Child Work Group Packet

Priority Overview Page: This includes the priority, a list of the objectives, and the selected performance measures (NPM = National Performance Measure / SPM = State Performance Measure).

Priority State Action Plan (SAP) Table: This outlines the key strategies within each objective. This also outlines another level of measurement (ESM = Evidence-based/-informed Strategy Measure).

Priority Resources: This outlines key initiatives, partners, websites, and other resources that you might want to look at or dig into related to your priority. These include a reference of where it might align in the SAP…but may or may not be directly called out in the table.

Priority Key Acronyms and Data: A compilation of acronyms that you might come across in conversations with your priority work. The key data outlines National Outcome Measures (NOMs) that are related to your priority population. This is in addition to the NPMs, SPMs, and ESMs noted elsewhere. Another resource is the NPM-NOM_Measures Table – this is where you can find the data trends for all of the measures associated with our work.

***Priority Data Summaries*:** These are the data summaries that will be included in the 2023 MCH Services Block Grant Application that will be submitted with our plan in August 2022.

PRIORITY 3

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

CHILD

OBJECTIVE 3.1

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

OBJECTIVE 3.2

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.

OBJECTIVE 3.3

Increase the proportion of MCH program participants, 1 through 11 years, receiving quality, comprehensive annual preventive services by 10% annually through 2025.

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

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

OBJECTIVE 3.1: Increase the proportion of children aged 1 month to kindergarten entry statewide who receive a parent-completed developmental screening by 5% annually through 2025.

Strategy	Description
3.1.1	Build MCH capacity to support coordination and two-way referrals with other providers offering community-based services through 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.
3.1.2	Provide guidance, training, and technical assistance to MCH local agencies and marketing and education to families on the importance of early/ongoing developmental screening, use of evidence-based screening tools (e.g., ASQ-3, ASQ SE-2, MCHAT), and follow up.
3.1.3	Partner in the development of an integrated, statewide developmental screening data-sharing platform to drive the implementation of an early childhood integrated data system (ECIDS).
3.1.4	Promote evidence-based programs and initiatives for community and health care providers regarding healthy child development and early learning (e.g., social-emotional development; developmental milestones/Learn the Signs, Act Early; early literacy/Turn a Page, Touch a Mind/Brush Book Bed/Imagination Library).

OBJECTIVE 3.2: 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.

Strategy	Description
3.2.1	Partner with school-aged programs, local school districts and the Bureau of Health Promotion to align core messaging around child health initiatives (e.g., physical activity [Move Your Way and Let's Move], nutrition, literacy, screen-time, self-determination).
3.2.2	Provide resources and supports to partner with local officials to support safe, inclusive school and community playgrounds, including adapted play equipment for children with mobility and sensory needs.
3.2.3	Partner with community organizations leading efforts on social-emotional health and provide programs that support the encouragement and empowerment to build healthy relationships with parents/caregivers, teachers, mentors, health care providers, and peers.

OBJECTIVE 3.3: Increase the proportion MCH program participants, 1 through 11 years, receiving quality, comprehensive annual preventive services by 10% annually through 2025.

Strategy	Description
3.3.1	Engage partners to promote the importance of comprehensive preventive child well visits utilizing all elements of the Bright FuturesTM guidelines.
3.3.2	Assess need and capacity to increase access to care coordination services and supports in all settings where children receive preventive well-visits and support activities.
3.3.3	Provide technical assistance to MCH local agencies in existing IRIS communities using developed implementation toolkits to actively engage around the Help Me Grow core health care provider outreach components to provide coordinated services, supports, and connections.

Child Resources

See also the Child, Adolescent, and CSHCN Supporting Document from the recent MCH Block Grant Application.

https://www.kdhe.ks.gov/DocumentCenter/View/5321/Program-Activities-Children-Adolescent-and-CSHCN-PDF

Obj	Description	Website
3.1.1	**1-800-CHILDREN:** Resource line available 24/7 in English, Spanish, and 200 additional languages to connect with information, local resources, and supports needed; For families, parents, providers, and community members; Can also connect through text/email (1800children@kcsl.org), online at 1800CHILDRENKS.org, or mobile app (1800ChildrenKS in iOS/Android)	https://1800childrenks.org/
3.1.1	**Integrated Referral and Intake System (IRIS):** Helps organizations connect those they serve to the right resources in their community. *Note: Not all KS communities are participating in IRIS at this time.*	https://connectwithiris.org/
3.1.2	**Ages & Stages Questionnaire (ASQ):** Reliable, accurate developmental and social-emotional screening for children between birth and age six. Parent-completed screening tool designed to pinpoint developmental progress and catch delays in young children. *Currently in the 3rd Edition (ASQ-3) for the general questionnaire and the 2nd Edition for the social-emotional questionnaire (ASQ:SE-2)*	https://agesandstages.com/
3.1.2	**KS Developmental Screening Passport:** Resource for parents to track their child's developmental screenings.	https://helpmegrowks.org/wp-content/uploads/2019/02/DevelopmentalScreeningPassport.pdf
3.1.3	**Early Childhood Integrated Data System (ECIDS):** Collects, integrates, maintains, stores, and reports information from early childhood programs across multiple agencies within a state that serve children and families from birth to age eight. *Kansas has begun efforts to create this.*	https://dasycenter.org/tag/ecids/
3.1.4	**Learn the Signs/Act Early:** CDC program aimed to improve early identification of children with autism and other developmental disabilities.	www.cdc.gov/ncbddd/actearly/index.html
3.1.4	**CDC Developmental Milestones:** Collection of infographics, checklists (printable and online), and resources related to the various milestones from birth to five years. There is also a mobile app available to help parents track their child's milestones.	https://www.cdc.gov/ncbddd/actearly/milestones/index.html
3.1.4	**Developmental Screening Family & Parent Resources:** Includes resources on early development/milestones, parenting, social-emotional health, supports for CSHCN, developmental monitoring, screening, and evaluation, home visiting, developmental activities, and quality child care.	https://helpmegrowks.org/family/
3.1.4	**Vroom:** Online/Mobile resource that provides science-based tips and tools to inspire families to turn shared, everyday moments into Brain Building Moments®.	https://www.vroom.org/
3.1.4	**Turn a Page, Touch a Mind (TAP-TAM):** Program in which pediatricians and family physicians give out books and early literacy advice to children and their parents at every well-child visit from 6 months to 5 years old.	http://www.kansasaap.org/wordpress/chapter-focus/kansas-pediatric-foundation/
3.1.4	**Brush, Book, Bed:** A program of the American Academy of Pediatrics (AAP) focused at establishing a predictable nighttime routine that includes healthy teeth brushing habits, literacy/reading, and regular bedtimes.	https://www.healthychildren.org/English/healthy-living/oral-health/Pages/Brush-Book-Bed.aspx
3.1.4	**Dolly Parton's Imagination Library:** Book gifting program that mails free, high-quality books to children from birth to age five, no matter their family's income.	https://imaginationlibrary.com/
3.2.1	**Move Your Way:** National initaitive to increase physical activity across all ages. Website includes tools, videos, and fact sheets on this page have tips that make it easier to get a little more active.	https://health.gov/moveyourway
3.3.1	**Bright Futures:** A national health promotion and prevention initiative, led by the AAP. Supports for primary care practices (medical homes) in providing well-child and adolescent care according to the "Guidelines for Health Supervision of Infants, Children, and Adolescents."	https://brightfutures.aap.org/Pages/default.aspx

3.3.1	**KanBeHealthy-EPSDT:** The Kansas Early and Periodic Screening, Diagnosis and Testing (EPSDT) program to provide comprehensive and preventive health care services for children under 21 enrolled in Medicaid. Provides screening and medically necessary health care services - even if the service is not available under the Kansas Medicaid plan.	https://www.kancare.ks.gov/kancare-ombudsman-office/kancare-general-information-fact-sheets
3.3.1	**Bright Futures Pediatric Symptoms Checklist (PSC):** Screening tool designed to facilitate recognition of cognitive, emotional, and behavioral problems. Two versions: Parent-Completed (PSC) and Youth Self-Reprot (Y-PSC).	https://www.brightfutures.org/mentalhealth/pdf/professionals/ped_sympton_chklst.pdf
3.3.2	**Holistic Care Coordination:** Title V initaitive to expand holistic care coordination from population-specific programming through the KS-SHCN program to broad public health implementation and pediatric primary care. These efforts align and connect with state-wide efforts to expand access to community health workers (CHWs) and establish sustainable funding for the services provided by CHWs and HCC providers.	https://www.kdhe.ks.gov/825/Holistic-Care-Coordination
3.3.2	**Bridges:** Bridges is a pilot care coordination program through the KS-SHCN Program that helps bridge the services from Infant-Toddler tiny-k to Early childhood Special Education services or other community programs.	https://www.kdhe.ks.gov/DocumentCenter/View/6162/Bridges-Information-PDF
3.3.3	**Help Me Grow Kansas:** A framework for helping Kansas communitites support the well-being and lifelong success of all children. Promotes integrated, cross-sector collaboration in a comprehensive early childhood system. Leveragees community resources, maximizes opportunities, and advances partnerships. Four core components: Family & Community Outreach, Child Health Care Provider Outreach, Data Collection, and Centralized Access Point (CAP). *The CAP identified for KS is 1800CHIDLREN. The other componetns are still being built out in conjunction with the All in for Kansas Kids Strategic Plan.*	https://helpmegrowks.org/
3.3.3	**Patient Health Questionnaire (PHQ):** The AAP Periodicity Table recommends screening for depression beginning at age 12 years. Title V staff will encourage and promote the PHQ. KSKidsMap created an algorithm that supports primary care providers with behavioral health screening during well visits and how to respond appropriately based on the results.	https://www.kdhe.ks.gov/DocumentCenter/View/2889/PHQ-9-Screening-Guidance-PDF

Child Key Acronyms	
AAP	American Academy of Pediatrics
ASQ-3	Ages and Stages Questionnaire, 3rd Edition
ASQ-SE-2	Ages and Stages Questionnaire - Social-Emotional, 2nd Edition
BaM	Becoming a Mom®
CAP	Centralized Access Point
EC	Early Childhood
ECCS	Early Childhood Comprehensive System (Grant Funding)
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
HMG	Help Me Grow
IRIS	Integrated Referral and Intake System
KBH	KanBeHealthy
KCCTF	Kansas Children's Cabinet and Trust Fund
KPCC	Kansas Perinatal Community Collaborative
MIECHV	Maternal and Infant Early Childhood Home Visiting (Grant Funding)
PHQ	Patient Health Questionnaire
PSC	Pediatric Symptoms Checklist
SEL	Social Emotional Literacy
TAP-TAM	Turn a Page, Touch a Mind
UHV	Universal Home Visiting
WIC	Women, Infant and Children Program

Child Key Data (Related to NPMs 6, 7, and 8)	
Alignment based upon Table 3 in the Block Grant Guidance Appendices	
NOM 13	Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)
NOM 15	Child mortality rate, ages 1 through 9, per 100,000
NOM 16.1	Adolescent mortality rate, ages 10 through 19, per 100,000
NOM 16.2	Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000
NOM 16.3	Adolescent suicide rate, ages 15 through 19, per 100,000
NOM 19	Percent of children, ages 0 through 17, in excellent or very good health
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)

Table 3. Evidence-based/informed National Performance and Outcome Measure Linkages*

National Outcome Measure		National Performance Measure														
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
#	Short Title	Well-woman visit	Low-risk cesarean delivery	Risk-appropriate perinatal care	Breastfeeding	Safe sleep	Developmental screening	Injury hospitalization	Physical activity	Bullying	Adolescent well-visit	Medical home	Transition	Preventive dental visit	Smoking	Adequate insurance
1	Early prenatal care															
2	Severe maternal morbidity	X	X												X	
3	Maternal mortality	X	X												X	
4	Low birth weight	X													X	
5	Preterm birth	X													X	
6	Early term birth	X													X	
7	Early elective delivery															
8	Perinatal mortality	X		X											X	
9.1	Infant mortality	X		X	X	X									X	
9.2	Neonatal mortality	X		X											X	
9.3	Postneonatal mortality	X			X	X									X	
9.4	Preterm-related mortality	X		X											X	
9.5	SUID mortality				X	X									X	
10	Drinking during pregnancy	X														
11	Neonatal abstinence syndrome	X														
12	New born screening timely follow-up															
13	School readiness						X									
14	Tooth decay/cavities													X		
15	Child mortality							X								
16.1	Adolescent mortality							X		X	X					
16.2	Adolescent motor vehicle death							X			X					
16.3	Adolescent suicide							X		X	X					
17.1	CSHCN															
17.2	CSHCN systems of care										X	X	X	X		X
17.3	Autism															
17.4	ADD/ADHD															
18	Mental health treatment										X	X				X
19	Overall health status						X		X		X	X		X	X	X
20	Obesity								X		X					
21	Uninsured															
22.1	Child vaccination															X
22.2	Flu vaccination										X					X
22.3	HPV vaccination										X					X
22.4	Tdap vaccination										X					X
22.5	Meningitis vaccination										X					X
23	Teen births	X									X					
24	Postpartum depression	X														
25	Forgone health care											X				X

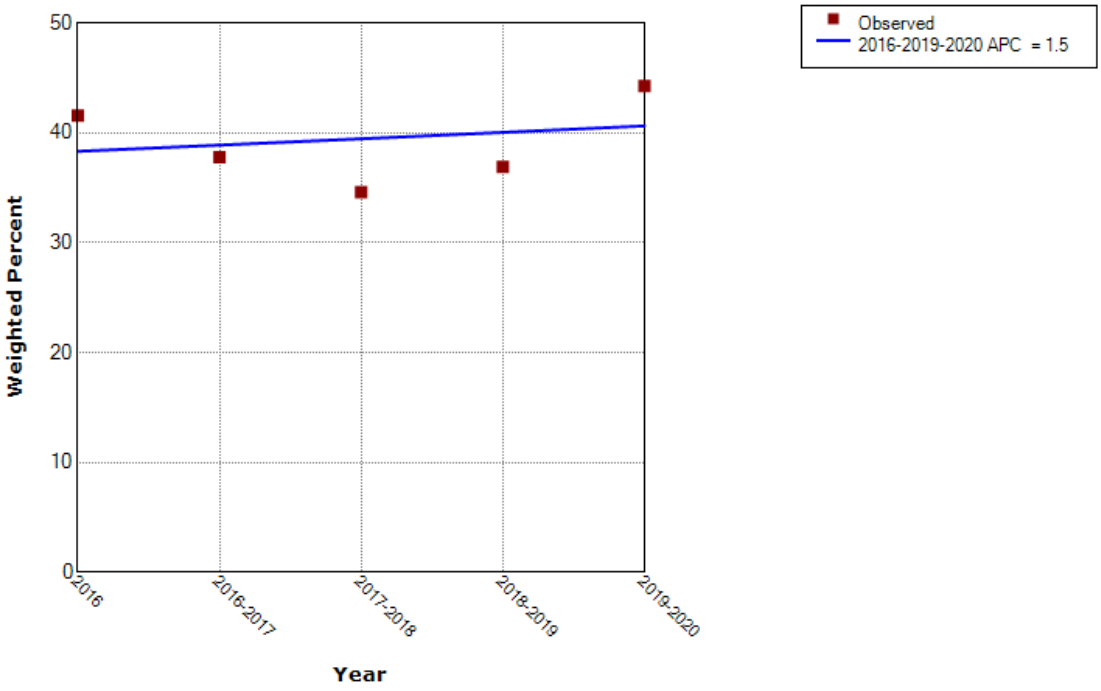
* Includes linkages based on expert opinion or theory in the absence of empirical scientific evidence. Associations with available empirical scientific evidence that is mixed or inconclusive are not included. This table is subject to revision as new scientific evidence becomes available. By definition, NPMs must be linked to at least one NOM; however, not all NOMs must have linked NPMs, as they may be important to monitor as sentinel health indicators regardless.

NPM6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year.

The American Academy of Pediatrics recommends that all children should be screened for developmental delays during their regular well-check visits at 9, 18, and 24 or 30 months. According to the 2019-2020 National Survey of Children's Health (two years of data combined), 44.3% (95% confidence interval [CI]: 33.3%-56.0%) of Kansas children, ages 9 through 35 months, received standardized developmental, behavioral and social screening using a parent-reported, standardized screening tool or instrument,* compared to 36.9% nationally (95% CI: 34.6%-39.3%). However, the difference was not statistically significant. Subgroup information is not available for this indicator, due to small sample size.

From 2016 (single-year estimate) to 2019-2020 (two-year estimate), no statistically significant changes were observed in this indicator.

Weighted Percent* of Children, Ages 9 through 35 Months, Who Received a Developmental Screening Using a Parent-completed Screening Tool in the Past Year, Kansas, 2016-2020†



* These estimates each have a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution.
† Note: After 2016, state-level estimates were produced using two-year combined data.
The Annual Percent Change (APC) was not found to be significantly different from zero at the alpha = 0.05 level.
Source: U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), National Survey of Children's Health (NSCH)

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.

* Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution.