KANSAS
MATERNAL &
CHILD HEALTH

Kansas Maternal & Child Health Council

JULY 19, 2017 MEETING

KANSAS MATERNAL & CHILD HEALTH

Welcome
Approval of Minutes

DENNIS COOLEY, MD, CHAIR

KANSAS MATERNAL & CHILD HEALTH

Parent & Family Engagement Reflection

CONNIE SATZLER, ENVISAGE

Family/Parent Engagement Review

At the April meeting, we discussed the importance of incorporating the perspectives of family and people with lived experiences.

At the end of this session, we discussed and the group provided feedback on…

- **What will you do next as an individual/organization to improve parent and family engagement?**
- **What should the council do next to improve parent and family engagement?**

Thanks to those of you who turned in a response card in April!

Results of Response Cards

Responses included items such as the following:

- Create Family Advisory Board in my organization/for my program
- Start incorporating family engagement in my organization/program
- Conduct family and/or staff trainings or focus groups related to this issue
- Engage families in development of policies and practices
- Document changes that have resulted from family/community engagement
- Set specific goals and objectives related to family and parent engagement

Discussion Questions

- How many of you have been able to work on your next steps in parent and family engagement?
- What are some examples of what you have done?
- What has worked well?
- What are some challenges you have faced?
- What can or should the KMCHC do to continue improving parent and family engagement in Kansas?

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Mental Health First Aid

PAT KINNAIRD, CENTRAL KS MENTAL HEALTH CENTER

Kansas MCH Website Info

http://www.kansasmch.org/mhfa.asp

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Title V MCH State Action Plan 2016-2020

Home | Domains | KMCH Council | Resources | Contact Us

Mental Health First Aid Training

Mental Health First Aid is an 8-hour course that teaches you how to help someone who is developing a mental health problem or experiencing a mental health crisis. The training helps you identify, understand, and respond to signs of addictions and mental illnesses.

Visit the website
Find a course near you!

How Training Furthers the Kansas MCH 5-Year Action Plan

Many of MCH's Priorities and Objectives could be furthered with Mental Health First Aid training.

- Priority 3: Developmentally appropriate care and services are provided across the lifespan
- Priority 5: Communities and providers support physical, social and emotional health
- Priority 6: Professionals have the knowledge and skills to address the needs of maternal and child health populations
- Priority 7: Services are comprehensive and coordinated across systems and providers
- Priority 8: Information is available to support informed health decisions and choices

What You Learn

Just as CPR helps you assist an individual having a heart attack, Mental Health First Aid helps you assist someone experiencing a mental health or substance use-related crisis. In the Mental Health First Aid course, you learn risk factors and warning signs for mental

Getting trained in Mental Health First Aid can help further MCH's 5-Year State Action Plan!

Priority 3: Developmentally appropriate care and services are provided across the lifespan
Priority 5: Communities and providers support physical, social and emotional health
Priority 6: Professionals have the knowledge and skills to address the needs of maternal and child health populations
Priority 7: Services are comprehensive and coordinated across systems and providers
Priority 8: Information is available to support informed health decisions and choices

Get trained in **Mental Health First Aid**

Find a course at: **www.mentalhealthfirstaid.org**

MENTAL HEALTH FIRST AID USA

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Action Plan Spotlight: KS Safe Sleep Initiative

CHRISTY SCHUNN, KIDS NETWORK

DR. CARI SCHMIDT, UNIVERSITY OF KANSAS MEDICAL CENTER

Developing a state-wide infrastructure for safe sleep promotion

Christy Schunn, LSCSW
Carolyn R. Ahlers-Schmidt, PhD
Stephanie Kuhlmann, DO
Zachary Kuhlmann, DO
Matt Engel, MPH

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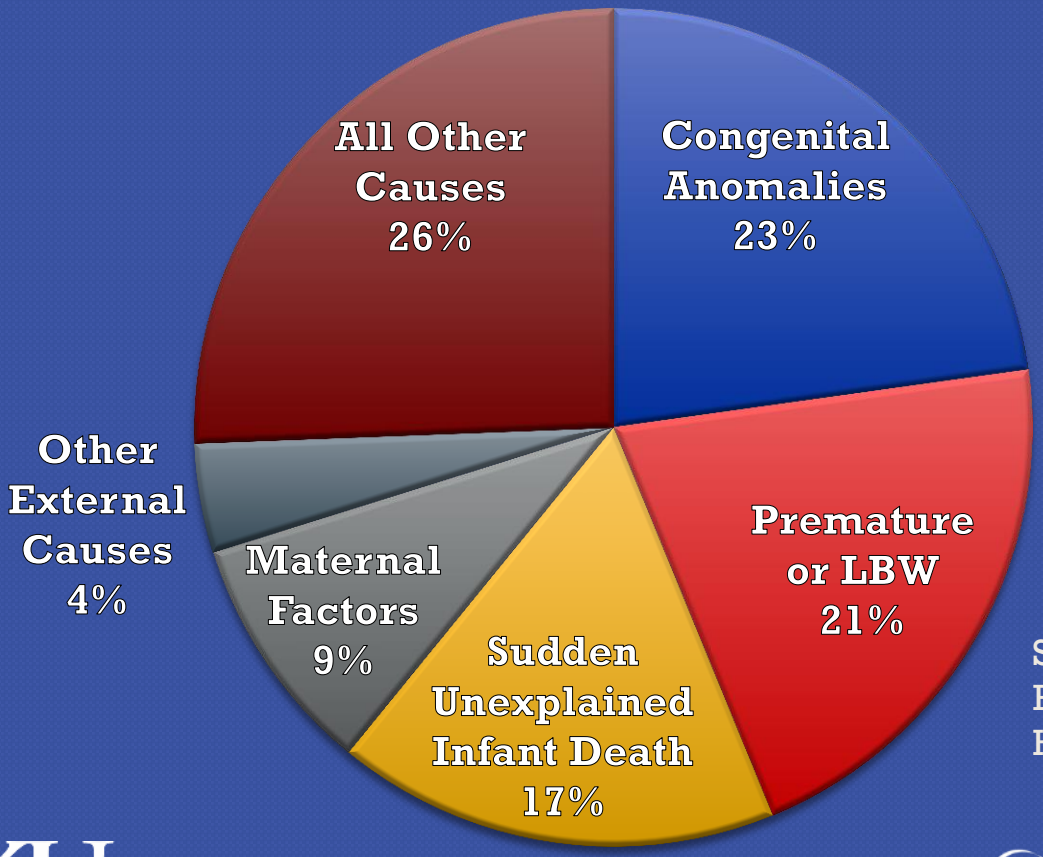
a Sedgwick County Kansas collaboration

Kansas Infant Mortality 2011-2015



Source: Bureau of Epidemiology and Public Health Informatics, KDHE

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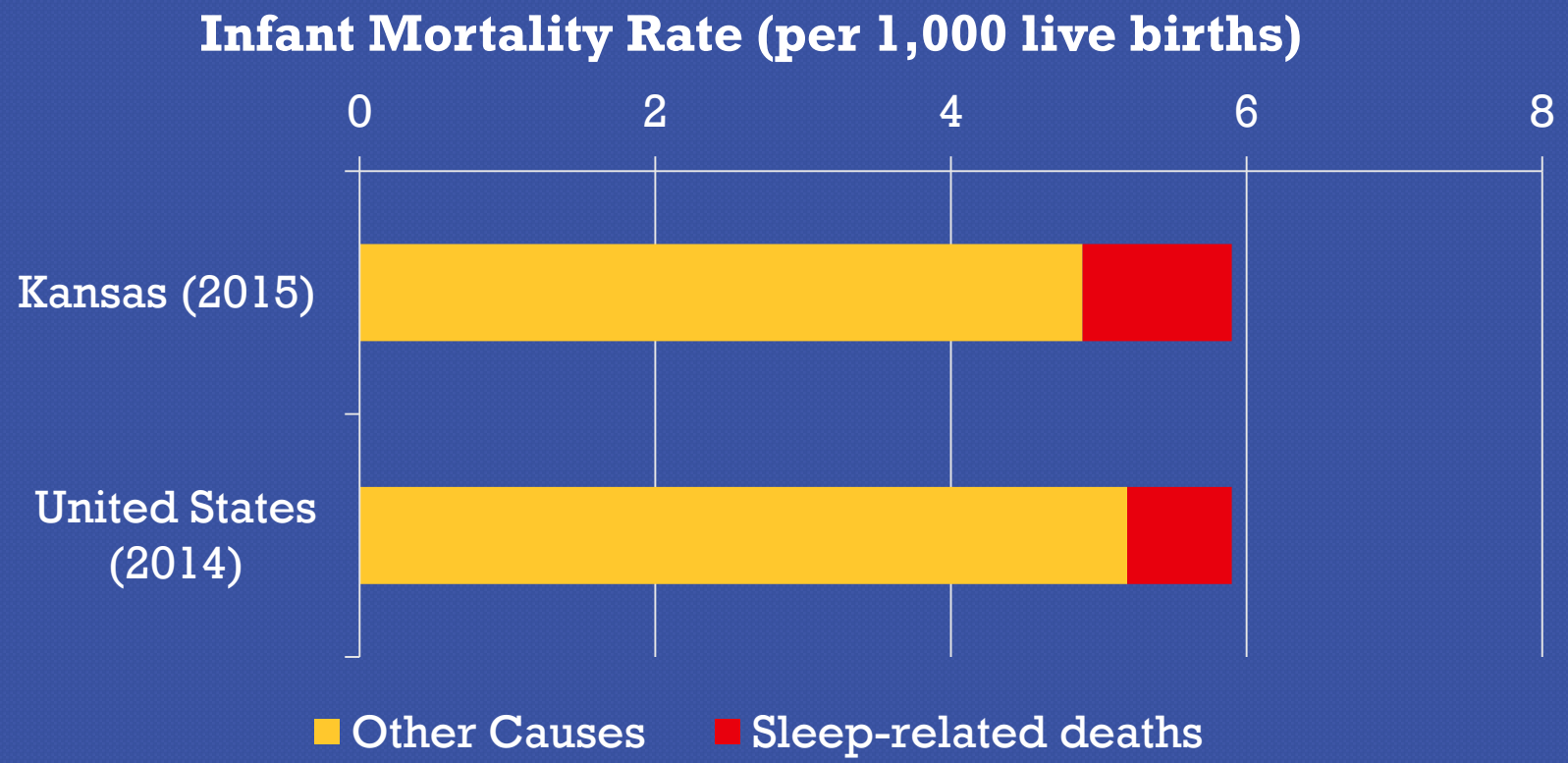
Kansas Infant Mortality



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Purpose

To build state wide infrastructure to enhance our capacity to share consistent safe sleep messages with providers, parents and caregivers.

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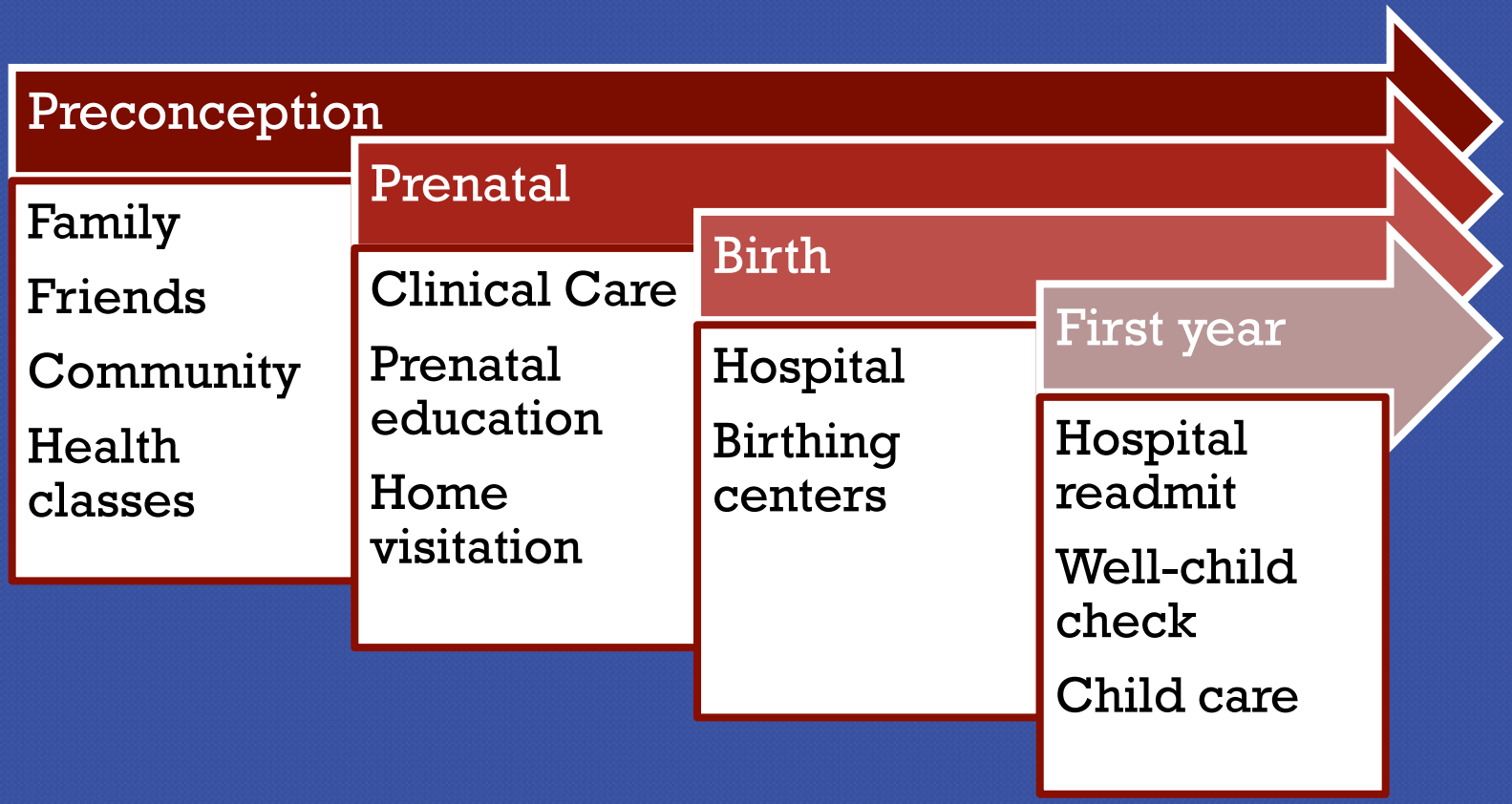
Strategy: Consistent Safe Sleep Messages



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Plan

- March of Dimes pilot project to test safe sleep instructor idea
- KDHE 3-year expansion includes state-wide:
  - Safe sleep trainings
  - Safe Sleep Community Baby Showers
  - Hospital safe sleep certification program
  - OB/FM/Peds safe sleep QI project

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2015 Pilot Project

- 23 Safe Sleep Instructors (SSI) from across Kansas convened for a 2-day training including:
  - Demonstration
  - Breakout sessions
  - Practice with feedback
- Instructors included physicians, nurses, community health professionals
- Instructors completed pre- and post-training test
- Instructors submitted 18-item pre- and post-training test scores for their trainees

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2015 Pilot Project: SSI Results

- SSI scores (18 possible)
  - Pretest = 13.5 (SD=2.4)
  - Posttest = 15.3 (SD=2.4)
- Incorrect responses were reviewed with all participants
- Those scoring <80% post-training (n=6) received additional instruction

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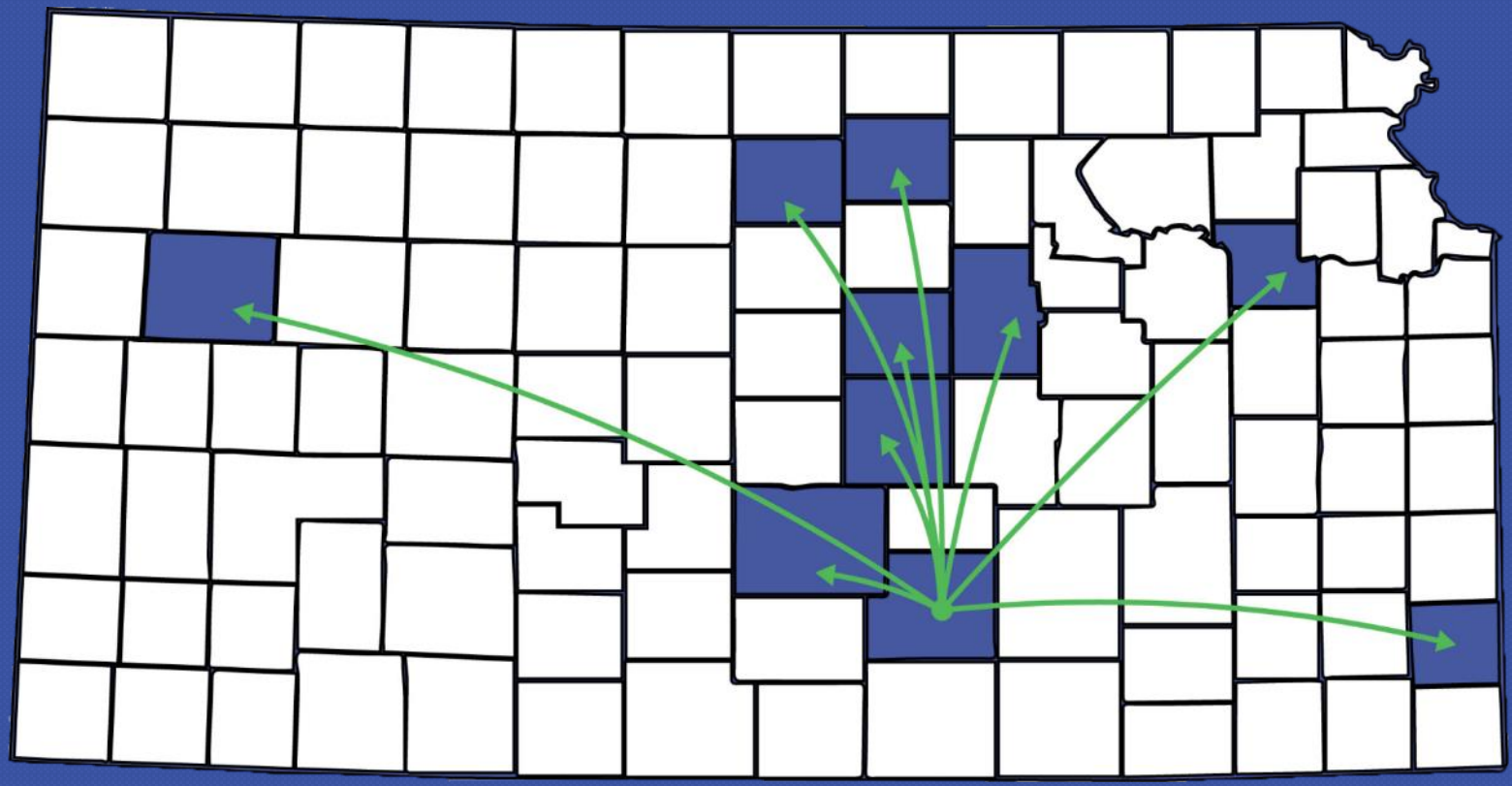
2015 Pilot Project



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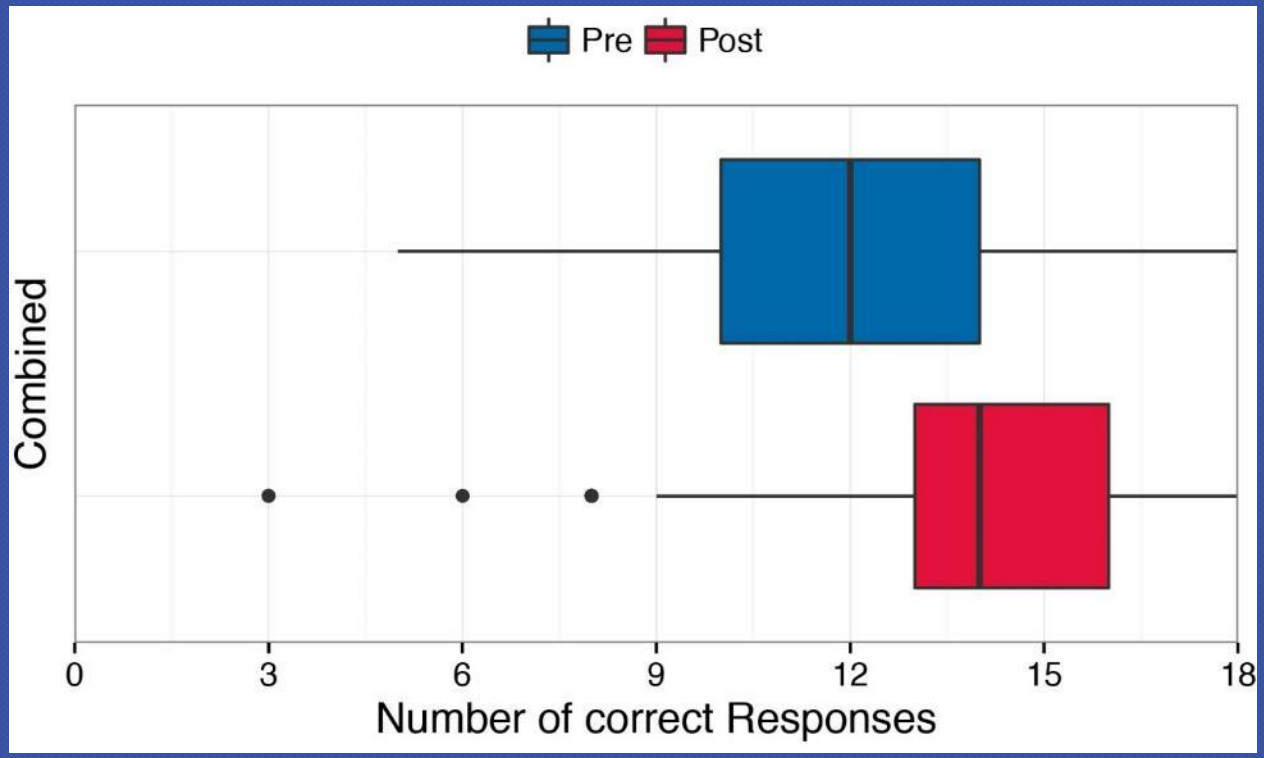
2015 Results

Pre/post scores of those trained by SSIs



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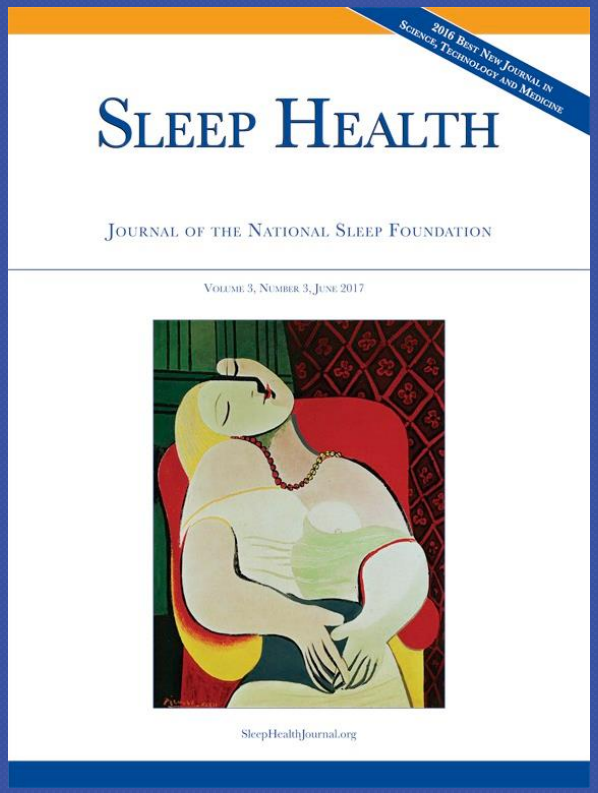
Statewide Safe Sleep Instructor Publication



Ahlers-Schmidt CR, Schunn C, Kuhlmann S, Kuhlmann Z, Engel M. Developing a state-wide infrastructure for safe sleep promotion. Sleep Health. 2017; 3(4):296-299.

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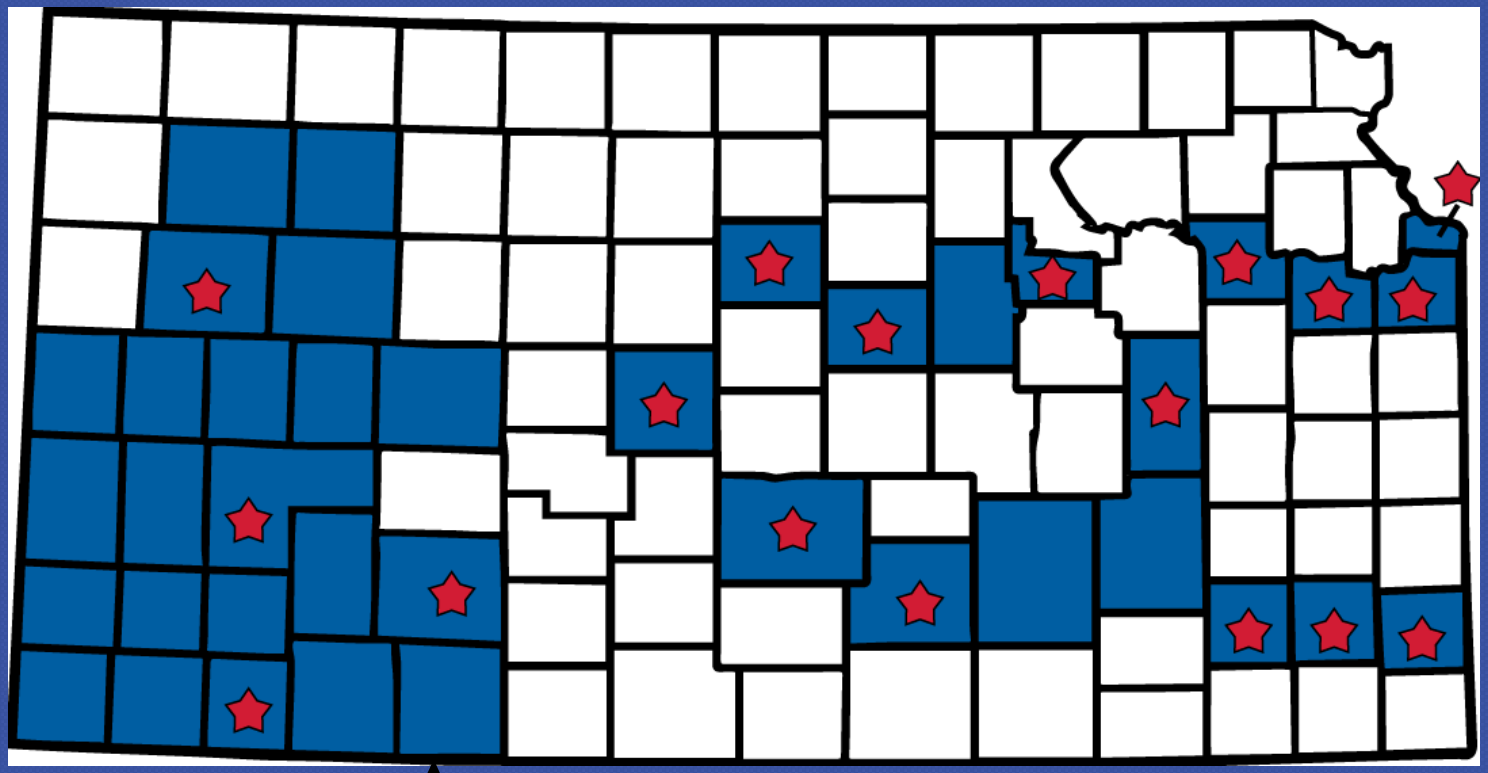
2016 Safe Sleep Instructors



★ **Trained SSI**

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2016 SSI Objectives

- SSI Training—Nov. 3 & 4, 2016
  - Safe Sleep Train-the-Trainer
  - Community Baby Shower/Crib Clinic
    - Safe Sleep
    - Breastfeeding
    - Tobacco Cessation

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2016 Expansion Training Results

- 35 new and returning instructors trained
  - Instructor knowledge high at baseline, but still reported significant increases in knowledge

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Safe Sleep Training Results

- 42 trainings by 17 instructors
- Trainings in 25 counties including 2 in Missouri and 1 in Oklahoma
- 665 trainees
  - Average training was 16 people
  - Professionals were present at 35 trainings
  - Caregivers were present at 15

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Professional Trainees

- Correct responses on assessments increased from 74% to 88% ($p<0.001$)
- On a 10-point scale, self-reported knowledge increased from 6.8 to 9.3 ($p<0.001$)

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Caregiver Trainees

	Pre-Training	Post-Training
Knowledge about ABCs	22%	86%
Back Positioning	92%	100%
Use of a crib/ avoiding co-bedding	93%	100%
Removal of soft objects	61%	96%
All improvements statistically significant ($p<0.05$)		

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Community Baby Shower Results

- 17 showers
- Women from 14 counties
- 830 pregnant women
  - 51% non-Hispanic White
  - 20% Hispanic
  - 20% Black/African American
  - 9% Multiracial/Other
- 65% ≤ high school diploma

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Community Baby Shower Results

- Safe Sleep Intentions

	Pre	Post	P-value
Safe Position: Back Only	85%	99%	<0.05
Safe Location: Crib, Bassinet, Portable Crib	88%	98%	<0.05
No Unsafe Items: Blankets, Bumpers, etc.	58%	89%	<0.05

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Community Baby Shower Results

- Tobacco Cessation
  - 9% currently smoking
    - 42% ready to quit in next 30 days

	Pre	Post	P-value
Identify ≥3 ways to avoid 2nd hand smoke	78%	98%	<0.05
Identify ≥3 local resource for cessation	16%	39%	<0.05

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Community Baby Shower Results

- Breastfeeding

	Pre	Post	P-value
Somewhat/Very Likely to Breastfeed	92%	93%	0.09
Confident Able to Breastfeed ≥6 months	43%	54%	<0.05
Identify ≥3 local resource for cessation	33%	64%	<0.05

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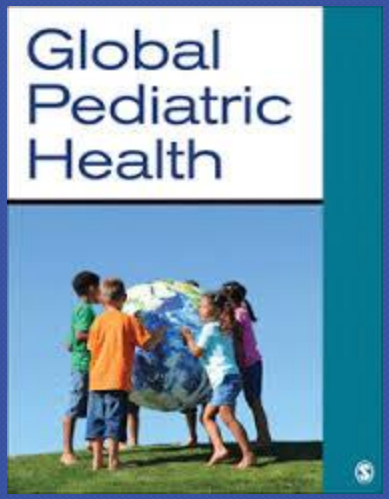
Community Baby Shower Publications

Ahlers-Schmidt CR, Schunn C, Dempsy M, Blackmon S. Evaluation of community baby showers to promote safe sleep. Kansas Journal of Medicine 2014;7(1):1-5.

Ahlers-Schmidt CR, Schunn C, Lopez V, Kraus S, Blackmon S, Dempsy M, Sollo N. A Comparison of Community and Clinic Baby Showers to Promote Safe Sleep for Populations at High Risk for Infant Mortality. 2016; Global Pediatric Health 2016;3:1-6.



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2017 SSI Objectives

- SSI Training—Sept. 28 & 29, 2017
  - New SSIs learn:
    - Safe Sleep Train the Trainer
    - Community Baby Shower
  - Returning SSIs learn:
    - Safe Sleep Outpatient Toolkit
      - SSI will partner with one OB/Peds/FM clinic to engage at one of three levels

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2017 SSI Objectives

- Bronze Level (70%)
  - Provides annual safe sleep training to clinic employees
  - Creates a safe sleep policy for caregivers
  - Provides caregivers with take-home materials on safe sleep
- Silver Level (20%)
  - Embed the Safe Sleep Quiz and provider script in visits at 28 weeks, 36 weeks, newborn and/or well baby check ups
- Gold Level (10%)
  - Engage in safe sleep education at the community level through health fairs, community baby showers or other community outreach at least twice a year

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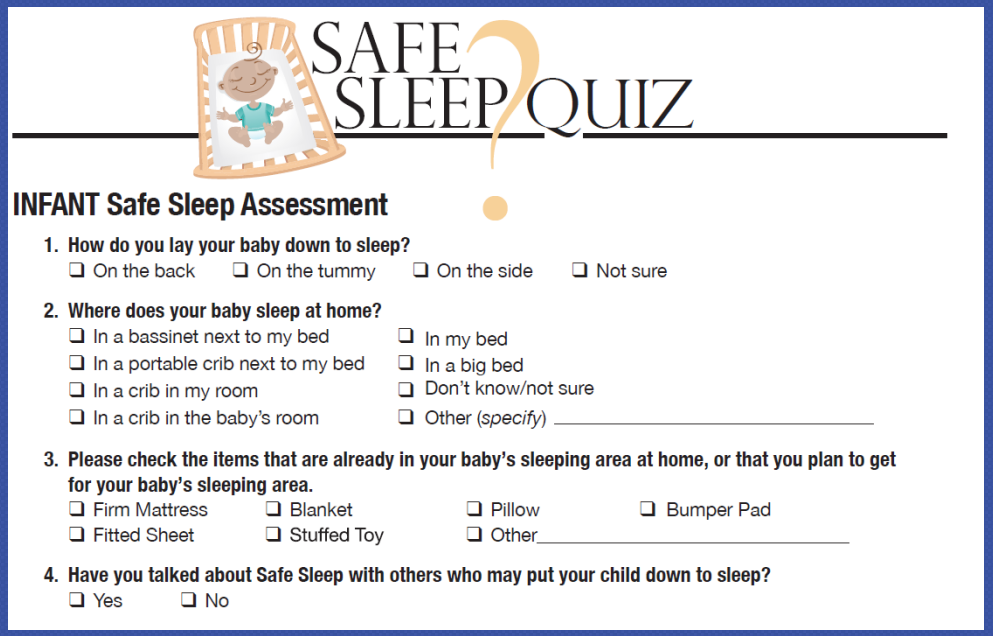
2017 SSI Objectives

- Outpatient Provider Safe Sleep Toolkit



SAFE SLEEP? QUIZ

INFANT Safe Sleep Assessment

1. **How do you lay your baby down to sleep?**
   ❑ On the back ❑ On the tummy ❑ On the side ❑ Not sure
2. **Where does your baby sleep at home?**
   ❑ In a bassinet next to my bed ❑ In my bed
   ❑ In a portable crib next to my bed ❑ In a big bed
   ❑ In a crib in my room ❑ Don't know/not sure
   ❑ In a crib in the baby's room ❑ Other (*specify*) _____
3. **Please check the items that are already in your baby's sleeping area at home, or that you plan to get for your baby's sleeping area.**
   ❑ Firm Mattress ❑ Blanket ❑ Pillow ❑ Bumper Pad
   ❑ Fitted Sheet ❑ Stuffed Toy ❑ Other_____
4. **Have you talked about Safe Sleep with others who may put your child down to sleep?**
   ❑ Yes ❑ No

MSSC SAFE SLEEP TASK FORCE

Brief Provider Script for Addressing Parent Concerns

1. In what position will/do you lay your baby down to sleep?

The safest position for baby to sleep is on their **back** for *every* sleep time. Some babies may seem happier on their tummies, however, babies will adjust to sleeping on their backs if you start placing them on their backs for every sleep time. Continue to place babies on their backs for every sleep time, even after they have learned how to roll over. Once babies start rolling over and choosing their own sleep position, you do not need to keep turning them over onto their backs.

2. Where will/does your baby sleep?

The safest place for baby to sleep is in the parents' room, but not in a shared bed. Always place baby to sleep on his/her back in his/her own safety-approved **crib, bassinet or pack-n-play**. Baby should never sleep on sofas, chairs, recliners, waterbeds, soft surfaces such as pillows, cushions, sleeping bags, sheepskins, or in any bed with another adult or child. Additionally, car seats and other sitting devices (such as baby swings, strollers, infant slings, etc.) are not recommended for routine sleep.

3. Please circle the items that are already in your baby's sleeping area at home, or that you plan to get for your baby's sleeping area.

A **firm mattress and fitted sheet** are all that you need in your baby's sleep environment. To create the safest sleep environment for your baby, it is important to remove all soft, fluffy, loose blankets and bedding (including pillows, bumper pads, blankets, sleeping bags, sheepskins, stuffed animals, etc.) and other soft items (such as stuffed animals, diapers, burp cloths, etc.) from the baby's sleep area. Additionally, bumper pads, wedges and positioners should *not* be used. When babies are able to roll over, it is even more important that their sleep environment is safe with nothing else in the area (blankets, pillows, soft toys, etc.) that can get near their face.

4. Have you discussed Safe Sleep with your child's other care providers?

Talk to grandparents, relatives, friends, babysitters, and child care providers about safe sleep for your baby and what works best to help baby fall asleep on his/her back for every sleep time. **Tell everyone** who takes care of your baby to follow these important safe sleep practices.

For more detailed information please see the Infant Sleep Position and SIDS: Questions and Answers for Health Care Providers booklet provided in your tool kit.

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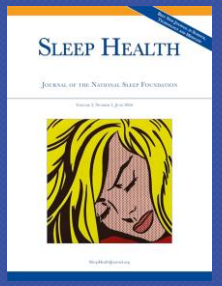
Safe Sleep Toolkit Publications

Ahlers-Schmidt CR, Kuhlmann S, Kuhlmann Z, Schunn C, Rosell J. To improve safe sleep practices, more emphasis should be placed on removing unsafe items from the crib. Clinical Pediatrics 2014;53(13):1285-1287.



Kuhlmann Z, Kuhlmann S, Schunn C, Klug B, Greaves T, Foster M, Ahlers-Schmidt CR. Collaborating with obstetrical providers to promote infant safe sleep guidelines. Sleep Health 2016;2:219–224.

Keene Woods N, Ahlers-Schmidt CR, Wipperman J, Williams T. Comparing self-reported infant safe sleep from community and healthcare-based settings. Journal of Primary Care and Community Health 2015; 6(3):205-210.

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2018 SSI Objectives

- SSI Training
  - New SSIs learn:
    - Safe Sleep Train-the-Trainer
    - Community Baby Shower
  - 2nd year SSIs learn:
    - Safe Sleep Outpatient Toolkit
  - 3rd year SSIs learn:
    - Cribs for KIDS Hospital Certification Program

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2018 SSI Objectives

- Cribs for Kids Hospital Certification

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Bereavement Services

Referring to the KIDS Network

- Let the family know you will contact the KIDS Network to provide support
- Call of fax provisional information to:

Kansas Infant Death and SIDS Network, Inc.
300 W. Douglas, Suite 145
Wichita, KS 67202
Phone: 316-682-1301 Fax: 316-682-1274
www.kidsks.org
Facebook: Christy Schunn Kids

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Zero To One: Disparities In Infant Mortality

Zero To One Shares the stories of five Kansas mothers who have lost their babies and asks health care professionals to rethink the policies and practices that may pose barriers to the high risk mothers they serve.

For more information, please contact Melody McCray-Miller at melodymiller56@gmail.com.

Zero To One Curriculum

H.E.A.T. Report

Introduction

Questions

Kansas Infant Death and SIDS Network, Inc.
Christy Schunn
316-682-1301
1148 S. Hillside, Suite 10
Wichita, KS 67211
KIDSKS.org
edirector@kidsks.org

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Health Care Reform Update

DENNIS COOLEY MD, FAAP

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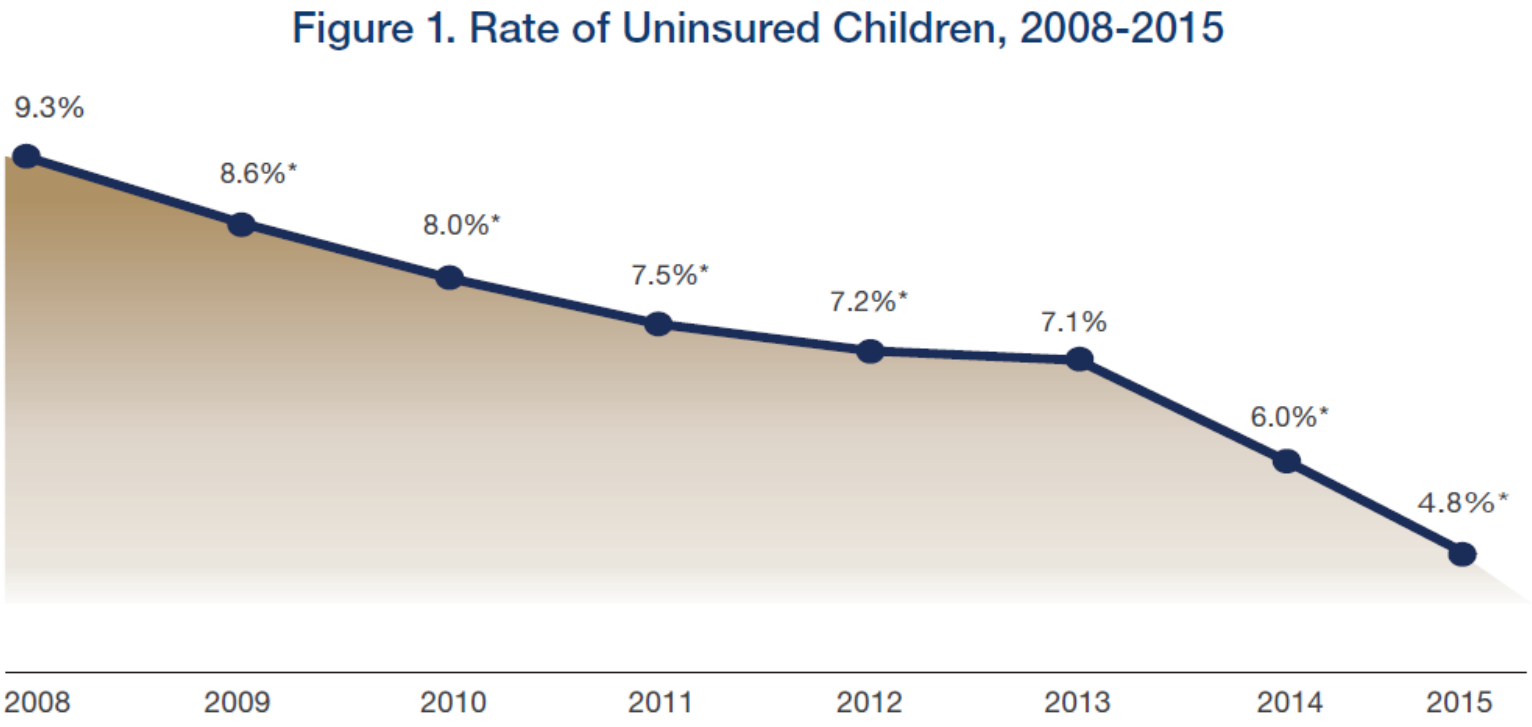
Historic Rate of Insurance for Children



* Change is significant at the 90% confidence level. 2013 was the only year that did not show a significant one-year decline in the national rate of uninsured children. The Census began collecting data for the health insurance series in 2008, therefore there is no significance available for 2008

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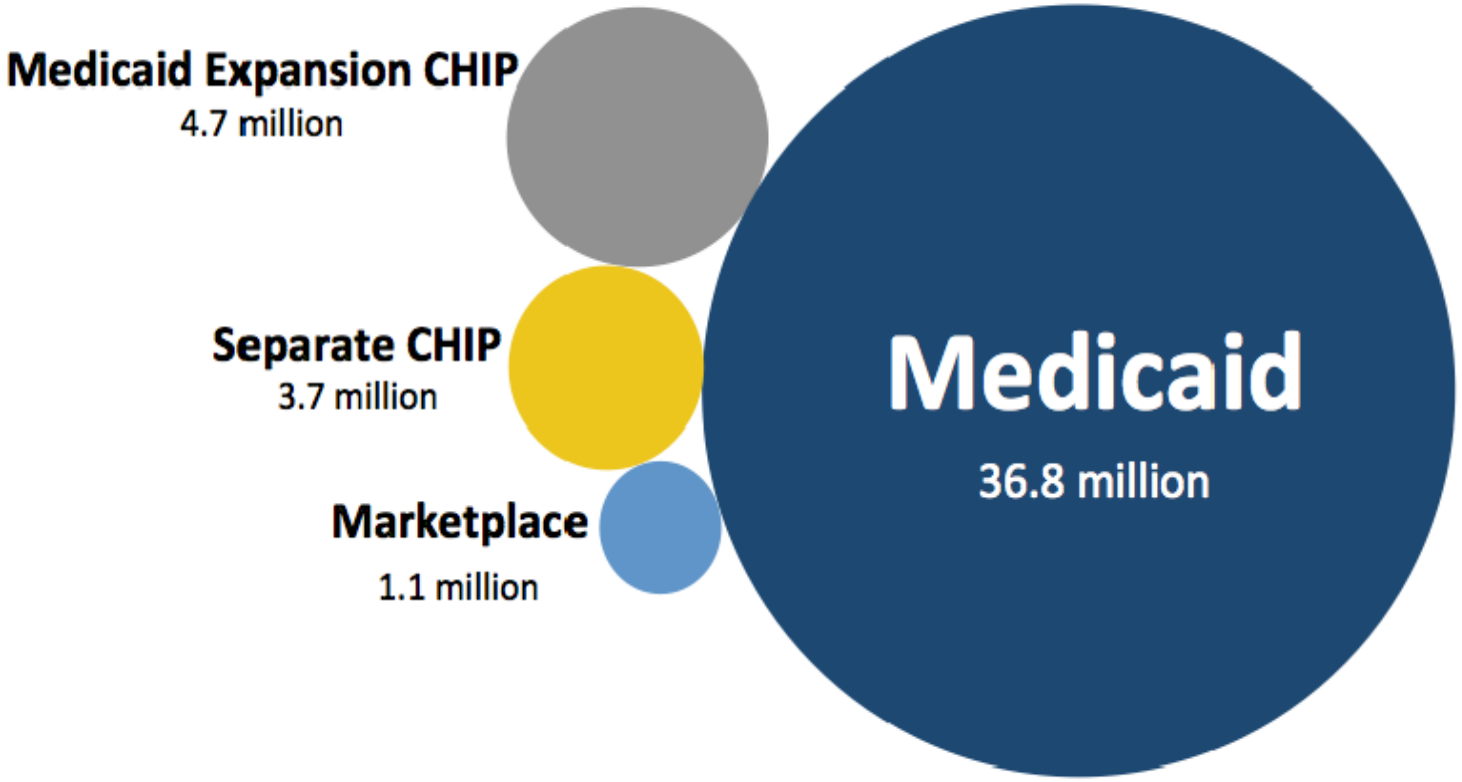
Public Coverage for Children



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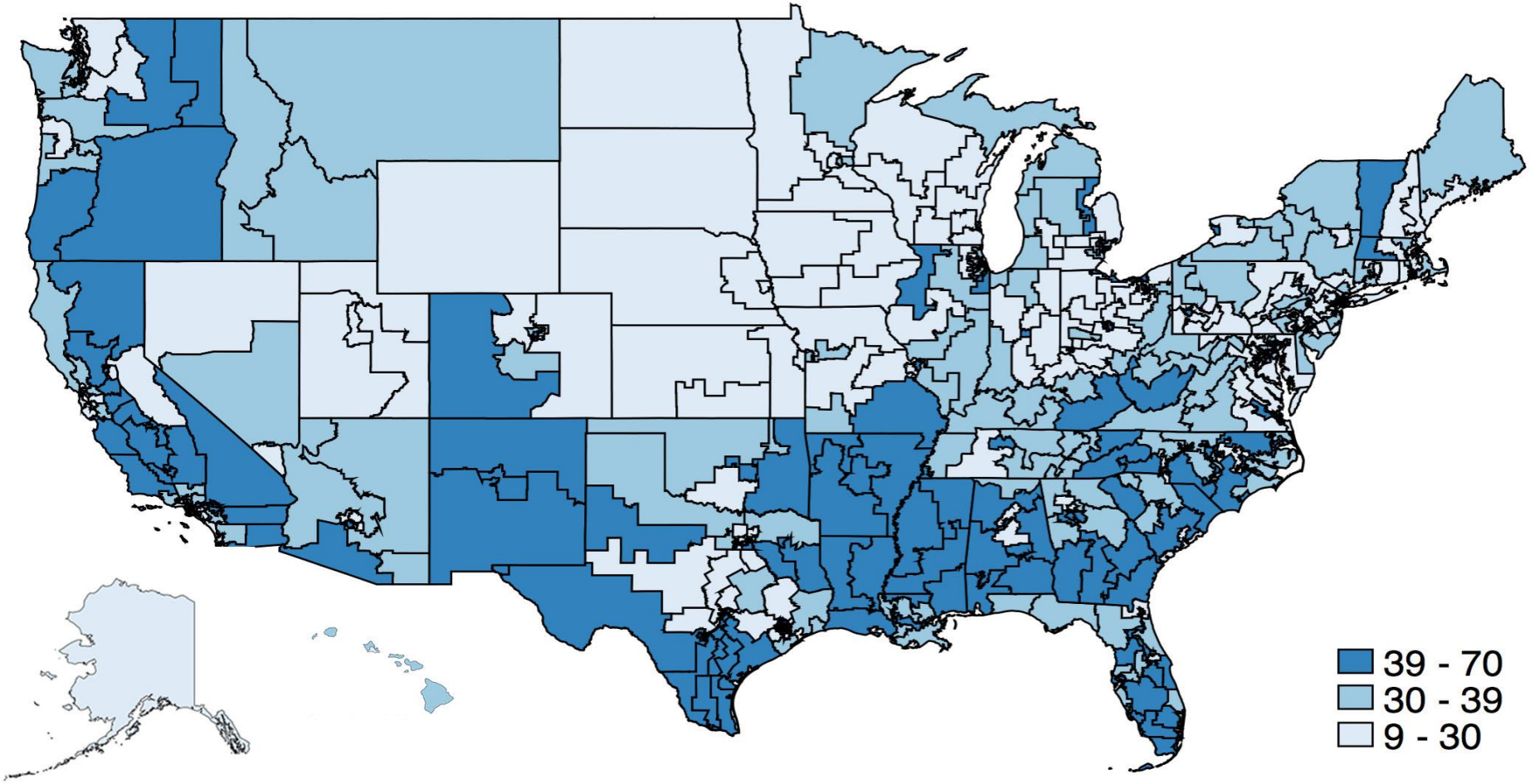
Percent of Children on Medicaid/CHIP by Congressional District



Note: In the lowest range presented, data are greater than or equal to the lower limit and less than or equal to the upper limit.
In each subsequent range, data are greater than the lower limit and less than or equal to the upper limit.
Source: U.S. Census Bureau, American Community Survey, 2015 single-year estimates.

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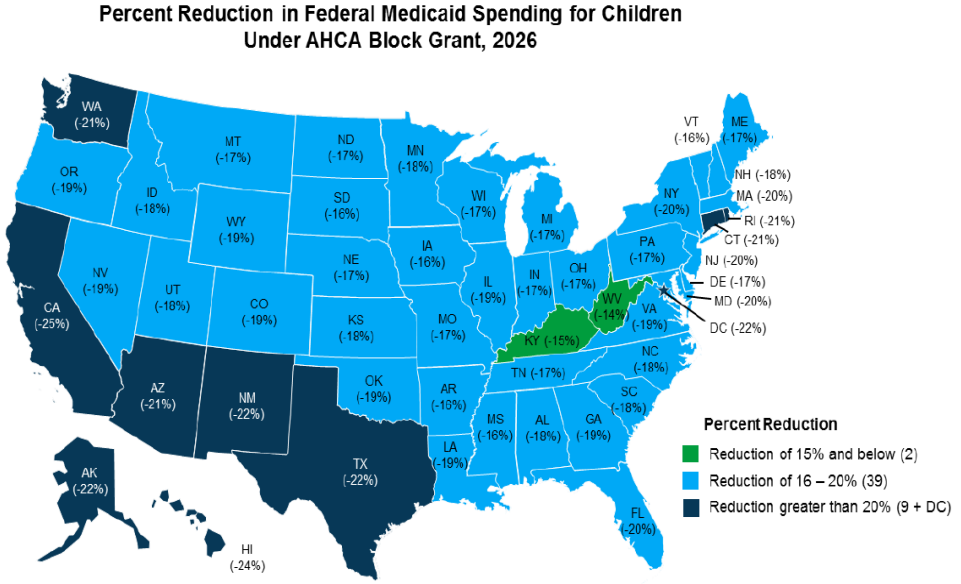
Children Will Be Hurt By Per Capita Caps

The per capita cap model will result in a $43B reduction in federal $ for non-disabled children from 2020-2026

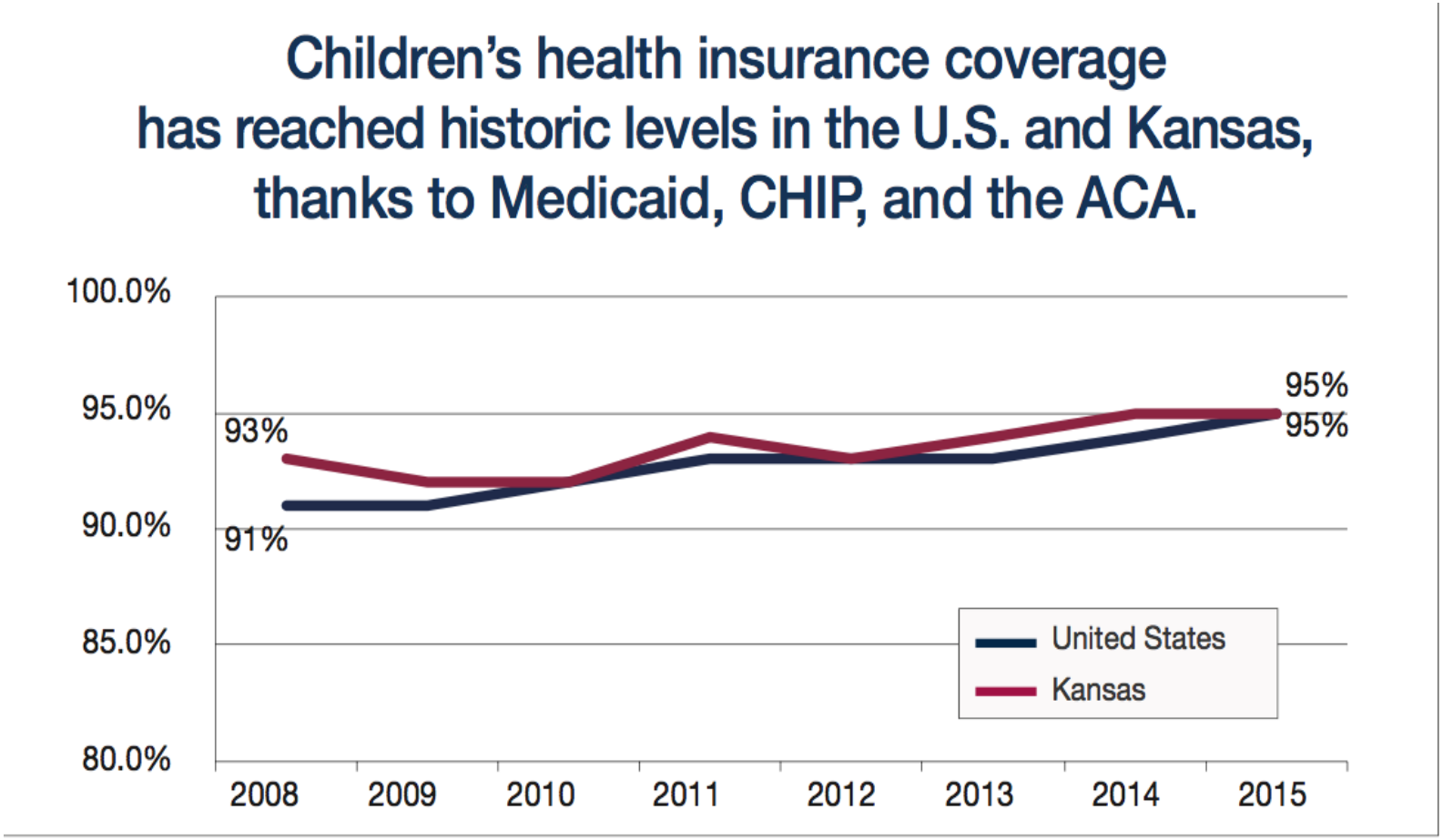
State impacts from caps range from reduction of $59 million in SD to $5.1 billion in TX

If all states select block grant option, children's Medicaid spending will decrease by $78 billion over 10 years

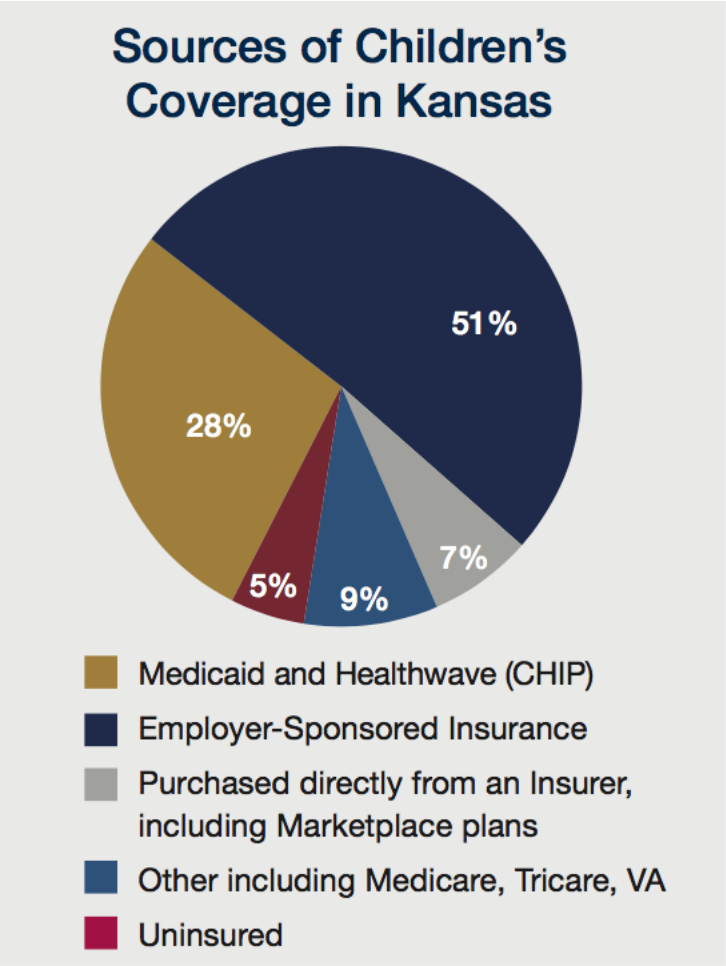


http://tinyurl.com/lla6j2g

Kansas


Children's health insurance coverage has reached historic levels in the U.S. and Kansas, thanks to Medicaid, CHIP, and the ACA.
100.0%
95.0%
90.0%
85.0%
80.0%
93%
91%
95%
95%
United States
Kansas
2008
2009
2010
2011
2012
2013
2014
2015

Coverage - Kansas



Coverage - Kansas

Medicaid 283,082

children in Kansas relied on Medicaid and CHIP at some point in FY 2016 to access the health care they needed to be healthy

Healthwave (CHIP) 79,319

Marketplace

10,000

children in Kansas were enrolled in Marketplace plans at the end of the 2016 open enrollment period

Health Care Reform

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ACA (Obamacare)

- 2009
- Current law of the land

AHCA

- Spring 2017

BCHA

- Pending (vote in the next 1 month?)

Key Elements

	ACA	AHCA	BCHA
# INSURED		-23 million	-22 million
MEDICAID	Entitlement	Grant	Grant
PEOPLE < 26YRS	Covered	Covered	Covered
EHB	Maternity/Contra	Limited	Limited
PLANNED PARENT	Funded	Defunded 1 year	Defunded 1 year
MENTAL HEALTH	EHB	Limited	Limited

Medicaid Funding

Grants
- Block
- Cap per capita

Baseline year 2016

Annual Increases based on Inflation
- AHCA based on medical inflation rate
- BCHA based on general inflation rate

Limits may be waved
- BCHA areas where disasters are declared

American Health Care Act

House passed AHCA, party-line

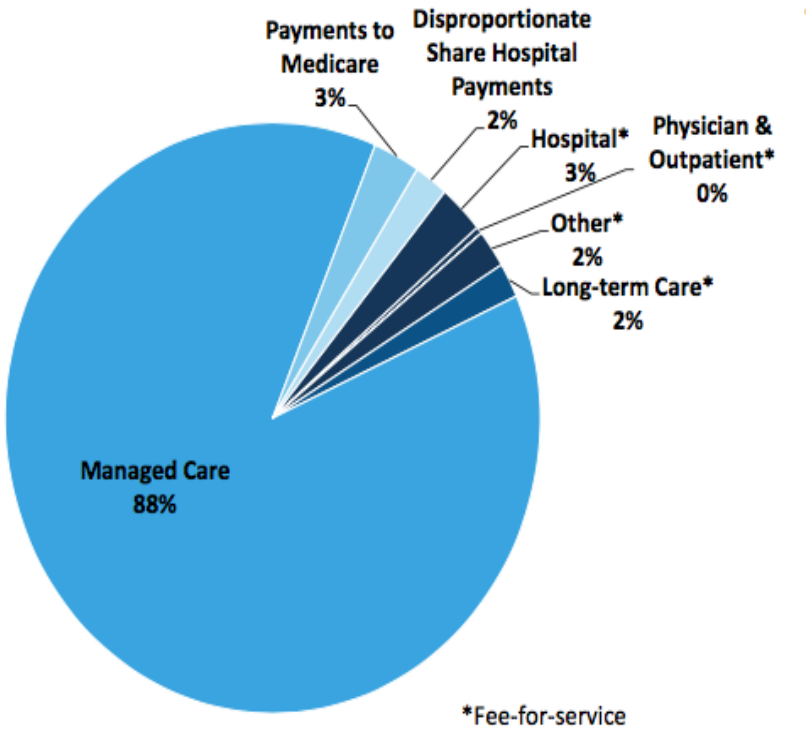
$880 billion Medicaid cut

Eliminates core patient protections

AAP and primary care partners oppose

Medicaid Spending in Kansas

In FY 2016, Medicaid spending in KS was $3.3 billion.



Estimates of Federal Medicaid Kansas Funding 2019-2028

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ACA (current)

- $26B

AHCA

- $25B

BCHA

- $23B

State Options if Costs Exceed Federal Portions

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Increase state's funding

Cut services

Decrease enrollment

Cut payments to providers

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Lunch & Networking

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MCH Block Grant Application/Report

UPDATES & DATA HIGHLIGHTS

2018 MCH Block Grant

- Public input period: June 16-July 7
- 2018 Application/2016 Annual Report Submitted: July 14
- Action Plan Updates: July-August (interim year)
- Federal Title V Block Grant Review: August 10
- Application & Annual Report Re-submit: September 2017
- Final publications and resources available by October 2017
- Access: www.kdheks.gov/bfh or www.kansasmch.org

NOTE: Federal Title V Guidance is undergoing Revision. Changes will impact NPMs, Cross-cutting domain, and more.

Published Links/Documents

KANSAS MATERNAL & CHILD HEALTH | TITLE V MATERNAL & CHILD HEALTH

5-YEAR STATE ACTION PLAN

FY 2016

KANSAS MATERNAL & CHILD HEALTH | TITLE V MATERNAL & CHILD HEALTH

5-YEAR STATE ACTION PLAN

FY 2016

PRIORITY 3
CHILD HEALTH

Developmentally appropriate care and services are provided across the lifespan

OBJECTIVE 3.1 (CYSHCN)	Increase the proportion of children aged 1 month to kindergarten entry statewide who receive a parent-completed developmental screening annually.
OBJECTIVE 3.2 (CYSHCN)	Provide annual training for child care providers to increase knowledge and promote screening to support healthy social-emotional development of children.
OBJECTIVE 3.3	Increase by 10% the number of children through age 8 riding in age and size appropriate car seats per best practice recommendations by 2020.
OBJECTIVE 3.4	Increase the proportion of families receiving education and risk assessment for home safety and injury prevention by 2020.
OBJECTIVE 3.5	Increase the percent of home-based child care facilities implementing daily routines involving at least 60 minutes of daily physical activity per CDC recommendations to decrease risk of obesity by 2020.
OBJECTIVE 3.6 (Adolescent Health)	Increase the percent of children and adolescents (K-12 students) participating in 60 minutes of daily physical activity.

NPM	Developmental screening (Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool)	SPM	Percent of children 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes/day
ESM	Percent of parents of child program participants that received education on child development and developmental screening		
NPM	Child Injury (Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents ages 10 through 19)		
ESM	Percent of program participants receiving car seat and/or booster seat safety education during an MCH visit		

How is Kansas Doing?

Kansas Department of Health and Environment

Title V Outcome Measures and Performance Measures

Kansas Maternal and Child Health Services Block Grant
2018 Application/2016 Annual Report

KANSAS MATERNAL & CHILD HEALTH

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

Handout

KANSAS MATERNAL & CHILD HEALTH

Kansas MCH: Selected Performance Measures

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

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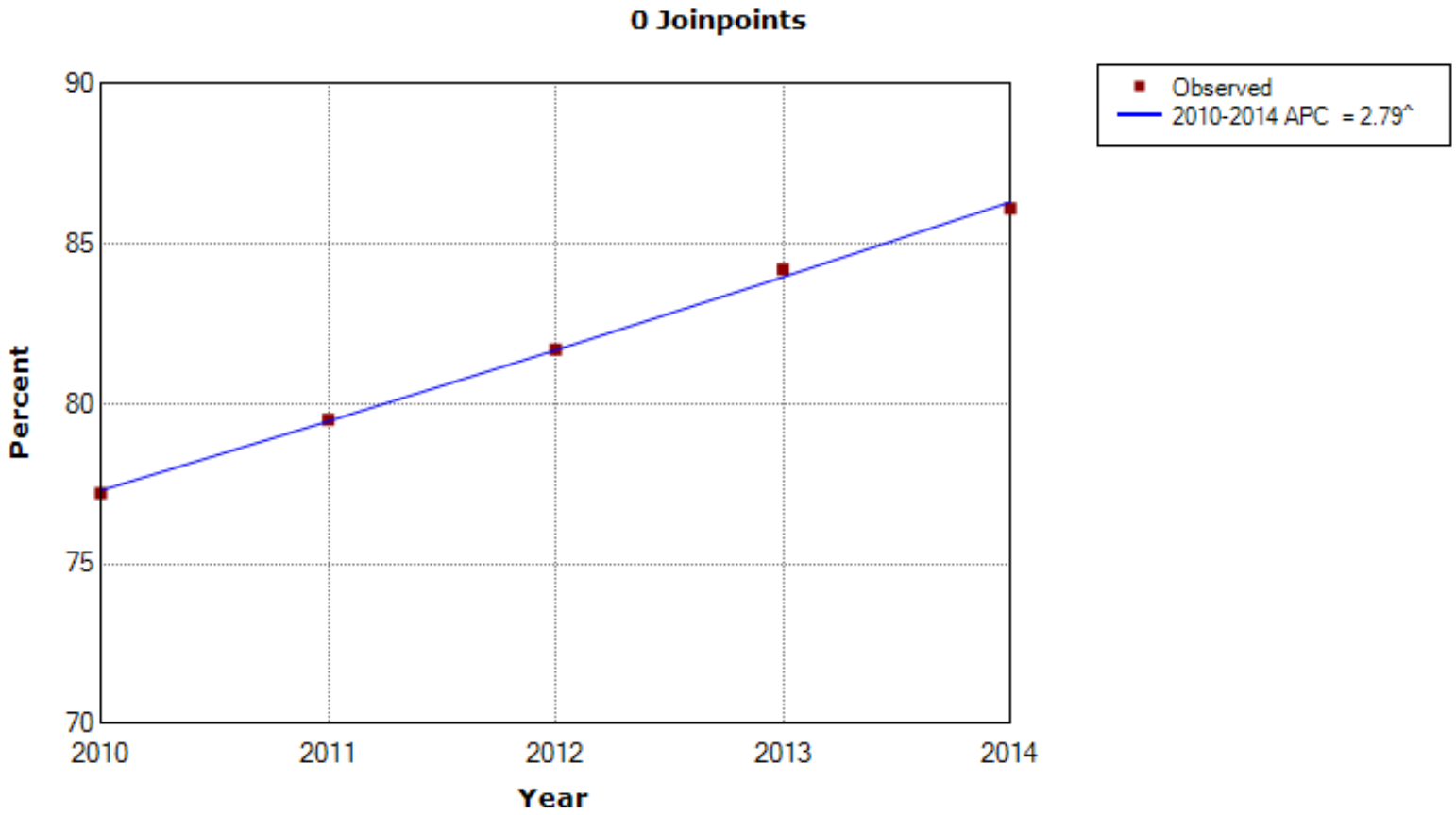
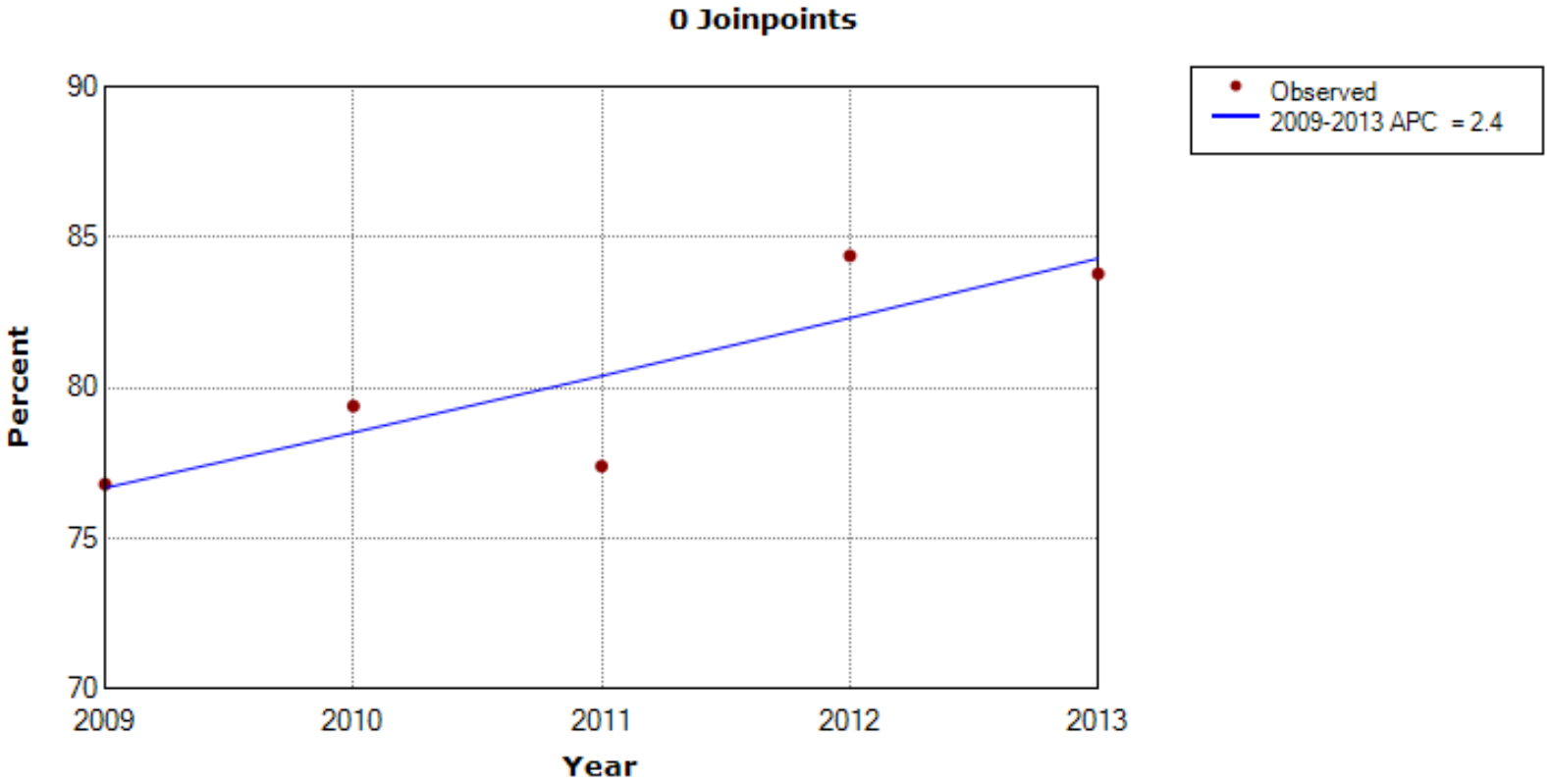
Positive Trends

NPM4: Breastfeeding: A) Percent of infants who are ever breastfed



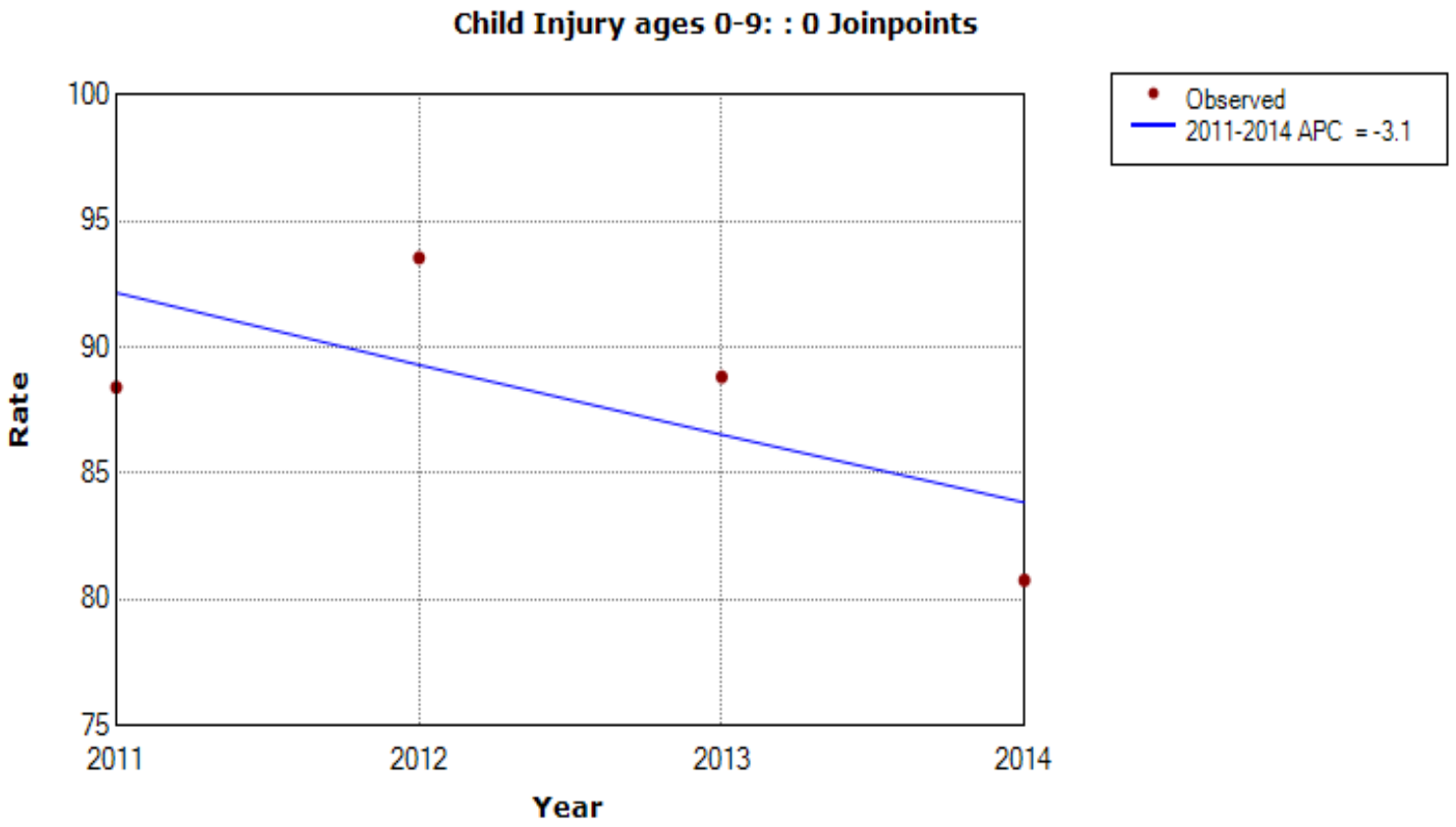
^The Annual Percent Change (APC) is significantly different from zero ($p<0.05$).
Note: Percents are plotted on a logarithmic scale.
Source: Bureau of Epidemiology and Public Health Informatics, birth certificate data

NPM4: Breastfeeding: B) Percent of infants breastfed exclusively through 6 months



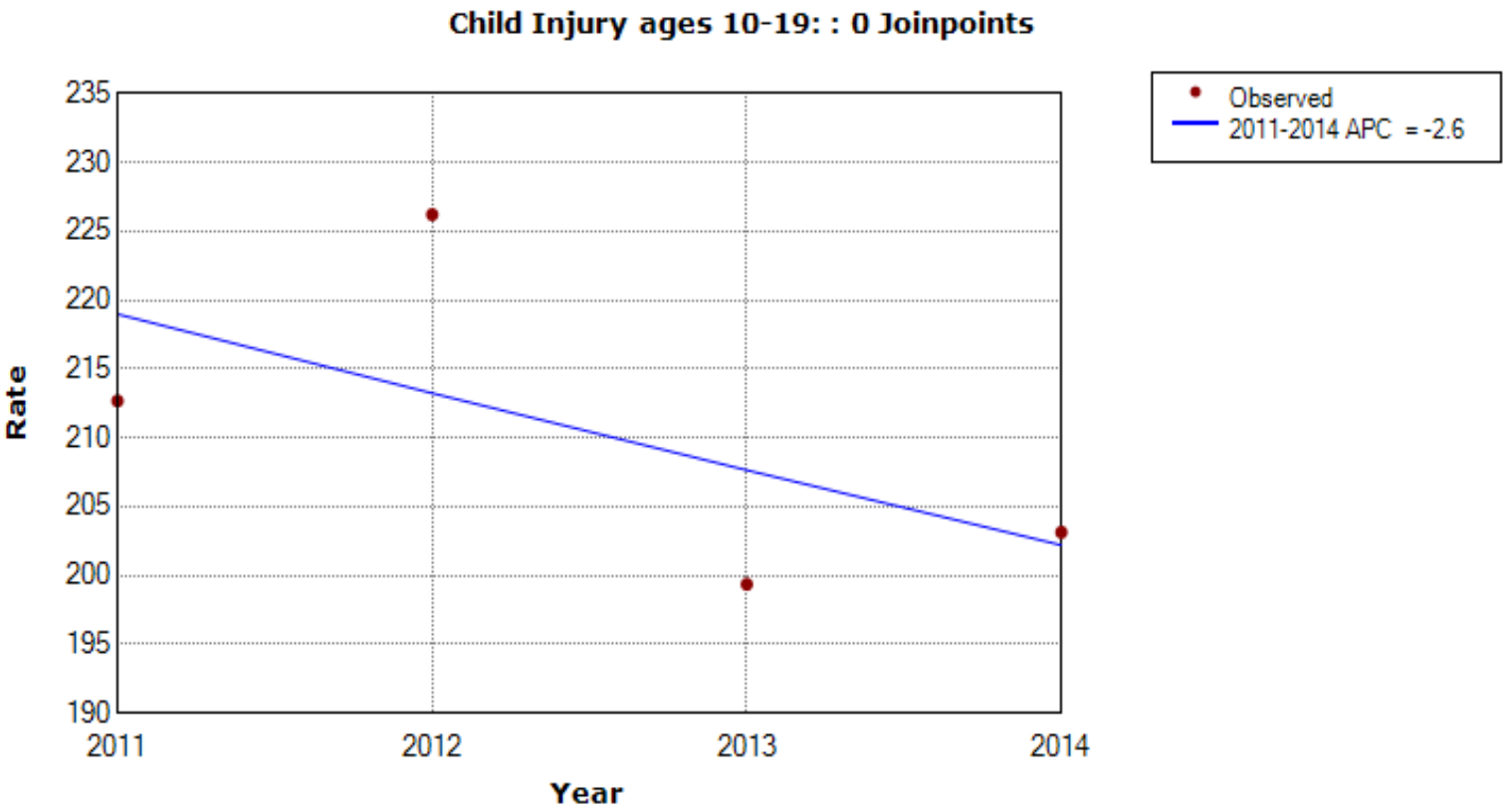
Note: Percents are plotted on a logarithmic scale.
Source: CDC, National Immunization Survey (Children born in 2010 - 2013)

Child Injury: Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9



^The Annual Percent Change (APC) is significantly different from zero (p<0.05).
Note: Rates are plotted on a logarithmic scale.
Source: U.S. Census Bureau. State Inpatient Databases (SID)

Child Injury: Rate of hospitalization for non-fatal injury per 100,000 adolescents ages 10 through 19



^The Annual Percent Change (APC) is significantly different from zero ($p<0.05$).
Note: Rates are plotted on a logarithmic scale.
Source: U.S. Census Bureau. State Inpatient Databases (SID)

NPM14: Smoking During Pregnancy and Household Smoking: A) Percent of women who smoke during pregnancy

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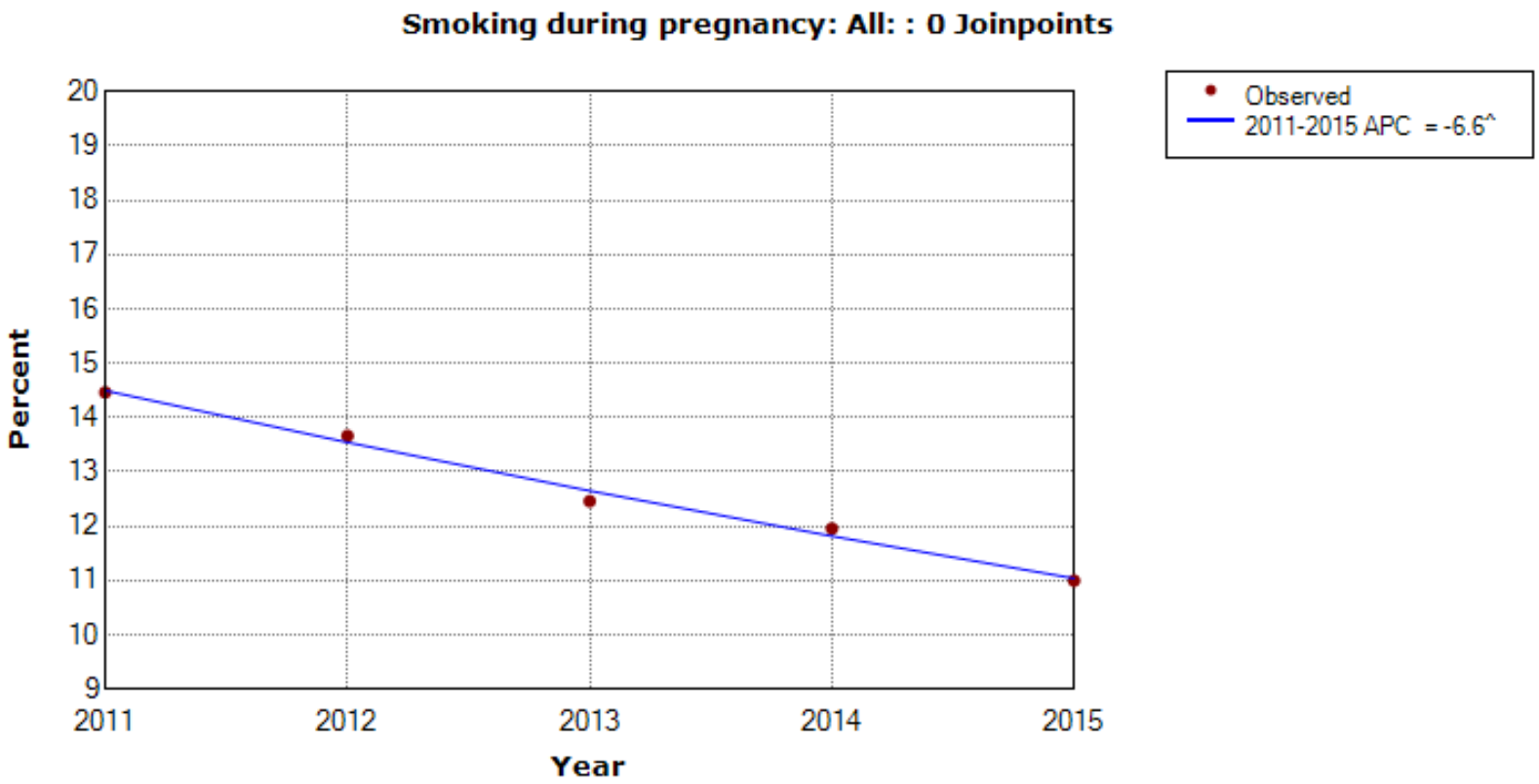
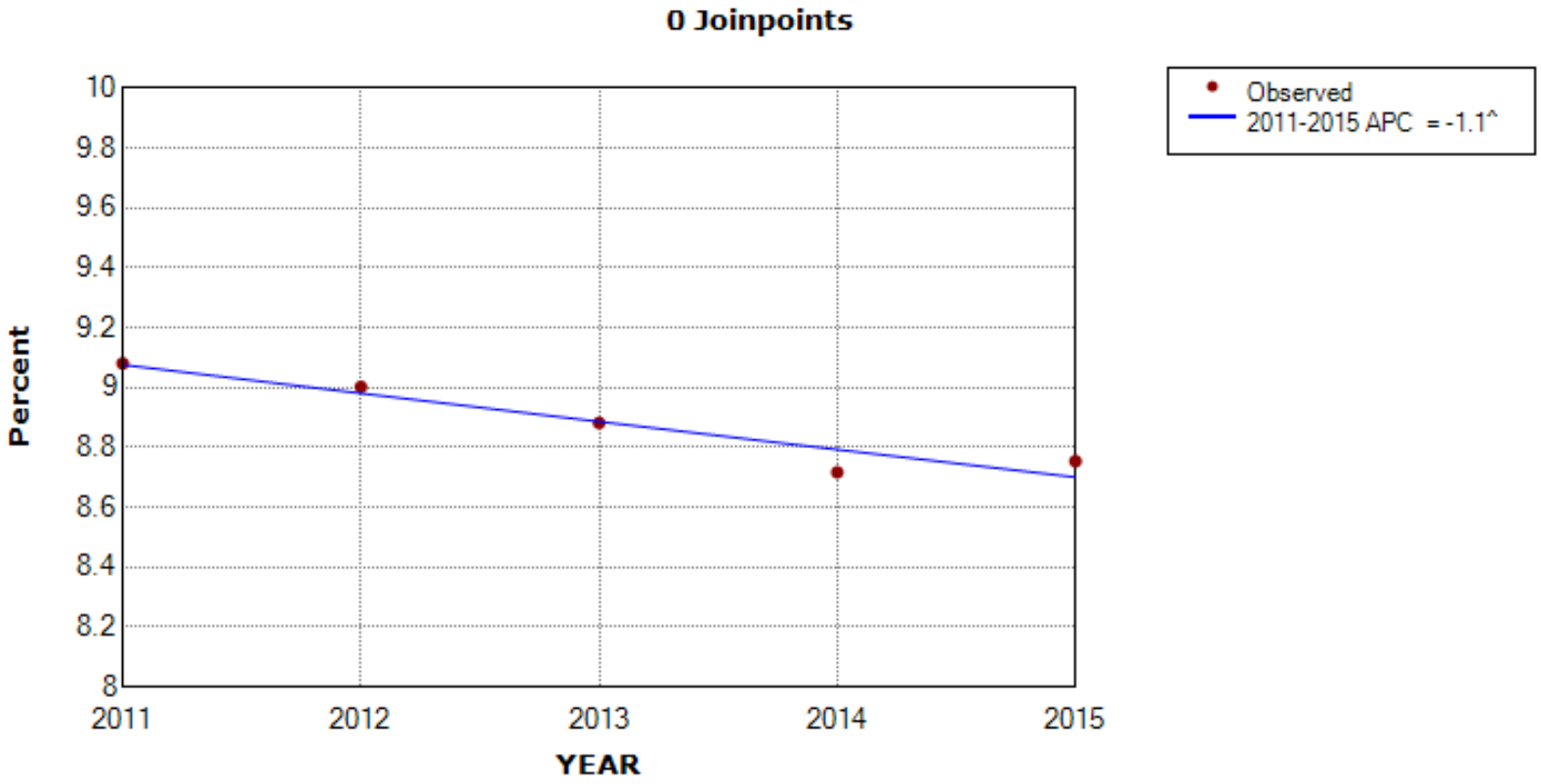


^The Annual Percent Change (APC) is significantly different from zero ($p<0.05$).
Note: Percents are plotted on a logarithmic scale.
Source: Bureau of Epidemiology and Public Health Informatics

SPM1: Percent of preterm births (<37 weeks gestation)



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

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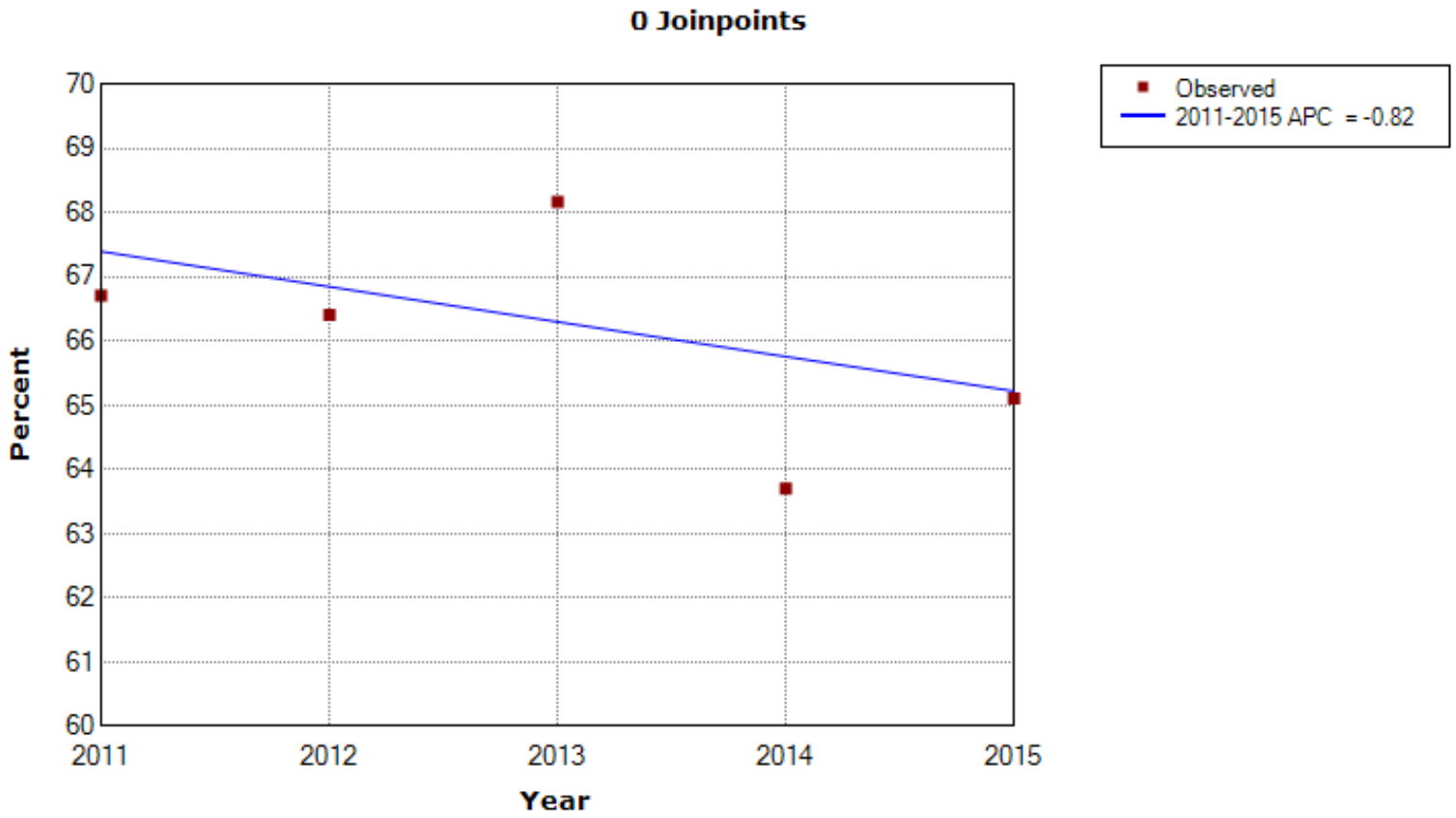
Negative Trends

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



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

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Domain Group Work

SPECIAL PRESENTATIONS W/REFLECTION

Domain Group Plan

1. Refer to the MCH State Action (focus on the priority assigned) as the facilitator reviews the. Consider progress and gaps.
2. Review the measures using the performance measures snapshot (handout) to determine how we are doing…what is the trend? (NOTE: NPMs have data sources that are not as timely as SPMs).
3. Discuss and record other accomplishments and activities have occurred as part of and/or resulting from MCH leadership, efforts, resources, etc. that are not captured.
4. Discuss and record any emerging issues not currently covered in the plan related to priorities and objectives that you think should be included/addressed over the next year.
5. Discuss and record any recommended changes to the plan for the coming year (use the key for appropriate # to capture the change and provide a description.
6. Move onto the 2nd priority assigned to your group.

Domain Group Worksheet

KANSAS MATERNAL & CHILD HEALTH

Workgroup: Women & Maternal Health

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

National Performance Measure (NPM)	Data Trend	State Performance Measure (SPM)	Data Trend
NPM 1: Well-woman visit (Percent of women with a past year preventive medical visit) **ESM:** Percent of women program participants that received education on the importance of a well-woman visit in the past year		**SPM 1:** Percent of preterm births (<37 weeks gestation)	

Possible Plan Revisions (refer to the # below; note the corresponding #s and recommendation details in table)

#1 1 or more strategies completed; no further action needed (please note which strategies)
#2 Recommend removing 1 or more strategies
#3 Recommend revising or rewriting 1 or more strategies
#4 Recommend adding a new strategy
#5 Recommend adding, editing, or removing objective (include rationale)
#6 Status Quo: Maintain current efforts
#7 Raise priority: Begin work or increase resources to 1 or more strategies
#8 Lower priority: On-hold/de-emphasize effort or resources to 1 or more strategies
#9 Policies or processes are preventing progress on objective or strategies
#10 Questions/Need more information
#11 Other:

Objective	Accomplishments	Emerging Issues (not reflected in current plan)	Recommended Plan Revisions (Refer to Strategies)
1.1 Increase the proportion of women receiving a well-woman visit annually.			

Domain Group Assignments

Women & Maternal Health

- Priority 1 (WM)
- Priority 6 (CC)

Facilitators: Stephanie & Diane

Child Health

- Priority 3 (C)
- Priority 7 (CSHCN)

Facilitators: Kayzy & Debbie

Perinatal & Infant Health

- Priority 4 (PI)
- Priority 2 (CC)

Facilitators: Carrie & Connie

Adolescent Health

- Priority 5 (A)
- Priority 8 (CC)

Facilitators: Rachel & Heather

Ground Rules

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

KANSAS MATERNAL & CHILD HEALTH

Announcements

KMCHC MEMBERSHIP

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PRAMS Update: Year 1 Data Collection

LISA WILLIAMS & JULIA SOAP, KDHE

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KMCHC Member Announcements

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Future Meeting Dates

OCTOBER 4, 2017

JANUARY 17, 2018

APRIL 18, 2018

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Closing Remarks

DENNIS COOLEY, MD, CHAIR