to engage with families and consumers in their daily work and fully embrace the "nothing about and for us, without us" philosophy.

The FCP Program will ultimately build strong partnerships with families through peer supports, advisory opportunities, leadership and development, and technical assistance. An image depicting these four program areas can be found in the Family Partnership narrative. This dedicated program provides a framework for family engagement, and technical assistance, for local and state Title V partners, to assure families are engaged at the level they desire and assure families are provided opportunities to assist with planning, implementation, and evaluation of the services and programs they engage with, as well as policy at the local, state, and national levels.

Technical Assistance Activities: As a support for local and state partners, technical assistance has been built in as a key component of the FCP Program. Planned technical assistance include provision of information about the adopted family engagement frameworks, including recommendations and guidance to local grantees on the implementation of those frameworks; learning opportunities through conferences and webinars, a planning tool to support the adoption and implementation of family engagement efforts, and a special project to support local programs in developing a family engagement and partnership plan.

- MCH Manual: In preparation for the SFY2023 Aid to Local (ATL) application process, the team updated the MCH Manual for local grantees and added a section around family and consumer partnership. This section included information and references for the five frameworks outlined in the Family Partnership narrative. The manual also included examples of engaging families at all levels across MCH programming and MCH populations.
- ATL Application Questions: New questions were added to the SFY2023 ATL Application to learn more about how the grantees engage families in their programming. These questions provide an opportunity to hear about the amazing engagement activities already happening at the local level, identify areas where technical assistance could be provided or may be desired, and establish baseline data for this objective. These questions included:

7. How does your program encourage families and consumers with lived experiences to participate in planning, implementing, or evaluating the services you provide? (Note: this is different than encouraging families to access, or use, the services you provide) (1 point)

☐ Surveys: Service satisfaction	☐ Serve on planning/evaluation teams
☐ Surveys: Services needed; Gaps analysis; Needs assessments	☐ Leadership/advocacy training to support policy change
☐ Focus groups/Listening sessions	☐ Key informant interviews
☐ Advisory group/Board/Council	☐ Paid team member/staff
☐ Peer support groups	☐ Other (specify other) _____

8. Title V is developing a Family and Consumer Partnership Planning Tool to help partners consider how to engage and partner with those they serve, which can help local MCH agencies in ongoing assessment of needs, evaluating program effectiveness, outreach and community awareness, and increase capacity to reach families in need of services. Would your agency be interested in learning more and possibly piloting this planning tool (additional funding would be available)? (No point value)

☐ Yes ☐ No

D7 - Family Services and Supports (9 Points)

Priority 7: Strengths-based supports and services are available to promote healthy families and relationships.

SPM 4: Percent of children whose family members know all of the time they have strengths to draw on when the family faces problems

For each of the following questions, describe your activities planned as it relates to engaging the individuals and families you serve in your community, particularly through strengths-based supports and services. If no formal activities are planned, indicate as such and describe supports or technical assistance you would appreciate.

1. In what ways does your organization recognize and affirm the strengths of the individuals and families served? (4 points)
2. Describe how your agency supports family peer to peer connections. (e.g., host family activities, refer to peer-to-peer support groups, promote Supporting You Kansas) (2 Points)
3. Describe your agency's role in providing holistic care coordination services to MCH populations. Learn more about holistic care coordination services at www.kdheks.gov/hcc. (2 points)
4. What additional activities are planned to assure strengths-based supports and services are available in your community to promote healthy families and relationships? (1 points)

In the coming years, the questions will continue to evolve beyond information gathering and will become a more prominent consideration for funding in the future and support the objective that by the end of the five-year state action plan, the majority of Title-V funded partners and projects will include a plan for family and consumer engagement.

- Planning Tool: In partnership with a graduate student through the University of North Carolina's MPH Program, Title V worked to establish a planning tool to support programs in developing a plan for family and consumer engagement. This can be used as a standalone resource, or in conjunction with the Family and Consumer Partnership Toolkit. Local MCH Grantees are encouraged to begin establishing plans for engaging families and consumers in program planning and design activities, implementation and service delivery, and evaluation. This is what is meant by "engaging families at all levels." The planning tool includes the following sections:
    - Considerations to Begin Program Planning with Families and Consumers in Mind – This outlines five steps to determine the scope of the engagement plan the program would like to establish.
    - Integrating Families and Consumers into Your Program – Aligned with the Family Engagement in Systems Assessment Tool (FESAT) developed by Family Voices, this describes examples or strategies to associated with the four domains of family engagement: commitment, transparency, representation, and impact.

The remaining portion of the planning tool consists of a worksheet to help programs establish a plan.

- Program Reflection/Pre-Planning Assessment – Questions designed to help programs define the scope of their effort and assess their current activities associated with commitment to family engagement, outreach and communication, supports for families, and adequate representation across diverse populations served.
- Identifying Goals, Anticipated Outcomes, and Desired Results – Intended to help the program consider what they really want to get out of their engagement efforts. They are asked to

consider their goals and what they'd like to see changed based on their responses to the pre-planning questions.
- Define Your Stakeholders & Describe Desired Outcomes and Expectations – Structured to help them be completely open about who they need at the table, determine the experiences or expertise they desire to hear from, and what they are hoping to accomplish with their engagement efforts.
- Determine Engagement Level – Aligned with the AMCHP Levels of Family Engagement framework, this helps them think through the level at which they want families to engage (input, advisory, leadership)
- Identify Potential Needs – Supports the program in describing what supports they feel they can offer to families/consumers who are participating and the resources they will need to provide those.
- Take Action – Provides examples for programs to consider outlined by level of engagement. For example, under "Input" examples noted include surveys, focus groups, and key informant interviews. Following that, there is another 1 page "worksheet" designed to help them think through exactly what they hope to do and how they will do it.

Implementation Toolkit and Website: In partnership with the Family Leadership Team and the Early Childhood Recommendations Panel, Title V will be completing the development of the FCP Implementation Toolkit. In addition to a strategy under the Kansas Title V plan, this toolkit will be integrated into the All in for Kansas Kids Strategic Plan as part of their family engagement strategy guide, "Support family engagement efforts at the local level by developing toolkit of family engagement strategies and highlighting best practices and effective models In Kansas during biweekly webinar."

The toolkit is designed to support programs across Kansas in all sectors and settings to establish family engagement standards and include contextual frameworks from various service delivery and family support systems, resources and tools compiled from other state and national partners, and examples of practical and real-life implementation opportunities. Additionally, the tool kit is being aligned to address the Title V MCH Leadership Competencies.

Upon completion of the toolkit a series of trainings will be provided to state and local program staff to begin learning about the importance of and the programmatic and community benefits of FCP. Training topics will include the importance of family-centered services and supports to: strengthen families; promote strong, healthy, and safe family environments; address diverse needs of families; and build supportive communities. Dissemination and integration of the FCP Toolkit will begin with state program staff, including integration of FCP principles and resources and provision of training for grantee networks and core partners. Additionally, FCP plans will be expected as part of funding and grant opportunities in the future and the toolkit will be provided as a technical assistance resource to support the creation and development of these plans over time. Lastly, the Title V FCP Consultant will facilitate and lead, in collaboration with All in for Kansas Kids partners, a call for proposal for local community partners to implement components of the toolkit. The funding available for these will vary depending on the type of activity (e.g., focus groups, establishing an advisory council, family advocacy or leadership activity).

Objective: Increase the number of individuals receiving peer supports through Title V-sponsored programs.

Peer & Social Networks: Title V staff will continue to support pregnant and new mothers through the KPCC model, which allows mothers to connect with one another during this important time and share lived experiences in an authentic and supportive environment. Plans to extend the program past birth are underway, which will provide an opportunity for mothers to share birth stories as well as postpartum struggles – reinforcing a network that can reduce isolation and promote healing and resilience. For women not participating in BaM, Title V staff will vet and promote secure and safe peer support options through social media, training and marketing including those offered through Postpartum Support International (PSI).

In partnership with Wichita State University's Community Engagement Institute (CEI), health care practitioners/organizations and interested groups can receive support in the development of peer support

groups within their community. CEI manages the Kansas Support Groups website. Individuals can search for support groups by type of group and/or location of group meetings. Support groups can register on the site, so individuals can find and participate in their groups. CEI also developed a *Perinatal Support Group Guidebook* which serves as a resource for local communities wanting to start or revamp a perinatal support group. The Guidebook includes information on recruitment and promotion, establishing a support group agreement, group structure and environment, choosing a group's location (e.g., in-person and virtual meeting place considerations), facilitator roles and responsibilities, and how to keep a support group going.

Ongoing enhancements and expansion efforts continue for the Supporting You Network This includes adding two new Network Programs each year for the next 3 years. A new change request has been completed, based on desired enhancements outlined last year to develop a connection dashboard for all users. Included in the dashboard change requests were: separate designs for the level of user (Network Administrator, Program Coordinator, Peer Support Administrator, Support Peer, and Connected Peer), snapshots for programs of how many peers they have and how many matches are ongoing, network announcements bulletin, a shared documents page for programs, match snapshot page with peers information for each peer (Support or Connected), and an in-network messaging platform.

Support Peer Connection Dashboard	• Information, profiles, and activity logs • Easy access to matched peers • Long-term goal: interactive, integrated communication system
Integrated Training Platform	• Trainings integrated into the peer registration platform (current: GoToStage) • Easier Network oversight and tracking and training communications
Performance & Evaluation Metrics	• Multi-tiered evaluation plan to evaluate user experience/satisfaction and Network processes and activities • Post-Connection Satisfaction Survey (SP/CP); Annual Survey (SP)

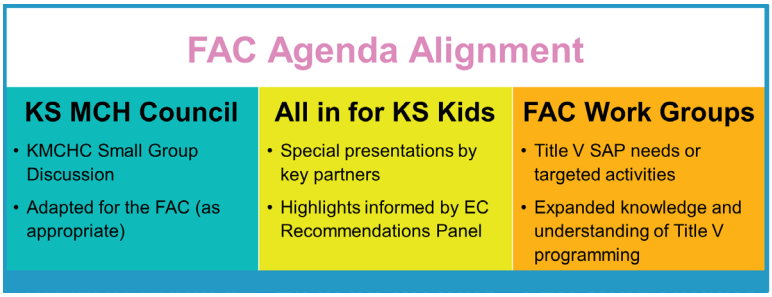
Ongoing enhancement activities for Supporting You include: looking into creating a bi or multi-lingual accessible platform for our non-English speaking families/communities across the state, developing a plan for Promotional Partners, and creating guidelines for what a partnership between two different entities that serve the same population could look like in collaboration within the Supporting You System.

Objective: Increase the number of families and consumers engaging as leadership partners with the MCH workforce through the FCP Program.

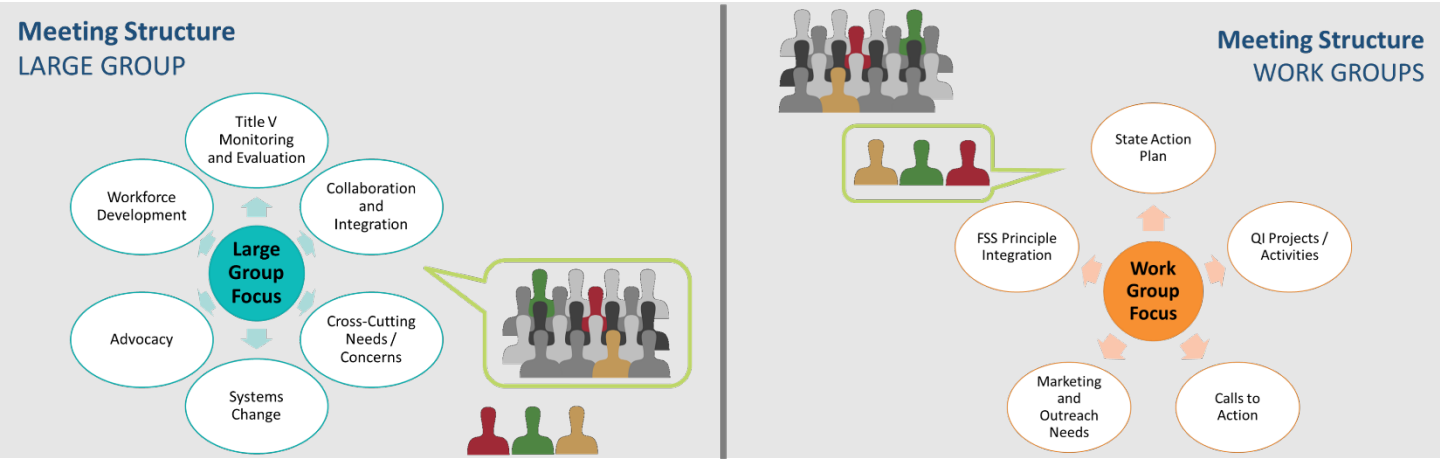
Family Delegate Program: Expanding family leadership efforts across Title V programs is a high priority and supporting stronger efforts to equip and empower families to engage as partners with the MCH workforce. As part of this effort, there will be continued focus on the Kansas AMCHP Family Delegate program, under the FCP Program. This includes the development of a Family Delegate Handbook that goes over all the requirements and expectations of a Family Delegate and the Title V team support they will receive. This will be used as an orientation/onboarding tool to help guide the Family Delegate in his/her role and to provide ongoing guidance as he/she serve their Family Delegate term.

Family Advisory Council (FAC): As outlined in previous sections of this application, the FAC expanded not only in population domain focus, but also as an opportunity to more strategically align with the Kansas MCH Council (KMCHC), comprised primarily of professional organizations and providers. The FAC and KMCHC will meet at similar schedules (e.g., 3rd week of January, April, July, and October) to support timely discussion of similar topics and shared learning opportunities. This will also offer additional opportunities for MCH programs to engage families and consumer with lived experiences at all levels: as program evaluators, co-trainers, interns, paid staff or consultants, mentors, grant reviewer, active participants in assessment processes, and more.

One strategy to align the work across Title V and the Early Childhood Systems is as simple as agenda development. This alignment (below) assures connection to the KS MCH Council and the All in for Kansas Kids Strategic Plan, while maintaining the goal of flexibility and member-driven agendas. Large group agenda time is dedicated to the KMCHC and All In for Kansas Kids and then the FAC Domain Work Groups dig in deeper to Title V activities and programming. The Executive Committee meets two weeks after FAC meetings to make recommendations and proposal for the next meeting agenda, based on the activities and discussions among FAC members during the recent meeting (framing the All In portion of the agenda). KDHE will make recommendations for the KMCHC aligned portion of the agenda as those Council meetings are planned. FAC Work Group agendas will be directly tied to the "next steps" identified by the members during their meetings or in ongoing discussion/coordination with the groups' Co-Chairs.



As outlined below, large group discussions will focus on cross-cutting topics and updates for all populations. Population domain work groups will have dedicated time to focus on their specific priority work – which will be established with their Work Group charter.



For SFY23 the FAC will focus on their individual work group charters and explore the interests of their work group members based on the 5-year Title V State Action Plan objectives and measures. The first meeting of SFY23 scheduled for October is being planned as the first in-person meeting since the pandemic began and will be designed to be a two-day planning retreat for the members of the council. During this meeting the members of each work group will be able to dig into the plan further and gain a greater understanding of what they will be able to do to help assist parts of the plan and advance the work. For the remainder of SFY23, the members will work on their chosen priority areas selected within the scope of the Title V State Action Plan. Ongoing recruitment for the council will continue as the Title V team strive to have a full council with diverse backgrounds and experiences, while anticipating and planning for any possible membership turnover as the council grows.

Family Advisory Council Work Group Charter Development Guide

What is a Work Group Charter? The charter is a living document that guides the work of a group or team; consider it the "North Star" for this group. It should describe the group's mission, scope, priorities and objectives, and commitment. Effective group charters outline the group's focus, direction, and boundaries with a goal to reduce confusion, duplication, and repetition among other groups.

The groups' Charter will identify their priority objective and outline what they hope to accomplish, and by when. This will serve as their "AIM" statement and guide their work. Groups are also asked to discuss the specific

membership diversity they need to advance the work and will be supported in identifying ways to engage diverse populations not currently represented (e.g., recruit new members, engage a professional subject matter expert, conduct interviews/research to gain insight and the views of those populations). The Charters will also outline their groups' communication preferences and plans, to assure all members are able to actively participate and engage in the outcomes, deliverables, or recommendations that come from the group. Lastly, this allows opportunity for all Council members to discover their roles and responsibilities as a group member, as compared to the roles of the Co-Chairs. The following chart is outlined to provide them this guidance.

Objective: Increase the number of MCH-affiliated programs providing holistic care coordination through cross-system collaboration.

Holistic Care Coordination (HCC) Implementation Toolkit: Title V recognizes the HCC model established and implemented by KS-SHCN, adapted in partnership from the Boston Children's Hospital, has shown to be effective in meeting the needs of those engaged in care coordination. Title V desires to expand this model across Title V/MCH programs and beyond through the provision of resources, information, and targeted technical assistance. Building from the established KS-SHCN model, and aligned with the National Care Coordination Standards for CYSHCN, an implementation toolkit has been developed but will continue to be refined over the next year based on feedback form users. This toolkit will be used to support providers, practices, and programs interested in establishing a care coordination model at different stages, both in public health and primary care settings. The toolkit includes foundational context, resources and tools for planning/implementation, evaluation and sustainability, sample job descriptions and training plans for care coordinators, and other resources to support needed technical assistance. Title V was already focused on expansion beyond the KS-SHCN program and across other MCH programs, so with the implementation of this toolkit, Title V will be able to spread and scale holistic care coordination to location across Kansas. The All in for Kansas Kids plan has identified this as a strategy under Goal 2: Community-Level Coordination and in partnership with this work will include a focus on primary care settings.

The expansion for primary care will be led by the System of Support Section Director with support from the System of Care (SOC) Consultant, a new position established in November 2020 to support this expanded effort. The expansion across MCH programming will be led by the CSHCN Director, who initially established the model and is leading the care coordination expansion efforts within the KS-SHCN program, Bridges. More information about Bridges can be found in the CSHCN Plan narrative. While these expansion efforts are happening in parallel, the synergy between all of these initiatives is complimentary and collaborative. Throughout the implementation toolkit development, the SOC Consultant has focused on outreach and promotion, provider input, and quality improvement focused development activities. To date, a video series was created (more information in the CSHCN Report narrative), a provider survey was conducted to assess knowledge, attitudes, and practices in holistic approaches to care coordination, four focus-group or roundtable input sessions were held to learn about interest in the Standard domains, and eight presentations to providers participating in the Turn a Page, Touch a Mind program. Ongoing and future activities include the establishment of a robust branding, marketing, and promotional campaign to promote the toolkit across primary care settings. The HCC website (www.kdhe.ks.gov/825/Holistic-Care-Coordination) was established to support ongoing awareness and transparency in this project.

In the coming year, following the analysis of the provider input activities, a short-term quality improvement project will engage provider offices to utilize a variety of quality improvement methods to implement key tools and resources within each of the Domain areas to provide input, feedback, and insight into the following areas: planning needs; ease of implementation; evaluation opportunities; and possible sustainability pitfalls

Practices will be asked to establish teams of three (provider, nurse, and patient/family member) to assist with the implementation. Each will be provided a tool or set of tools to implement and provide feedback on, based on their practice interest and application for the project. All participants will be reimbursed for their participation upon completion of submitted data, feedback, and/or recommendations. The target participation would include at least two teams per Domain, or a total of 12 teams from varying regions and areas of the state. We plan to offer this opportunity to include primary care pediatric, primary care family medicine, public health clinic, and federally qualified health centers in the effort to engage their input and build relationships for future implementation activities.

Additional pilots will be developed over the coming year, the toolkit refined and technical assistance provided to pilots sites. Participating practices will be funded to establish a holistic care coordination program through development of policies, protocols, and processes that will support the implementation of key activities to meet nationally developed care coordination standards. Practices will be incentivized to establish a patient advisory board to support the pilot project and will receive technical assistance through the KDHE Family and Consumer Partnership program, utilizing the FCP Implementation Toolkit, to establish practices that will support sustainability of the board.

Practices will engage in a "readiness assessment" to determine what they already provide as it relates to care coordination. Through this assessment, an individualized technical assistance plan will be developed. This may include one or more of the following: assisting with development of policy; establishing a job description and hiring a care coordinator; engaging in community-level conversations to support cross-system referrals and partnership development for the practice; training and support for the care coordinator (to be supported by the KS Special Health Care Needs Program); establishing evaluation strategies or plans; developing sustainability plans; recommendations for policy advocacy; or any other activity deemed of interest and within scope from the practice. Dependent on the assessment and where the practice is in terms of planning, implementing, or evaluating their care coordination efforts and their individual interest, they will be assigned to a 3, 6, or 12-month cohort. Just like HCC programs meet the family where they are, this approach will meet the providers and practices where they are and assure success. Those practices placed in the 3-month cohort will have already established some level of care coordination in their practice and already employ a care coordinator. Those placed in the 6-month cohort will have already established protocols and practices they intend to implement, however do not have the resources or supports to effectively hire or train a care coordinator. Those placed in the 12-month cohort will have a willingness to establish a program, however they have not yet begun planning.

Care Coordination Training Curriculum: Title V will be developing a robust continuing education curriculum for case managers, care coordinators, and community health workers on the provision of holistic care coordination services, adapted from the training conducted with the KS-SHCN Care Coordinators. The training modules will utilize both virtual and in-person learning and skills-building opportunities and will be included as a portion of the HCC Implementation Toolkit.

At a minimum, the training modules will cover the following topics, however, will be adapted and expanded throughout the development phase with input from patients and providers:

- *Building Patient/Family-centered Care Coordination Through Ongoing Delivery System Design.* Describe key components of a high performing care coordination model; compare existing care coordination models or efforts; assist learners in recognizing opportunities for improvement; and encourage learners to develop action steps for improving collaboration and teamwork
- *Care Coordination as a Continuous Partnership:* Explore the nature and dynamics of different kinds of "care coordination partnership relationships; define the core components of building partnerships with families; and inform practices going forward
- *Integrating Care Coordination into our Everyday Work:* Focus on longitudinal care; improve communication and accountability among providers; embrace the role of Care Coordinator as an agent of change; recognize patients/families as members of the medical home; and integrate patient/family input, appreciating that family satisfaction is central to successful care coordination
- *Strategies to Assess and Address in the Family-Centered Medical Home:* Social determinants of health; social service systems, supports, and common needs; barriers to assessing unmet needs; and strategies to address unmet needs

Trainings will also be developed to provide in depth review of a variety of established protocols and tools used in providing HCC to families. This will include a detailed overview of the KS-SHCN HCC Structure and processes that was modified from the Boston Children's Hospital Model. Providers who are interested in replicating this model will be given these resources to structure their own care coordination process. Additionally, all trainings will be based upon the National Care Coordination Standards CSHCN currently under development with strategies, techniques, and recommended guidance to deliver HCC services at the highest standard.