Dear Kansas Maternal and Child Health Partner,

On behalf of the KDHE Bureau of Family Health, we want to provide a special invitation to review the latest results of our 2015 application and 2013 annual report (DRAFT). We welcome your comments, suggestions, and questions regarding the information.

Thank you for your time, interest, and commitment to improving maternal and child health in Kansas.

Maternal and Child Health Services Title V Block Grant

State Narrative for Kansas

Application for 2015 Annual Report for 2013

Document Generation Date: Thursday, June 05, 2014

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and Certifications are provided as an attachment to this section.

If you have any further questions or concerns, please contact:

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D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

Over seventy individuals and organizations were invited to provide input into the MCH Block Grant five year needs assessment process. The group reviewed past priorities and activities undertaken to address them. They reviewed current data and selected new priorities. All of the materials generated through this process were placed on a website along with workplans for the coming year. Listserv's were used to advertise the availability of the website for public comment: Kansas MCH Advisory Council, CSHCN, Families Together, local health departments, school nurses, and other.

Dear Maternal and Child Health (MCH) stakeholders:

Thanks to those of you who participated in the five-year MCH needs assessment and planning meetings these last few months.

This spring, KDHE Bureau of Family Health staff developed logic models based on information provided by stakeholders during the November 2009 and January 2010 meetings. In completing the planning process, some priorities and strategies were modified based on expected capacity and available resources to implement over the next five years.

We wanted to give you a special invitation to review the latest results online if you haven't already. Go to this page to see the MCH 2015 priorities, strategies, and logic models:

http://www.datacounts.net/mch2015/results.asp

On behalf of the KDHE Bureau of Family Health, we welcome your comments, suggestions, and questions! Thank you again for your interest and work in improving maternal and child health in Kansas.

For a copy of other comments received, please contact Bureau of Family Health.

/2012/ For the 2012 application and 2010 annual report, a new methodology was used to obtain public comment. A draft document was posted for 30 days prior to submission on the Bureau of Family Health homepage requesting public comments on the plan. This posting was announced through all MCH/CYSHCN listserv's and newsletters. Comments received were incorporated into the final document prior to submission to the extent that they were feasible. Public comments are available through the office of the Bureau of Family Health. //2012//

/2013/ Dear Maternal and Child Health (MCH) stakeholders,

On behalf of the KDHE Bureau of Family, we want to provide a special invitation to review the latest results of our 2013 application and 2011 annual report. We welcome your comments, suggestions, and questions regarding the information.

Thank you for your time, interest, and commitment to improving maternal and child health in Kansas.

For the 2013 application and 2011 annual report, a draft document was posted for 15 days prior to submission on the Bureau of Family Health homepage requesting public comments on the plan. The posting was announced through all MCH/CYSHCN listserv's and newsletters. Comments received were incorporated into the final document prior to submission to the extent possible. Public comments are available through the office of the Bureau of Family Health. //2013//

/2014/ Public input is a required component of the annual MCH Block Grant application process. This year, the Kansas Title V MCH (Bureau of Family Health - BFH) initiated various first-ever applied mechanisms (adapting Wisconsin and Tennessee's resources) to solicit public input for the 2014 Application. BFH developed a web page on the BFH homepage with a separate Title V information page that provides a link to the Title V annual public input survey. MCH staff also developed resources (listed below) to increase knowledge and understanding about the Kansas Title V MCH federal-state partnership, services, Block Grant, and state's priority issues for 2011-2015.

The following email was sent by the Title V Director to: Local Health Department Administrators, KDHE Department of Public Health Directors/staff, Kansas Maternal & Child Health Council members, Kansas Perinatal Quality Collaborative members, Mother & Child Health Coalition of Greater Kansas City, March of Dimes, Kansas Chapter of American Academy of Pediatrics, KIDS Network, Kansas Action for Children, United Methodist Health Ministry Fund, Kansas University Medical Center/Kansas University, Kansas Public Health Leadership Institute and Core Public Health Programs, Kansas Health Foundation, the Blue Ribbon Panel on Infant Mortality, Kansas Chapter of Family Physicians, Managed care organizations, Cerebral Palsy Research Foundation, Families Together, Youth Advisory Council, Family Advisory Council, Newborn Screening Advisory, Newborn Hearing Advisory, Kansas Foundation for Medical Care, Sunflower Foundation, School nurses, Teen Pregnancy Targeted Case Management and pregnancy maintenance initiative grantees, State Children's Institutions, Kansas Children's Service League, Children's Alliance, Department of Children and Families contacts, Birth Centers, MCH grantees/reps, WIC grantees/representatives, WIC Advisory Committee, Kansas Breastfeeding Coalition, High 5 for Mom and Baby, and Nutrition Physical Activity Collaborative.

"Dear Kansas Maternal and Child Health Partner:

As Director of the Kansas Title V Program, it is my pleasure to request your input related to Kansas Title V Maternal and Child Health (MCH) Services, a federal-state partnership/block grant administered by the Kansas Department of Health and Environment, Division of Public Health, Bureau of Family Health. Whether you are a parent, government official, advocate, or member of the general public, the MCH Block Grant likely touches your life. Its success lies in the strength of partnerships and collaborations to maximize reach and promote efficiency.

Please complete this short survey related to statewide MCH programs and services: http://www.surveymonkey.com/s/XD6ZQSM. In order to ensure that your comments are reviewed and incorporated into the 2014 Application/2012 Annual Report, we ask that you complete the survey by June 1. Your input is needed to assure the MCH Program is guided by the needs of Kansas families and MCH priority populations: women of reproductive age, pregnant women, mothers, infants, children, adolescents, and individuals with special health care needs. Please feel free to forward this message and survey link. Questions should be directed to Jamie Kim at jkim@kdheks.gov.

Resources to increase your knowledge about the Kansas Title V MCH Block Grant and state's priority issues for 2011-2015 are provided below. Included in the list is an Executive Summary which orients the reader to the Block Grant, highlights key programmatic themes and data points, provides specific examples of MCH program activities, and encourages comment concerning the document itself.

• Executive Summary (2013 Block Grant): http://www.kdheks.gov/c-f/downloads/Executive_Summary_KS_MCH_BG_2013_App_2011_Report.pdf
• Health Status Indicator Progress Report (2013 Block Grant): http://www.kdheks.gov/c-f/downloads/Indicator_Progress_KS_MCHBG_2013_App_2011_Report.pdf
• MCH Block Grant (full length 2013 Application/2011 Annual Report): http://www.kdheks.gov/cyshcn/download/FY2013_KS_MCH_Block_Grant_For_Public_Comment.pdf
• Quick Reference Guide for Block Grant: http://www.kdheks.gov/c-f/downloads/MCH_Quick_Reference_Guide.pdf
• MCH 5-Year Statewide Needs Assessment (MCH 2015): http://www.datacounts.net/mch2015/documents/MCH2015_Report.pdf
• MCH 2012 Biennial Summary: http://www.kdheks.gov/bfh/download/MCH_2012_Biennial_Summary.pdf
• KDHE Bureau of Family Health website: www.kdheks.gov/bfh (direct link to MCH Block Grant website: http://www.kdheks.gov/c-f/mch.htm)

Thank you for your dedication and commitment to working together for a healthier Kansas."

The public input was gathered via an on-line survey tool (Survey Monkey). The survey was structured to focus on major and emerging health concerns and unmet needs for the target populations served by the block grant. In addition, the survey asked for input on the service delivery system for these populations to include what is and is not working well. The tool generated 292 responses which expressed overall support for prevention-related services. The following issues were identified in the comments: support for access to and utilization of reproductive health services; assistance to families with newborns; immunization education and support; developmental screening and early identification services; parenting education and support services; adequate and appropriate nutrition/obesity prevention; mental health screening and services; oral health; strong adolescent health education and services; support infrastructure for health care system; breastfeeding education and support; childhood obesity; and supports for

families who have a child or youth with special health care needs. It was suggested the MCH program continue to find ways to make greater use of technology to provide health education and support services; improve access to and utilization of health care system in rural areas; support advocacy for policies to improve public health; improve health literacy of families; and encourage public/private partnerships between existing programs and services. The summary input from the survey and the MCH Grantees are included in the attachment.

For the current 2014 application and 2012 annual report, a draft was posted on the BFH homepage from July 2-12 requesting public comments on the plan. The posting was announced vial email through all MCH/CYSHCN listservs listed above. Comments received were incorporated into the final document prior to submission to the extent possible.

For the next year's application, MCH plans to post the final version of the 2014 application and 2012 annual report on the Title V MCH website following the review in August 2013. The MCH program/Kansas Resource Guide will monitor for public comment and inquiry throughout the year. MCH staff will review on a routine basis and incorporate into the next year's application. //2014//

/2015/As part of the annual Title V Maternal and Child Health (MCH) Block Grant Application process, Kansas MCH launched 1) Title V MCH Services Input Survey (following the block grant review in fall 2013 to collect ongoing input on services, emerging issues, needs, concerns, etc) and 2) Draft MCH Block Grant Feedback Survey (to collect comments and input on the draft application and annual report).

Title V MCH Services Input Survey: The purpose of this annual survey is to collect information, opinions, and perspectives from consumers and partners across the state who are informed of and concerned about the needs the maternal and child health (MCH) population, established services and resources, and existing factors that affect the implementation of policy and programs. (http://www.kdheks.gov/c-f/mch.htm#input)

Draft MCH Block Grant Feedback Survey: This survey is intended to collect information, opinions, and perspectives on the DRAFT 2015 Application/2013 Annual Report from consumers and partners across the state that are informed of and concerned about the needs of the maternal and child health (MCH) populations. The KDHE Bureau of Family Health staff will use the feedback from this survey to complete the Federal Fiscal Year 2015 Title V Block Grant Application.

Title V MCH Services Input Survey

Public Comment Period: November 20, 2013 - May 18, 2014
Methods: The email was sent out by the Title V Director to Kansas MCH Partners; the survey link was posted on the BFH website; postcards were made and distributed at vendor booths, conferences, meetings, other forums; announcements were posted online, via social media, and in newsletters.
Results: A total of 216 responses were received. More than half (55.8%) were a parent/guardian of a child age 0 - 21. About a sixth (16.2%) were a parent/guardian of a child with special health care needs (any age). Participants were asked to best describe their role (selecting multiple categories, if appropriate). The majority of respondents were Health care professional (56.9%), followed by community service provider (11.6%) and parent/guardian (9.3%). Respondents were asked if they had reviewed the current Kansas MCH block grant. Only one-third of respondents (32.5%) had reviewed the current grant. The key findings were similar to the previous year. The common/overarching/recurring issues were: healthy relationships, behavioral and mental health, health screening and preventive behaviors, breastfeeding, education and support, parenting education, growth and development, developmental screenings, immunization (up to date), obesity, oral health, family education and support, and care coordination.

Draft MCH Block Grant Feedback Survey

Public Comment Period: June 5, 2014 - June 19, 2014
Methods: The email was sent out by the Title V Director to Kansas MCH Partners; the survey link was posted on the BFH website.
Results: In progress //2015//

II. Needs Assessment

In application year 2015, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

/2015/ Needs Assessment Update for Interim Year

a. Any changes in the population strengths and needs in the State priorities since the last Block Grant application.

Changes in the population strengths and needs have not been noted since the last Block Grant application.

b. Any changes in the State MCH program or system capacity in those State priorities since the last Block Grant application.

Since the last Block Grant application, there have been changes in system resource capacity to address Priority Needs. The agency is currently involved in strategic planning to align human/economic resources with priority outcomes.

The Governor's Roadmap for the State of Kansas focuses on economic growth to help build strong families. Within this framework, the state will continue to grow the Kansas economy, reform state government, excel in education and protect families.

MCH has requested technical assistance through this Block Grant Application to assist in developing a base funding formula for MCH Aid to Local grants. A request to assist with integration/coordination of the MIECHV program with the Healthy Start Home Visitor program and related work in the MCH Unit was previously submitted and in process. Technical assistance was also requested for development of a state adolescent health plan and is in process.

c. A brief description of any activities undertaken to operationalize the 5-Year Statewide Needs Assessment.

Pregnant Women and Infants

Pregnant Women and Infants Update: The following activities are directed toward improving birth outcomes and reducing infant mortality: 1) Utilization of Kansas Tobacco Quitline by those seeking resources to reduce or quit smoking tobacco/using tobacco products, especially before, during and after pregnancy; 2) Promoted use of social media to bring awareness to health-related topics for women before, during and after pregnancy. For example, Healthy Babies Kansas public awareness Facebook campaign and text4baby free health text messaging program for pregnant women and new moms; 3) Kansas Blue Ribbon Panel recommendations to reduce low birth weight babies delivered and other activities focused on decreasing the rate of infant mortality; 4) the Kansas Perinatal Quality Collaborative (KPQC) was established in fall 2012 to improve Kansas' maternal and infant health outcomes by assuring quality perinatal care using data-driven, evidence-based practice and quality improvement processes; and 5) partnership with March of Dimes to expand local perinatal collaboratives that address health disparities and implementation of the Becoming a Mom prenatal education curriculum.

Breastfeeding Update: The KPQC identified their first priority project is to increase the

number of infants exclusively fed breast milk.

Children and Adolescents

Medical Home Update: The Kansas Maternal and Child Health Council (MCH advisory group) now includes a member from KanCare, the state's Medicaid program. Information regarding KanCare outstation workers and accessing the federal health care marketplace was distributed to local MCH grantees, school nurses, and other partners.

Reducing Risk Behaviors Update: KDHE established a contract with Kansas State University, School of Family Studies and Human Services -- Extension, to conduct a state level needs assessment addressing adolescent health and to develop a Kansas Adolescent Health Strategic Plan. These products expect to be completed in the summer and fall of 2014 and will also inform the next five-year state MCH needs assessment. KDHE partners with Kansas Department of Education in 2014 to offer teachers training on "Teaching Adolescent About Avoiding Risky Behaviors".

Overweight and Obese Children Update: The NWS section continues work with local and state partners to encourage and promote events aimed at increasing healthy eating behaviors and physical activity of Kansas children. The NWS section participates in the KS Nutrition and Physical Activity Collaborative (NuPAC) -- a collaborative of federally and privately funded nutrition programs working on enhancing partnerships to improve the nutrition and physical activity of Kansans. In addition, NWS staff continues to work to increase the number of well-trained MCH staff who plan, facilitate, deliver and evaluate healthy eating and physical activity messages by sponsoring and promoting training opportunities. The Kansas MCH program supports reducing the number of overweight and obese children and encourages local MCH grantees to participate in any relevant, evidence-based programs in support of this goal as part of their staff development process. Local community leaders are organizing walks and runs to encourage exercise.

Children and Youth with Special Health Care Needs

Medical Home Update: The KS-SHCN program continues to promote medical home objectives individually and in cooperation and collaboration with other state and local programs. The focus of this goal is improving access to and expanding services available within a Medical Home. The primary strategies to address this priority objective are: 1) educate families, youth and providers about the components of a medical home; 2) inform community partners and stakeholders of local, state, and national initiatives to support effective and successful system change; and 3) utilize community partnerships by linking community services and resources for CYSHCN and their families. The KS-SHCN program has been in a new strategic planning phase which has identified care coordination as a top priority. A care coordination project is being developed with implementation to begin in the next few months in Kansas as part of a Medical Home. Through these efforts, the program strives to empower consumers to take an active role in their health care and partner with providers in health care decisions.

Youth Transitioning into Adult Services Update: The KS-SHCN program continues to be at the forefront of improving the transition of youth with special health care needs into adult services. Specialty clinics supported by KS-SHCN offer transition clinics for older youth with special health care needs to begin the transition process from pediatric to adult health care systems. All youth involved in the CYSHCN program will receive Transition services through the new care coordination project. Partnerships with Families Together, Inc. has provided opportunities to promote the personal health care and transition notebooks for families and youth with special health care needs to encourage youth to take a more active role in their health care. Additionally, through this partnership, a number of transition workshops and conferences have been held to educate and inform

parents and families about necessary steps for successful transitions. A focus was placed on preparing youth to improve the integration and coordination of transition supports and services including health care, education, employment, and independent community living. A comprehensive transition model was developed with the youth and their families in the center of the model. The model includes tools and resources across disciplines related to family health care supports, medical and school coordination, health care provider engagement, individualized health planning, and youth-directed healthcare education. Additionally, a partnership with the University of Kansas allowed for the development of a transition website, specific to Kansas resources and supports. This website is currently being modified and will be available for use in the near future. It is designed to help families and youth navigate the complex world of transition to adulthood. Work is being done with the Heartland Genetic Collaborative on projects related to individualized health plans that can be utilized by school nurses to assist in the transition process.

Financial Impact on the Family Update: The KS-SHCN program continues to work towards minimizing financial impact on families, while ensuring that the program itself remains financially solvent. To address the growing needs of CYSHCN, the program reached out to local communities and implemented a regionalization to offer services at the community level, rather than a state level. In partnership with local health departments and other local entities, six regional offices across Kansas began providing a local point of entry into the program since July 2012. Along with the regional office expansion, an expansion of clinic services through outreach to the Western regions of Kansas has taken place over the last year, making services more accessible for CYSHCN. One way the KS-SHCN program will be assisting families is through the development of the new care coordination project. As part of this serves families will receive supports and assistance to meet their financial needs. An expansion of the Kansas Resource Guide, a navigational tool kit component, is planned for the near future. The KS-SHCN program is dedicated to providing services to families at the community level and will continue to move towards improved community-based services.

d. A brief description of ongoing activities to gather information from the community and to evaluate implementation of the 5-Year Statewide Needs Assessment.

The Title V Director and MCH Epidemiologist continue to collaborate with program(s) staff to coordinate needs assessment activities. These efforts include the collection and analysis of data for the annual MCH Block Grant application that includes State priority needs. //2015//

III. State Overview

A. Overview

This section puts into context the MCH Title V program within the State's health care delivery environment. It briefly outlines Kansas' geography, demography, population changes, and economic considerations. The overview provides an understanding of the State Health Agency's current priorities/initiatives and the Title V role in these. It includes a description of the process used by the Title V administrator to determine the importance, magnitude, value, and priority of competing factors impacting health services delivery in the State including current and emergent issues and how these are taken into consideration.

Geography/Demography

Located in the central plains region of the United States, Kansas encompasses 81,815 square miles or about 2% of the land area of the U.S. It is bordered on the north by Nebraska, on the south by Oklahoma, on the east by Missouri, and on the west by Colorado. The topography of the state changes from hills and wooded areas in the east to flat, treeless high plains in the west.

Population Density/Distribution

There were 34.2 persons per square mile in the state in 2008 compared to 86.0 for the U.S. Five cities in the state, all located in the eastern half, have populations that exceed 100,000, including Wichita (366,046), Overland Park (171,231), Kansas City, 142,562), Topeka (123,446), and Olathe (119,993). In 2008, 35 of 105 counties in Kansas had population densities of less than 6.0 persons per square mile. These are located mostly in the western part of the state. The most sparsely populated county was Wallace along the Colorado border with a density of 1.5 persons per square mile. The most densely populated county was Johnson with 1,119.7 persons per square mile. This county is on the eastern border of the State.

Urban/Rural

Most of the population growth over the past decade occurred in the eastern portion of the state, where the majority of the population lives. While there are many rural areas in eastern Kansas, particularly in southeastern Kansas (Kansas Ozarks), the most rural counties are located in western Kansas. Rural county residents tend to have lower median household incomes, higher poverty rates, and higher unemployment rates.

Population Growth/Change

The 2008 population estimate for Kansas was 2,802,134 or about 1% of the U.S. population (U.S. Census Bureau). Percent growth for Kansas' population from 2000-2008 was lower than for the U.S. 4.2% compared to 8.0%. For younger age groups, however, the population growth rate was slightly higher for Kansas than for the U.S. For children under age 5, the growth rate was 7.2% for Kansas compared with 6.9% for the U.S. For children under age 18, Kansas' population growth was 25% versus 24.3% for the U.S. Women comprise 50.3% of the population roughly comparable to the U.S.

Age

Kansas' population is aging but at a slower pace than the rest of the U.S Median age is 36.2 years which is only slightly younger than the national median age of 36.8. Since 2002, Kansas' population of school age children has decreased 2.5 percent while the older cohorts have steadily increased. The school age population (age 5-17 years) is expected to remain stable through 2010 and then gradually increase.

The under age 5 cohort was unchanged from 2002 to 2005. Since 2005, it has steadily increased. Proportionally, this cohort represents 7.2 percent of the total state population, up 3.3 percent from 2007 to 2008. In 2008, there were 41,815 resident births in Kansas.

Women of reproductive age (15-44) accounted for 19.8%, or 553,481 of the estimated 2.8 million people in the State. There were about 57,321 women ages 15 to17.

Twenty eight percent (28%), or 788,500, of the State's population were children age 19 and younger. In 2008, there were an estimated 521,400 children and adolescents aged 5 to 17.

Race/Ethnicity

White persons comprise a higher proportion of Kansas' population (88.7%) than the proportion for the U.S. (79.8%), There is a lower proportion (6.2%) of Black persons in Kansas compared to the proportion for the U.S. (12.8%). American Indian and Alaskan Native persons are 1.0% for both Kansas and the U.S. Asian persons comprise 2.2% of Kansas' population, but 4.5% of the U.S. population. The proportions for those reporting two or more races are roughly comparable for KS and for the U.S., 1.8% and 1.7% respectively.

The proportion of persons reporting Hispanic origin is only 9.1% for Kansas compared to 15.4% for the U.S.

Diversity/Languages

Kansas' population is fairly homogenous. Only five percent (5%) of Kansas' population is foreign born compared with 11.1% for the U.S. Percent homes in which languages other than English are spoken is only 8.7% compared with 17.9% for the U.S. Refugee health program data for 2009 are representative of about half the annual recent arrivals to Kansas. Of approximately 500 foreign born immigrants in 2009, 21% spoke Nepalese, 18% Burmese,16% Karen, 11% Arabic, and the remaining 34% Chinese, Dari, Farsi, Kayaw, Kurdish, Kunama, Laotian, Somali, and Vietnamese. Refugees located mostly in about five counties in the state: Wyandotte (KC), Sedgwick (Wichita), Johnson, Finney, and Douglas.

Education

Kansas compares favorably with the U.S. average in terms of educational attainment with an 86.0% high school graduation rate compared with 80.4% for the U.S. Twenty five percent (25.8%) of Kansans have a bachelor's degree or higher compared with 24.4% for the U.S.

Income/Poverty

The median household income for Kansas in 2008 was $50,174 compared to $52,029 for the U.S. Per capita income for Kansas was $20,506 compared with $21,587 for the U.S. Proportionately fewer Kansans live below the federal poverty level, 11.3% compared with 13.2% for the U.S. See attachment for distribution of number of children in poverty by county and distribution of percent children in poverty by county.

Economy

The Kansas economy entered a significant downturn in 2009 following the U.S. and global economic downturns. There was a slow period of employment growth through most of 2008, followed by significant job losses in manufacturing during 2009, especially in Wichita's aircraft manufacturing industry. Unemployment for the first 3 months of 2010 was 7.2, 6.8, and 6.9 percent, these compare unfavorably with rates in late 2008 that were approaching 4 percent. http://klic.dol.ks.gov Consumer spending slowed considerably as did State revenues. For the state fiscal year starting July 1, 2010 state legislators faced a projected budget shortfall for the

3rd year in a row. The projected shortfall was estimated at $500 million.

Health Insurance Coverage

In 2007-2008, 12.4 percent of Kansans were uninsured, not statistically different from either the 12.5 percent who were uninsured in 2006-2007 or the 11.3 percent in 2005-2006, but greater than the 10.5 percent who were uninsured in 2004-2005. The percentage of Kansas children (under 19) without health insurance in 2007-2008 was approximately 9.6 percent, up from 7.8 percent in 2006-2007 and 7 percent in 2005-2006. The percentage of Kansans without health insurance in 2007-2008 (12.4 percent) was lower than 15.3 percent for the U.S. Approximately 338,000 Kansans were without health insurance in 2007-2008. Based on 2006-2008 three-year averages, the Kansas uninsured rate was higher than 13 other states and lower than 26 other states. See attachment for percent of children that were uninsured by county for 2006.

Counties with high percent uninsured children per county are clustered in the southwestern part of the state, a largely Hispanic populated area and presumably many are not Medicaid or SCHIP eligible. The southeastern portion of the state (Kansas Ozarks), on the other hand, has a cluster of counties with large number/percent of children in poverty but the children are less likely to be uninsured than those in the southwestern part of the state.

Health Care Delivery Environment

Primary Care Access/Workforce

The most prominent barrier to care in Kansas is lack of financial access as measured by income and uninsurance rates. Although the most recently available data for the uninsured rate in Kansas, the U.S. Census Bureau's March 2008 Current Population Survey, is from before the current economic recession, it found that approximately 340,000 Kansans were uninsured in 2006-2007, up from 307,000 in 2005-2006. Of these, 61.4% were considered low-income (household incomes at or below 200% of the federal poverty level) and likely unable to afford the cost of health insurance premiums or the full cost of personal health care services when needed. Kansas was one of 10 states that showed an increase in its uninsured rate during this period. Kansas moved from 11th to 20th among states with lowest uninsurance rates. Kansans with insurance still had access issues due to the lack of primary care providers throughout the state.

Currently, Kansas has 84 federally-designated, primary care Health Professional Shortage Areas (HPSAs). These include entire counties, cities, or areas with underserved populations. Of the current primary care HPSAs, 28 are geographic HPSAs and 56 are population HPSAs, indicating both geographic and financial access problems among residents across the state. Only twelve of Kansas' 105 counties do not have a primary care HPSA within their borders. Only five others have primary care HPSAs that only make up a portion of their counties. In the remaining 88 counties, the entire county is federally designated as a Health Professional Shortage Area.

The state of Kansas has shown a commitment to funding the provision of medical services in underserved areas. In 1992, beginning with $800,000 in state funding for nine primary care medical projects targeted to uninsured and other underserved populations, the program has grown substantially, especially within the last four years. Current funding for state fiscal year 2010 is $7.48 million dollars in funding to 38 clinics around the state with sites in 31 Kansas counties. There has also been a rapid expansion in Federally Qualified Health Centers (FQHCs) in Kansas over the last few years, from 7 in 2000 to 15 FQHCs and one FQHC look-alike in 2010. The expansion of access to primary care services is a major achievement in the state but often the inability to find needed providers by these clinics has hindered their ability to provide primary care services at full capacity.

A number of reports are generated annually by state programs and other entities on primary care access. Among these are the "Primary Care Access Report" the "Annual Report of the

Statewide Farmworker Health Program" Special studies focus on workforce issues such as the aging of the workforce study -- www.kdheks.gov/ches/download/AgingPhysician2009.pdf

The state agency in partnership with the Dental Association and numerous other organizations has completed workforce analyses resulting in policy initiatives on dental workforce.

Public Health System

Kansas has 105 counties and just fewer than 300 school districts. Almost every county has a local health department (99 counties) and every county has some type of public health 'presence.' Many school districts utilize contracts with local public health nurses for school nursing services, particularly in the smaller counties. In order to meet national public health accreditation standards, many of the smaller county health departments have considered organizing as regional public health entities. Importantly, local health departments are not state operated. Rather, they are units of local and county government and operate autonomously of the State health department.

There is a strong partnership between the State and local public health departments that is manifest in collaborative activities such program planning and policy development. The Kansas Public Health Association provides a forum for many of these activities and the Kansas Association of Local Health Departments coordinates communications among local health departments and between the State health agency and local agency council. As well, there are many other joint conferences and events that serve to bring together state and local public health workers.

There are four very active health foundations in the state that are major drivers of public health policy. These include the Kansas Health Foundation, Sunflower Foundation, United Methodist Health Ministries, and Kansas City's REACH Foundation. The State has a very active public health-focused research institute, the Kansas Health Institute. It is a source of much public health information and analysis for policy making. The institute convenes legislators and public health staff in forums to consider policy options and these no doubt serve to inform public policy. Beginning in Fall 2009, the KHI initiated a series called "Children's Health in All Policies" convening MCH staff, legislators and others. This contributed to the many positive outcomes in the 2010 session such s reinstatement of funding for teen pregnancy prevention, protection of funding for social services, education, early childhood, and Medicaid.

State funding of public health is largely targeted towards specific activities and programs, unlike some other states that have large amounts of funding portioned out to counties on a per capita basis for core public health activities. This is not to say that there is no per capita funding, but the 75 cents per capita funding provided through the "State Formula Fund" is a very small portion of the overall state funding for local public health activities in the state.

Public Health Insurance

Previously located in the state social services agency, Kansas' Medicaid agency was relocated to the Kansas Health Policy Authority, a separate state agency, in 2005. The Authority is responsible for coordinating a statewide health policy agenda that incorporates effective purchasing and administration with health promotion strategies. All health insurance purchasing by the State is now combined under the Authority including publicly funded programs (Medicaid, State Children's Health Insurance Program, and Medikan) and the State Employee Health Benefits Plan (SEHBP). The Authority is responsible for compiling and distributing uniform health care data in order to provide health care consumers, payers, providers and policy makers with information regarding trends in the use and cost of health care for improved decision making. The KHPA is governed by a nine-member board, including health care, business, and community leaders appointed by the Governor and the Legislature, as well as eight ex-officio members that include State Cabinet Secretaries and the Executive Director of KHPA.

The interface between Title V MCH and Title XIX Medicaid is documented in the KHPA/KDHE Interagency Agreement. The document is updated at regular intervals to clarify roles and responsibilities and the most recent update of this document is dated September, 2009. KHPA staffs participate in Title V activities such as the MCH Advisory Committee and they advise on matters pertinent to both agencies.

State Health Agency Current Priorities and Initiatives

The state health agency's current priorities and initiatives were apparent in the initiatives introduced and shepherded through the 2010 legislative session: clean air act (smoking ban in public places); expansion of child care licensing inspections to registered family day care homes (the so-called Lexie's Law - health and safety while in out-of-home care); changes to the Vital Statistics statutes to allow use of birth certificates for maternal surveillance purposes such as PRAMS and FIMR; maintenance of dedicated use of tobacco settlement funds for programs serving children ages birth through five (including MCH home visiting, Infant Toddler Services, and Newborn Screening); primary seat belt law, requirement for Kansas colleges to have a plan for controlling tuberculosis on campuses; opt-out for HIV infection screening of pregnant women; audiologist licensure requirement of doctorate or equivalent; certification of radon technicians; prohibition of texting while driving.

Obesity reduction measures such as school vending, menu labeling, and tax on sugar sweetened beverages did not pass despite considerable public approval for these measures. Likewise, increased taxes on cigarettes and other tobacco products did not pass. It is anticipated that obesity and tobacco use reduction measures will move forward into the next legislative session. The state school board has moved on the school vending machine proposal.

The state health agency focus is on prevention/wellness, social determinants of health, life course perspective, and health equity. The agency has established a bureau of environmental health encompassing Environmental Public Health Tracking, lead screening and abatement, radon and radiation protection and control, among others. There has been renewed focus on reducing racial and ethnic health disparities with the office of minority health taking a larger role and the establishment of the Blue Ribbon Panel on Infant Mortality.

Title V MCH Roles and Responsibilities in Agency Initiatives

The mission statement for the Bureau of Family Health embodies its roles and responsibilities both outside and within the agency: to provide leadership to enhance the health of Kansas women and children in partnership with families and communities. While other bureaus in the division of health have initiatives relating to the health of women and children, none has as its exclusive mission the health and wellbeing of women and children.

A major focus of all the policy and program initiatives is partnership. There is stakeholder involvement in all Title V activities that includes both providers and consumers. Title V MCH is a leader in the agency in drawing on key players to help them play important roles in shaping the future of the state. Through existing forums, Title V has engaged stakeholders in advocacy for improving the health status of women and children. Title V has provided or assisted in project management for special groups such as the Governor's Child Health Advisory Committee, Early Learning Coordinating Council, State Genetics Plan Stakeholders, Newborn Screening Advisory Council, Families Together, the Blue Ribbon Panel on Infant Mortality, and the emergent Kansas Breastfeeding Coalition. Title V has provided staffing and resource support to other emergent issues including H1N1, bioterrorism coordinating council, Developmental Disabilities Council, Autism Task Force, Food Security Task Force, Health Department Accreditation, and Healthy Kansas 2020. The Kansas MCH Coalition (a merger of the Kansas Perinatal Council and the Kansas AAP Advisory Group) has served as a forum for policy and priority issues relating to the health of Kansas mothers and children.

A good example of partnership activities during the past year is the ABCD+ initiative. This initiative focuses on behavioral and mental health screening and treatment. Survey data of healthcare providers on the issues of mental health diagnosis and treatment for children and adolescents revealed pediatric providers are uncomfortable diagnosing and managing mental health disorders even common ones such as depression and anxiety. It was also apparent that an overwhelming majority of providers experienced a lack of resources. Finally, most primary care physicians were willing to provide these services if given adequate training and resources.

The Kansas Chapter, American Academy of Pediatrics (KAAP) and the KDHE MCH staff convened a multi-agency task force to increase the number of children (ages 0-18) that receive mental health screening and appropriate mental health referral and treatment. Other agencies involved included: Kansas Health Policy Authority (KHPA) - Medicaid; Kansas Department of Social and Rehabilitation Services (SRS) - mental health and substance abuse designated agency and Kansas Health Solutions provider network; Association of Community Mental Health Centers of Kansas (ACMHCK) Community Mental Health Centers in Kansas; Private Mental Health Consultant of the Governor's Children's Mental Health Council; Kansas Behavioral Science Regulatory Board (KBSRB); Kansas Health Institute (KHI); and the Kansas Academy of Family Physicians (KAFP). The task force is patterned after the Assuring Better Child Health and Development (ABCD) project, a quality improvement initiative in primary care practice to improve developmental screening.

The project developed a three-pronged approach. First, develop an easily accessible web-based resource list -- KidLink Resource Directory -- with contact information including a stratified level of care of all Kansas public and private mental health providers and therapists that serve the pediatric population. Second, develop and deliver education to healthcare providers in the use of evidence-based screening tools and appropriate early intervention resources to increase their competence level in diagnosis and treatment of childhood developmental and mental health disorders. Third, teach healthcare providers to navigate the KidLink Resource Directory of mental health providers in their geographical regions in Kansas with the ultimate goal to get children and adolescents into treatment interventions as soon as possible. Regional networking and collaboration between primary care providers, child/adolescent psychiatrists, and other mental health providers is essential to improving mental health in children.

Another example of work across agencies is the State Child Death Review Board (SCDRB). MCH represents the Kansas Department of Health and Environment on this board. The SCDRB was created by the Kansas Legislature in 1992 and is administered by the Kansas Attorney General's Office. The SCDRB ten-member multi-disciplinary panel whose appointments are defined by statute are comprised of medical, law and social service professionals. The purpose of the SCDRB is to "determine the number of Kansas children who die annually, describe trends and patterns of child deaths, identify risk factors . . . [and] develop prevention strategies in order to lower the number of child deaths."

A third example of partnership is school nursing services. MCH is responsible for guidance to local school district nurses. The 2010 Guidelines for Medication Administration in Kansas Schools is a revision of the 2001 guidelines providing guidance and resources for school personnel responsible for children with acute and chronic illnesses requiring medication during the school day. School districts must meet this need in the interest of facilitating school attendance and compliance with applicable state and federal laws, establishing policies and implementing procedures that meet all legal requirements for administration of medication required during school hours. Medication administration procedures must be consistent with standards of medical, nursing, and pharmacy practice guidelines. The revised expanded guidelines include sample forms, supporting documents, and links to resources and information facilitating safe and timely medication administration in the school setting.

Beginning in May of 2009, the Kansas MCH program was an integral partner in the agency

response to pandemic influenza. Nursing and epidemiology staff assumed additional responsibilities serving on the H1N1 Phone Bank assisting with calls from health providers and the general public, development of resource materials posted on the Kansas Department of Health and Environment (KDHE) Web site, and education of MCH staff in the local agencies. Other staff worked with the Center for Public Health Preparedness (CPHP) deploying supplies from stockpile warehouses out to Kansas providers. MCH served on the KDHE Community Mitigation Team. This team was charged with assisting with weekly statewide telephone conference calls with local health departments and providers and development of educational and resource materials.

The current public health leadership within the agency has pursued a course of greater public awareness of the importance of public health to the overall health of the population, the important roles and responsibilities of the state public health agency in achieving and maintaining a healthy population. The achievements in the 2010 legislative session are a testament to the positive impact of this approach with policy makers and the public. Whereas previously the focus was on insurance status and access to care, there has been a shift in public opinion to the merits of public health strategies.

In summary, the MCH role within the state Title V agency is to provide leadership to issues and concerns at the state and local levels affecting the health and wellbeing of Kansas mothers and children. This is manifest in many program and policy initiatives that are described here and elsewhere in this application. Overlaying all these initiatives and challenging many of our efforts, is the state's budget situation. The budget will remain the most significant issue for the state and for MCH in the foreseeable future. At the same time that budget pressures threaten program services, there is increased demand for services and supports by families impacted by the economic recession. Revenues remain unstable at both the state and local levels.

In addition, there are anticipated changes. Health care reform is slowly changing the face of the service system. A change in leadership in state government is expected during the coming year and along with this change, priorities and policy shifts may be expected. The agency including MCH is developing a public health agenda with these changes in mind.

References:
1) Kansas Quick Facts, U.S Census Bureau 4/22/2010
http://quickfacts.census.gov/qfdstates/20000.html
2) Governor's Economic and Demographic Report, 2009-2010, Kansas Division of Budget, January 2010
3) Kansas Health Institute, April 2010 Reports www.khi.org
4) Kansas Annual Summary of Vital Statistics, 2008
5) KDHE Primary Care and Farmworker Health Programs.

/2012/ The 2000 to 2010 Census Results show a 6.1% increase in the Kansas population (2,688,418 to 2,853,118) compared to 9.7% for the U.S. Population density increased to 34.9 persons per square mile compared to 87.4% for the U.S. Kansas remains in the bottom quartile of states in terms of population density along with such states as Oregon and Utah.

Wichita, Overland Park, Kansas City, Topeka, and Olathe remain the most populous cities, although Kansas City showed a negative growth rate (-0.7%) from 2000 to 2010. Olathe, to the south of Kansas City, had a growth rate of 35.4%. This was the highest of any city in the state, followed by Shawnee a western suburb of Kansas City (29.6%) and Derby (24.4%) in the southeast Wichita metropolitan area.

County growth rates were strongest in Johnson County (20.6%) that in 2010 displaced Sedgwick County as the most populous county in the State. Johnson Co. includes Mission, Overland Park and Olathe. Geary County with its military base (23.0%) and Miami County (15.6%) located on

the southern border of Johnson County also had high growth rates. Wyandotte County, among the most populous counties, had a negative growth rate (- 0.2%) possibly due to out-migration into Johnson and Miami counties. Growth remains strongest in the eastern half of the state.

The state's population continues to become more diverse although not so diverse as the U.S. For Kansas, 83.8% reported white race compared to 72.4% for the U.S., 8.9% black (12.6% U.S.), 1.0% American Indian, Alaska Native (0.9% U.S.), Asian alone 2.4% compared to 4.8% U.S., other races and 2 or more races 6.9% compared to 9.1% U.S. Those reporting white race dropped from 88.7% in 2000 to 83.8% in 2010. Kansas population growth by race/ethnicity was significant for those of Hispanic/Latino ethnicity with a 59.4% increase from 2000 to 2010. In 2010 Hispanics comprised 10.5% of the state's population compared to 16.3% for the U.S.

Comparing 2008 and 2009 data, for the 0-24 age group population, the largest population increases occurred in the 1-4 and the 20-24 age groups. These increases held across white, black and Hispanic populations. For 2009 data for live births to women by age group, there were 36 births to women less than age 15 and 1,162 to women age 15-17. There was overrepresentation of young black women in births to women less than age 17. Seventeen percent (17%) of births to those less than age 15 were to young black women and 11% of births to those 15-17 were to young black women. There was also overrepresentation among Hispanics on this teen pregnancy indicator -- 47% of live births to those less than age 15 were to Hispanic women and 34% of live births to those women age 15-17 were to Hispanics.

There was an overall decrease in deaths to those in the MCH population (ages 0-24) from 2008 (767) to 2009 (686). There were declines in number of deaths for all age groups except for age 5-9 (slight increase) and 10-14 (relatively unchanged). The most dramatic decreases were for the white population. For the non-Hispanic population, declines were most evident for ages 1-4 and 20-24. For the Hispanic/Latino population, declines were evident in infant (0-1) and young adult (20-24) populations.

Miscellaneous data for enrollment of infants and children in various State programs (TANF, SCHIP, foster care, and WIC) appears relatively unchanged from 2008-2009 with the exception of Medicaid and Food Stamp (SNAP) programs. For these two programs there were substantial increases and increases are reflected across all racial/ethnic groups.

From 2008-2009, there were no major changes in numbers of children living in metro versus non-metro areas. No major changes in urban/rural residence for Kansas children. From 2008 to 2009, a slight decrease is evident for the Kansas population while increases were reported for percent population living in poverty: below 50% FPL-Federal Poverty Level (4.8 to 5.1%); 50-100% FPL (12.7 to 13.7%); 100-200% FPL (31.5 to 33.0%). From 2008-2009, with a slight increase in population from 0-19, there was very little change in the poverty status for those living below 50% FPL, 50-100% FPL, and those 100-200% FPL. As one would expect, Kansas children are more likely to live in poverty than the general population. Five percent (5.1%) of the general population live below 50% FPL but 6.1% of children ages 0-19; only 13.7 of the general population but 18.0% of children live 50-100% FPL; and 33% of the general population versus 40.9% of children live between 100-200% FPL.

In 2009, 7.3% of all Kansas live births were born weighing less than 2,500 grams; 5.6% of live singleton births weighed less than 2,500 grams. About 1.4% of live births were born very low birth weight at 1,500 grams. And 1.1% of live singleton births weighed less than 1,500 grams. These figures have remained relatively unchanged over the past 5 years.

In 2009, the death rate per 100,000 due to unintentional injuries among children ages 0-14 was 10.2 up from a low of 9.3 in 2008. Death rate per 100,000 for children ages 0-14 due to unintentional injuries related to motor vehicle crashes (MVCs) was 2.7 down from 3.6 in 2008. There has been a steady decline in the latter over the last five years with improved childhood seat belt legislation a possible contributing factor. There had been a steady decline in unintentional

injuries related to MVCs in 15-24 year olds from 28.9/100,000 in 2006 to 21.9 in 2009. The rate per 100,000 of nonfatal injuries among children ages 0-14 from hospital discharge data is 242.6. The rate per 100,000 of nonfatal injuries due to MVCs for children 0-14 was 13.8, for 15-24 year olds it was 87.6. In this latter category the decline is significant down from 135.6 in 2006.

Chlamydia rates per 1,000 for 15-19 year olds have been slightly variable over the last 5 years with the calendar year 2010 rate at 27.7, up from the 2006 low of 26.2. The 2010 rate for 20-44 year olds was 10.1/1.000 women, up from a low of 8.3 in 2006.

The rate for children hospitalized for asthma per 10,000 (ages 0-5) was 24.8 down from a high of 33.7 in 2006. The percent of Medicaid infant enrollees who received at least one initial periodic screen was 87% slightly down from a high of 89.4 in FFY 2007. The percent for SCHIP infant enrollees was 77.9 for the same time period. Kansas Kotelchuck Index (observed-expected prenatal visits) for 2009 was 79.0 slightly increased from 2006.

The percent of potentially Medicaid eligible children who have received a service was 83.1% down from a high of 95.7% in 2006. The percent of EPSDT eligible children ages 6-9 who have received any services during the year was 58.6% up from a low of 53% in 2006. There has been a steady progress from year to year in this area.

Fifteen percent of State SSI beneficiaries receive rehabilitation services through the CYSHCN program.

Disparities persist in health status for Medicaid recipients. 8.5% of Medicaid enrolled mothers have low birthweight babies compared to 6.7 for non-Medicaid. There are 9.4 infant deaths per 1,000 live births for Medicaid enrolled compared to 5.5% for non-Medicaid . 61.6% of women who deliver births covered by Medicaid received early prenatal care compared to 83.1% for non-Medicaid. 68% of Medicaid enrollees had appropriate observed to expected prenatal visits on the Kotelchuck index compared to 87% for non-Medicaid. Medicaid eligibility levels remain at federally required levels: 150% FPL for infants, 133% FPL for children ages 1-5, 100% for ages 6-18, and 150% for pregnant women. Eligibility levels for SCHIP were 241% FPL for children ages 0-18 and 200% for pregnant women.

Data capacity of Kansas to support MCH programs includes annual linkage of birth and infant death records, access to hospital discharge data, and annual birth defects reporting system. There is no annual linkage of birth records and Medicaid paid claims data, no annual linkage of birth records and WIC, no annual linkage of WIC-Medicaid, no annual linkage of birth records and newborn metabolic screening files, and no PRAMS. The Kansas State Department of Education (KSDE) and KDHE's Bureau of Health Promotion (BHP) in partnership with local school districts conduct the Youth Risk Behavior Survey. KDHE's BHP conducts the Youth Tobacco Survey. //2012//

/2013/ In 2010, the teen birth rate (ages 15-17) was 19.1 per1,000 females. This was 7.3% lower than 2009 (20.6). However, no statistically significant difference was observed. In 2010 (the most recent year preliminary national data for this age group is available), the birth rate for Kansas young teenagers 15-17 years was higher than the national rate (17.3 per 1,000). Teenage birth rates for ages 15-17 for white non-Hispanic and Hispanic decreased in 2010. The non-Hispanic black teen birth rate in 2010 (35.6) was significantly higher than the rate in 2009 (26.5). Hispanic teens had the highest rate (47.7) in 2010. Overall, there was a slightly decreasing trend observed over the 10 year period, 2001-2010. However, the APC (annual percent change) was not statistically significant.

The suicide rate among Kansas youth ages 15-19 was 13.7 per 100,000. This was 128.3% higher than 2009 (6.0). For the period 1999-2010, using rolling 3 year averages, overall, there was a stable trend in completed suicides by Kansas youth (15-19) during 1999-2001 and 2008-

2010. The APC was not significant.

The mortality rate for children ages <= 14 as a result of unintentional injury--motor vehicle crash was 4.0/100,000 children, a 48.1% increase from 2009 (2.7). Overall, there is a significant decreasing trend observed over the 10 year period, 2001-2010. The APC was significant (-6.89). According to the 2011 Annual Report (2009 Data) of the Kansas State Child Death Review Board (SCDRB), in 2009, there was an 11% reduction in the number of child deaths from 2008. The Unintentional Injury - Motor Vehicle Crash (MVC) category showed a reduction of 25% from 2008. The Board attributes this drop to the Kansas Legislature enacting the booster seat and primary seat belt law for all children under age 17.

There were 689 deaths to children ages 0-24 with 253 of deaths to infants. As seen in previous years, the largest number of deaths were for infants. Based on the proportion of black or African-American children in the Kansas population, black children have proportionately greater numbers of deaths than other races. Black children comprise 9.0% of the States' children but 12.0% of the deaths to children, a slight decrease from 2009 (13.3%). Black infants comprise 10.2% of the States' infants but 13.4% of the deaths to infants, a decrease from 2009 (15.2%). Hispanic children comprise 15.7% of the States' children and 13.9% of the deaths to children. Hispanic infants comprise 19.8% of the States' infants and 7.3% of the deaths to infants. These latter data suggest that there may be a slightly greater risk for Hispanic children as they age.

The rate of asthma hospitalizations has decreased 7.8% from 24.8/10,000 in 2009 to 26.9/10,000 in 2008. The percent of Kansas women (15 through 44) with a birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index (adequate and adequate plus prenatal care) was 79.8% in 2010, significantly higher than the previous year (79.0%).

Medicaid paid for the delivery of 13,159 (32.8%) Kansas live births, a 16.7% increase from 2009 (28.1%). For Medicaid births, 8.8% were low birth weight compared to 6.2% for non-Medicaid births. About two-third (62.4%; n=1,720) of births to non-Hispanic black women were paid by Medicaid. More than one-third (36.0%; n=2,254) of births to Hispanic women were paid by Medicaid, followed by 29.4% (n=8,486) births to non-Hispanic white women were paid by Medicaid. The infant mortality rate was highest for the Medicaid service population (7.3 per 1,000 live births) and lowest for the non-Medicaid population (5.5). Only 61.4% of Kansas Medicaid infants were born to women receiving PNC in the 1st trimester of pregnancy. The eligibility level for pregnant women for Medicaid coverage in Kansas is 150% federal poverty level (FPL). Low-income undocumented women can qualify for Medicaid coverage under the Sixth Omnibus Budget Reduction Act (SOBRA). Both poverty status and undocumented status have been associated with delayed prenatal care.

Although the overall rates for Chlamydia in females aged 15-19 (29.5 cases per 1,000) and females aged 20-44 (11.2 cases per 1,000) have remained stable in Kansas over the last several years, a number of disparities exist for teenage and reproductive women in Kansas. Chlamydia rates are the highest for women aged 15-19 (29.5 cases per 1,000) followed by women aged 20-24 years (33.9 cases per 1,000). Chlamydia rates are two times higher for Hispanic women (19.1 cases per 1,000 women aged 15-19 and 8.7 cases per 1,000 women aged 20-44), and six times higher for non-Hispanic black women (62.5 cases per 1,000 women aged 15-19 and 27.1 cases per 1,000 women aged 20-44) compared to their respective non-Hispanic white peers (10.5 cases per 1,000 women aged 15-19 and 4.4 cases per 1,000 women aged 20-44).

Kansas's Supplemental Nutrition Assistance Program (SNAP) changed its policy in October 2011 to count the income of all members in a household, including illegal immigrants. Between October and November 2,006 children were closed in SNAP. The majority of these children were American citizens of Hispanic descent.

Kansas's Temporary Assistance for Needy Families (TANF) began requiring eligibility staff to

reference an employment verification service (The Work Number) to substantiate income for processing applications, performing a case review, and reviewing interim reports in May of 2011. No significant changes have been observed in the percent of denials or closed cases.

Juvenile crime in Kansas has declined by 30% over the last year. This decline can partially be explained by Kansas Bureau of Investigation following the FBI's decision to no longer collect data on runaways. In 2010, there were 1,413 reports of runaways in Kansas and accounted for 9.1 percent of all juvenile crime reports in that year.

Nearly one in four Kansas children live in households at or below 100% of the Federal Poverty Level (FPL). This is higher than the one out of seven individuals in Kansas households living at or below 100% FPL. In another analysis using the 2000 Decennial Census and the 2006-2010 American Community Survey indicated that high poverty census tracts of more than 30 percent of the population living in poverty increased from 25 census tracts areas in 2000 to 66 census tracts areas in 2010. The 2010 federal poverty level is $22,314 per year for a family of four. Of the 41 newly identified census tract areas, the most changes occurred in the metropolitan counties of Sedgwick (13 census tract areas), Wyandotte (11 census tract areas), and Shawnee (5 census tract areas).

On 1 May 2011, Healthwave (Kansas SCHIP) increased legibility for children from 200% to 238% of 2008 Federal Poverty Level. A number of significant changes were made in Medicaid policies in FY2011 that affect children. Kansas implemented express lane eligibility and allowed for passive renewal of Medicaid insurance for children. Beginning on 1 October 2010, all Medicaid eligible beneficiaries had hospice service limited to 210 days. On 1 July 2010, Kansas eliminated coverage for attendant care services in schools under the Medicaid School Based Services Program. To help prepare for an affordable care act requirement, Kansas Medicaid added concurrent care for children receiving hospice services.

Kansas has the data capacity to support MCH programs including annual linkage of birth and infant death records, access to hospital discharge data, and birth defects reporting system. Kansas has no PRAMS. In 2011 BEPHI and MCH launched a formal effort to annual create linked files of vital events data to other datasets. The latest matching initiative builds on initial linked birth, Medicaid, WIC (Pediatric and Pregnancy Nutrition Surveillance System - PedNSS and PNSS) methodology to probabilistically link de-identified hospital discharge data and Medicaid claims information for 2009 events. Linking 2010 data is scheduled to proceed in the summer of 2012. //2013//

/2014/ KanCare, launched in January 2013, is the Kansas Medicaid program. KanCare is delivering whole-person, integrated care to more than 360,000 consumers across the state. Kansas has contracted with three health plans, or managed care organizations (MCOs), to coordinate health care for nearly all Medicaid beneficiaries. The KanCare health plans are Amerigroup of Kansas, Inc. (Amerigroup), Sunflower State Health Plan (Sunflower), and UnitedHealthcare Community Plan of Kansas (United). The Kansas Department of Health and Environment (KDHE) and the Kansas Department for Aging and Disability Services (KDADS) administer KanCare. KDHE maintains financial management and contract oversight while KDADS administers the Medicaid waiver programs for disability services, mental health and substance abuse, as well as operates the state hospitals and institutions. BFH staff are meeting with the MCOs as necessary to discuss MCH outreach and services, ensuring coordination of the different types of care a consumer receives.

Kansas, along with many national and regional organizations, is exploring options to improve health in communities through increasing collaborative relationships between primary care providers and public health. Successful models of integration share common goals of improving population health, involving the community in defining and addressing needs, relying on strong leadership across disciplines, and sharing data and analysis. KDHE including BFH/MCH kicked off this important conversation in June 2013 with a statewide listening tour which concluded in

August 2013 after six listening sessions held across the state. The tour was designed to bring together individuals to: provide information about potential opportunities in cross-sector collaboration; explore current integrated delivery system examples in Kansas communities; and discuss potential opportunities and perceived challenges. Partner organizations include community hospital administrators, local public health department administrators, mental health providers, private medical providers, and safety net clinic administrators. Dr. Robert Moser, a family physician serving as the State Health Officer and Secretary of KDHE, attended each session to provide comments and rationale for this discussion. Results and feedback have been reviewed and compiled. A summary follows:

Events:
State Summit: June 11 -- Topeka
Regional Listening Sessions:
- June 26 -- Wichita
- July 1 -- Chanute
- July 8 -- Garden City
- July 16 -- Salina
- August 1 -- Colby
- August 6 -- Topeka
- August 19 -- Kansas City

Attendees (286 total):
63 - State or Regional partner organizations
63 - Local Health Departments (representing 42 county health departments)
57 - Hospitals
41 - Clinics, Health Centers
26 - State Health Agency (KDHE)
24 - Academia/Schools
10 - Federal, State or County elected or appointed
2 - Other (not specified) 2

Responses: scale of 1 -- 5

1. At the start of the meeting, where were you (your organization, your practice) on the continuum of Primary Care and Public Health Integration most respondents answered between 3 and 4 (3.4) and the average of all responses was 3.1.
2. At the conclusion of the meeting, where are you (your organization, your practice) on the continuum of Primary Care and Public Health Integration most respondents answered very close to 4 (3.8) and the average of responses was 3.3.

3. When asked "Which of the following benefits of integration would be of value to primary care?" attendees were able to choose any number from a list. Over half of the attendees at every event selected:
- Linking patients to resources
- Reducing costs
- Improving health and wellbeing of patients.
Less frequently selected were:
- Increasing patient satisfaction
- Improving efficiency

4. When asked "Which of the following benefits of integration would be of value to public health?" attendees were able to choose any number from a list. Over half of the attendees at every event selected:
- Improving population health
- Improving sustainability
- Deepening partnerships

Less frequently selected was:
- Cultivate public health supporters

5. What do you see as the #1 benefit for increasing collaboration between primary care and public health? (open-ended question) All responses were assigned to one of the following categories and the frequency of responses is as follows:
79 - Improved health outcomes for all
32 - More effective services that reach more individuals
18 - Collaboration and sustainability
15 - Leverage resources and reduce costs 15

6. What do you see as the #1 barrier for increasing collaboration between primary care and public health? (open-ended question) All responses were assigned to one of the following categories and the frequency of responses is as follows:
46 - Funding, payment streams and policies
42 - Perceived competition, territory
35 - Awareness, understanding of roles, lack of supportive structure
13 - Infrastructure - time and facilities

According to the 2013 KIDS COUNT Data Book released by the Annie E. Casey Foundation, overall, Kansas ranked 16. KIDS COUNT has ranked states annually on overall child well-being using an index of key indicators. The KIDS COUNT index consists of four domains that capture what children need most to thrive: (1) Economic Well-Being, (2) Education, (3) Health and (4) Family and Community.

Although Kansas ranked 8 on the Economic Well-Being domain, the State worsened in all four of the economic well-being indicators. Approximately 19% of children (134,000 children) lived in poor families in 2011, up from 15% in 2005 (100,000 children). A quarter of all children in Kansas (181,000 children) lived in families where no parent had full-time, year-round employment in 2011, up from 22% in 2008 (151,000 children). In 2011, 30% of children (215,000 children) lived in households with a high housing cost burden (i.e., children in households that spend more than 30% of their income on housing), compared with 26% in 2005 (175,000 children). In 2011, 6% of youth were disconnected from both work and school. About 10,000 teens between the ages of 16 and 19 were neither enrolled in school nor working, up from 8,000 teens in 2008 (5%).

Kansas has shown the most improvement in the Education and Health categories. Kansas ranked 11 on the Education domain and 26 in Health domain. From 2009 to 2011, about 44,000 3- and 4-year-olds were not enrolled in preschool, representing more than half (54%) of all children in that age group. This is a slight improvement over 2005-2007, when 57% did not participate in a pre-K program. An alarming 64% of fourth graders in public school were reading below proficient levels in 2011, a slight improvement from 2005, when the figure was 68%. There was greater improvement in eighth-grade math achievement in Kansas. Approximately 59% of public school eighth graders scored below proficient math levels in 2011, compared with 66% in 2005. For the 2009/10 school year, 5,786 high school students (15%) did not graduate on time. However, this is an improvement from 2005/06, when 22% did not graduate in four years. Low birthweight babies represented 7.1% (2,881 babies) of all live births in 2010, a slight improvement from 2005 (7.2%). The percentage of children without health insurance decreased from 8% in 2008 (58,000 children) to 6% in 2011 (46,000 children). In 2010, 253 children and youth ages 1 to 19 died in Kansas in 2010, which translates into a mortality rate of 33 per 100,000 children and teens. The rate declined from 2005, when it was 35 per 100,000. In 2010-2011, 7% of teens ages 12 to 17 had abused or were dependent on alcohol or drugs during the past year, declining from 9% in 2005-2006.

In the Family and Community categories, Kansas ranked 23. The percentage of children in single-parent families rose from 27% in 2005 to 31% in 2011. In 2011, 11% of children in families where the household head lacks a high school diploma, compared to 12% in 2005. During the

period from 2007 through 2011, 7% of children lived in high-poverty areas, a total of 51,000 children. This represents an increase of 37,000 children since 2000, when the rate was 2%. In 2010, there were 3,865 babies born to females ages 15 to 19. That translates into a birth rate of 39 births per 1,000 teens, which represents a decrease from 2000, when the rate was 41 births per 1,000 teens.
Source: Press Release by Kansas Action for Children, June 24, 2013 and 2013 KIDS COUNT Data Book

The Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program is administered in the BFH and the program was formally integrated into the MCH unit as part of the 2012 BFH reorganization. KDHE continued to receive MIECHV annual state formula funds and, in September 2012, was awarded a two-year competitive Development Grant to further expand the program. The Kansas MIECHV program has increased the number of at-risk families with pregnant women and children (0-5) served by Early Head Start, Healthy Families America, and Parents as Teachers evidence-based home visiting programs in Wyandotte County (Kansas City, KS) and in Montgomery, Labette and Cherokee counties (rural southeast KS). Also in Wyandotte County, the Team for Infants Endangered by Substance Abuse (TIES) Program, a promising approach serving pregnant and postpartum women affected by alcohol or other drugs, was implemented. Collectively, over 200 families were served in 2012 and over 275 families were currently enrolled as of June 2013. A new coordinated outreach and referral system, My Family, was established in the three southeast Kansas counties and the Connections Centralized Screening and Referral System in Wyandotte County was expanded. An in-home intervention for mothers identified with depression was initiated in June 2013 in conjunction with the Wyandotte County MIECHV program sites. A cross-program performance management and data system was developed and implemented to collect and report program implementation and outcomes data including over 35 indicators in the six MIECHV benchmark areas. To support effective monitoring of implementation and improvements in practice, a robust continuous quality improvement process has been developed. Rigorous utilization-focused process and impact evaluations are being conducted for the Development Grant and the TIES promising approach program. In addition, Kansas was selected and local sites began participation in the Maternal Infant Home Visiting Program Evaluation (MIHOPE), the national cross-site MIECHV program evaluation.

In prior years, the Newborn Metabolic Screening program had received funding from the Children's Initiative Fund. For state fiscal year 2014, this fund was no longer avialable for our use. After discussion and varying support for the implementation of a minimal fee for the Newborn Screening test, new legislation was passed this past year that allowed for a new fee fund for laboratory and follow-up program expenditures related to screenings. This will allow for expansion and growth of the follow-up program in future years.

Additionally, to build capacity, the Special Health Services (SHS) Section is proposing enhancements to the data management system, currently utilized by SoundBeginnings, the Kansas Newborn Hearing Screening Program (NBHS). Proposed enhancements include development of the Metabolic Newborn Screening (NBS) and Birth Defects (BD) modules, with the potential future addition of the Special Health Care Needs (SHCN) program.

This proposal aligns with the Mission of KDHE and the agency's priorities. This proposal will: allow for more collaborative and coordinated work through use of a shared system for three programs utilizing the birth record, improve the effectiveness and efficiency of follow-up, tracking, and services to the community, and enhance the program's capacity to: 1) identify, collect, and analyze data collected through state mandated NBS and BD reporting; 2) provide better services to our consumers; 3) support future programmatic growth; 4) develop a long-term NBS follow up program and active BD surveillance system; and 5) support collaboration among other KDHE initiatives, such as the Meaningful Use Public Health Reporting activities around surveillance.

The Bureau took note of July 1, 2013, the effective date of several new laws impacting the

agency. Officially, the Division of Health (DOH) became the Division of Public Health (DPH). The change reflects the essence of each program in that division and aligns programs with the ongoing initiative to improve collaboration and coordination between the public health and primary care sectors across Kansas. The Kansas Health Information Technology (KHIT) Act transfers the responsibilities of KHIE, Inc., to KDHE. The purpose of the statute amendment was to sustain the program that facilitates the critical sharing of electronic health records (EHRs) among healthcare organizations and providers throughout Kansas. Because KDHE can conduct the same work without the salary and overhead expenses incurred by KHIE, Inc., this transition is expected to save taxpayers approximately $300,000 annually. As of today, responsibility for the following resides in KDHE's Office of the Secretary: (1) Promulgate, publish and enforce policies related to the electronic sharing of health information in Kansas; (2) Monitor the operations of those organizations that provide health information sharing services in Kansas (3) Provide a means by which an individual may elect to restrict access to his/her electronic health information stored in the exchange. KHIT oversight aligns well with health IT work already being performed at KDHE, such as the Medicaid EHR Incentive program and the disease surveillance applications like BioSense and WebIZ. More about KDHE's HIT initiatives can be found in the agency's 2012 Annual Report at http://www.kdheks.gov/reports/2012_Annual_Report.pdf.

Other actions from the 2013 Legislative session worth highlighting include:
- Communicable Disease (HB 2183) -- This law allows KDHE to develop regulations to protect first responders in the event of accidental exposure to bodily fluids.
- High Security Lab employees (HB 2302) -- This ensures KDHE's high security lab maintains best practices by allowing background checks and drug screenings for certain employees.
- Medicaid (KanCare) Oversight Committee (HB 2025)
- Human Trafficking (SB61) - Addresses treatment and other services for children who are victims of human trafficking between the states and to ensure those children are placed in appropriate facilities pending the need for their testimony at the trial of perpetrators of human trafficking crimes. The legislation establishes crimes, punishments and criminal procedures related to human trafficking. The legislation also establishes the official human trafficking advisory board and creates a new type of child care facility, a "staff secure facility", for housing victims of human trafficking. Regulations for this new type of care facility are to be in effect by January 1, 2014.
//2014//

/2015/ Kansas increased in population from 2,871,238 residents in 2011 to 2,885,905 residents in 2012, a 0.5 percent increase. Geary, Stevens, and Pottawatomie Counties had the largest relative increases in population from 2008 to 2012 with percent changes of 21.9, 13.8, and 13.2 respectively. Elk, Finney, and Wilson counties had the largest relative decreases in population, with changes of 10.7, 9.3 and 6.1 percent respectively.

The population density of Kansas was 35.3 inhabitants per square mile in 2012, a 14.2 percent increase from 30.9 persons per square mile in 1993. For comparison, the population density of the U.S. increased from 69.1 to 88.9 persons per square mile from 1993 to 2012, a 28.7 percent increase. In 2012, 36 of the state's 105 counties had population densities of less than 6.0 persons per square mile. The most sparsely populated counties were Greeley and Wallace, with a density of 1.7 persons per square mile. The most densely populated county was Johnson, with 1,182.8 persons per square mile.

The percent increase in the Kansas total population from 1993-2012 was 14.0 percent, including a 15.4 percent increase for Kansas males and a 12.7 percent increase for Kansas females. Shifts in the Kansas population distribution by age from 1993 to 2012 included a decrease in the 35-44 age group of 12.7 percent. An increase of 46.8 percent in residents 45-54 years of age and 73.8 percent in residents 55-64 reflected the aging of the baby boomers. Furthermore, there were 9.1, 3.1, 16.6, 0.5, 11.3 and 12.0 percent increases in the 0-4, 5-14, 15-24, 25-34, 65-74 and 75 and over agegroups respectively. According to the 2012 Census Bureau estimates, 77.4 percent of Kansans were White non-Hispanic and 5.8

percent were Black non-Hispanic. Hispanics made up 11.0 percent of Kansas' population.

During 2012, there were 40,304 live births to residents of Kansas. This was an increase of 1.7 percent from the 39,628 births reported in 2011. The birth rate increased 1.4 percent, from 13.8 births per 1,000 population in 2011 to 14.0 births per 1,000 population in 2012. In 2012, there were 28,995 births to resident White non-Hispanic mothers, an increase of 2.2 percent from the 28,382 births reported in 2011. The birth rate for White non-Hispanic mothers increased 2.4 percent, from 12.7 births per 1,000 population in 2011 to 13.0 births per 1,000 population in 2012. There were 6,286 births to Hispanic mothers in 2012, a decrease of 0.1 percent from the 6,293 births reported in 2011. The birth rate for His-panic mothers decreased 2.5 percent, from 20.3 births per 1,000 population in 2011 to 19.8 births per 1,000 population in 2012. There were 2,682 births to Black non-Hispanic mothers in 2012, a decrease of 1.0 percent from the 2,708 births reported in 2011. The birth rate for Black non-Hispanic mothers decreased 2.5 percent, from 16.3 births per 1,000 population in 2011 to 15.9 births per 1,000 population in 2012.

Of the 40,304 resident births in 2012, 8.3 percent (3,331) were to mothers under the age of 20; 56.9 percent (22,950) were to mothers 20-29 years of age; 32.8 percent (13,229) were to mothers 30-39 years of age; and 2.0 percent (793) were to mothers aged 40 or over. Of the 28,995 resident births to White non-Hispanic mothers, 1,915 (6.6%) were to mothers under the age of twenty. Of the 2,682 births to Black non-Hispanic mothers, 345 (12.9%) were to mothers under the age of 20. Of the 6,286 births to Hispanic mothers, 894 (14.2%) births were to mothers under the age of 20.

Prenatal care data was provided for 39,871 out of 40,304 (98.9%) live births in 2012. Prenatal care began in the first trimester for 31,457 live births (78.9 percent of live births where prenatal care data was available), in the second trimester for 6,860 live births (17.2%), and in the third trimester for 1,202 live births (3.0%). No prenatal care was indicated for 352 live births (0.9%). White non-Hispanic mothers started prenatal care in the first trimester in 82.7 percent of live births (23,778). Black non-Hispanic mothers started prenatal care in the first trimester in 69.3 percent of live births (1,829). Hispanic mothers started prenatal care in the first trimester in 66.6 percent of live births (4,126).

Of the 40,304 Kansas resident live births in 2012 for which the adequacy of prenatal care utilization (APNCU) category could be determined, 81.9 received adequate or better prenatal care, including 31.3 percent with adequateplus care. About eighteen percent (18.1) received less than adequate prenatal care, including 11.7 percent with inadequate care.

Among singleton Kansas live births, 20.5 percent of mothers gained less than the recommended weight during pregnancy, 31.8 percent gained the recommended weight, and 47.7 percent gained more than the recommended amount.

During 2012, 14,805 (36.7%) of the 40,304 resident live births in Kansas were to unmarried mothers. There were 8,857 (30.5%) out-ofwedlock births to White non-Hispanic mothers; 1,916 (71.4%) to Black non-Hispanic mothers; and 3,306 (52.5%) to Hispanic mothers. The percentage of out-of-wedlock births declined in 2012 for the second year in a row, from 37.3 percent in 2011 to 36.7 percent in 2012. However, out-of-wedlock births were 42.8 percent higher than the 25.7 percent of live births reported in 1993.

Vaginal delivery was the most common final route of delivery for most Kansas resident live births in 2012 (28,132 live births, or 69.8% of all live births for which the final route of delivery was known). Most vaginal deliveries were "spontaneous," meaning no mechanical procedures like forceps or vacuum extraction were required (26,597 deliveries, or 66.0% of

live births for which the final route was stated). Other vaginal deliveries (forceps assisted or vacuum extraction) accounted for 1,535 live births (3.8%). Cesarean deliveries accounted for 12,160 live births (30.2%). White non-Hispanic mothers delivered via cesarean section in 8,888 live births (30.7%), Black non-Hispanic mothers in 905 live births (33.7%), and Hispanic mothers in 1,672 live births (26.6%).

Tobacco use at any time during pregnancy was reported for 5,494 births in 2012, amounting to fourteen (13.7) percent of births for which tobacco usage was reported. Tobacco use was known for 40,212 of the 40,304 births (99.8%) in 2012. Reported tobacco usage was highest in the three months immediately prior to pregnancy (6,456, or 16.1%) and decreased gradually with each trimester: to 5,422, or 13.5 percent in the first trimester; then to 4,781, or 11.9 percent in the second trimester; and finally to 4,624, or 11.5 percent in the third trimester.

It is important to look at all reported pregnancies to analyze fertility. The number of pregnancies is the sum of live births, reported stillbirths, and reported induced abortions. The total number of pregnancies for mothers under 20 years of age in 2012 was 3,823, down 6.6 percent from 4,095 pregnancies in 2011. The pregnancy rate for mothers under 20 years of age in 2012 was 19.7 pregnancies per 1,000 female age-group population, a decline of 5.7 percent from a rate of 20.9 pregnancies per 1,000 female age-group population in 2011. This was the lowest pregnancy rate for this agegroup in the past twenty years (1993-2012), down from a peak of 35.2 pregnancies per 1,000 female age-group population in 1993.

The pregnancy rate for females aged 15-17 years in 2012 was 17.0 per 1,000 female agegroup population. This surpasses the Healthy People 2020 target (FP 8.1) of 36.2 pregnancies among adolescent females aged 15 to 17 years by 2020. The pregnancy rate for females aged 18-19 years in 2012 was 70.8 per 1,000 female agegroup population. This surpasses the Healthy People 2020 target (FP 8.2) of 105.9 pregnancies among females ages 18-19 years by 2020. The birth rate for females aged 15-19 years in 2012 was 34.1 per 1,000 female age group population. The CDC Winnable Battles target for 2015 is 30.3 births per 1,000 females aged 15 to 19 years. To meet this target, birth for females 15-9 would have to decline from 3,303 in 2012 to about 2,935 by 2015.

Reference: Oakley D, Crawford G, Savage C. Kansas Annual Summary of Vital Statistics, 2012. Topeka, KS: Kansas Department of Health and Environment, 2013. http://www.kdheks.gov/hci/annsumm.html

KanCare services began in January 2013 for the approximately 380,000 Kansans who receive medical services through the joint federal-state Medicaid program. Under these Medicaid reforms, no one has lost eligibility and provider rates were not cut. KanCare/Kansas Medicaid held Health Home meetings in March 2014 for a specific group of KanCare members and their families (those with certain chronic conditions, like diabetes, asthma or mental illness). A Health Home is a comprehensive and intense method of care coordination and is a service that will begin under KanCare starting in July 2014. Health Homes integrate and coordinate all services and supports to treat the person across the lifespan. In KanCare, Health Homes will be a partnership between the managed care organizations and the health home partners, which can include many different types of providers, e.g., doctors, clinics, community mental health centers, and community developmental disability organizations. //2015//

B. Agency Capacity

This section addresses the capacity of the Kansas Title V Agency to promote and protect the health of all mothers and children, including CYSHCN. It describes Kansas' capacity to provide essential public health services for pregnant women and infants, children and adolescents, and children with special health care needs.

Kansas has established a vision, mission and goals for maternal and child health through a strategic planning process. Capacity assessment is included in the 5-Year MCH State Needs Assessment, MCH 2015. Through this process, Kansas has identified the priority health issues and desired population health outcomes for mothers and children. A review of the political, economic, and organizational environments for addressing the priority health issues is included in the MCH Services Block Grant application that accompanies the needs assessment. All relevant information is utilized to set strategic directions for the Title V program in terms of identification and implementation of organizational strategies to achieve the desired outcomes for the maternal and child health population.

Also, Kansas uses the ten essential public health services to guide decision-making in all aspects of program operation. For the five year needs assessment, essential services were used as the basis of building logic models and work plans to address priority needs through 2015. Following is an overview of Kansas' Title V capacity in relation to each of the ten essential maternal and child health services.

Essential Service #1. Assess and monitor maternal and child health status to identify and address problems. Kansas uses public health data sets to prepare basic descriptive analyses related to priority health issues. Data from the Prenatal Nutrition Surveillance System (PNSS) and the Pediatric Nutrition Surveillance System (PedNSS) are available through the WIC program database. Data from the Behavior Risk Factor Surveillance System (BRFSS) is readily available and MCH has an opportunity each year to support additional modules on emergent issues in MCH/CYSHCN. Oral health and women's health modules have been funded in recent years. The Youth Risk Behavior Survey (YRBS) is conducted each year by the state department of education in partnership with local school districts. Previously, the data were not considered representative of the youth population due to non-participation of some school districts. Now, through the auspices of the CDC Coordinated School Health Program, the data are representative and useful to the Title V program in tracking youth health behaviors.

Vital statistics data of high quality are available to Title V through an approval process. Since 2005 hospitals submit records electronically to the state agency via a web-based system. The system implements the new NCHS standards. In 2007, MCH first received data from the new system. Any analysis of trend data now takes into consideration the timeframe for conversion to the new system. Entry into prenatal care, adequacy of prenatal care and birth defects reporting are some of the variables that were affected by the conversion. The new system expands the amount of data available and improves the ability of Title V to assess birth/death and birth risk data.

Changes to the Vital Statistics statutes during the 2010 session allow use of the system to survey recent mothers for purposes of maternal health surveillance. MCH is identifying resources to conduct Prenatal Risk Assessment Monitoring System (PRAMS). Local agencies have identified resources to conduct Fetal Infant Mortality Review (FIMR) at the community level.

Other data sets maintained by other bureaus within the department that are used for various analyses include: immunization, cancer registry, child care licensing, STDs, HIV, State laboratory, primary care, farm worker health, trauma registry, as well as BFH program services data systems (WIC, MCH, CYSHCN, Part C, Family Planning, Newborn Screening, Newborn Hearing Screening). Use of these data sets is outlined in relevant sections of this application.

Title V has access to data sets outside the state agency such as Medicaid data (MMIS &

Clearinghouse), hospital discharge data, department of transportation data (motor vehicle accidents), Kansas Bureau of Investigation (intentional injuries), department of social services, education department (school lunch program, school injuries). The annual MCH Block Grant application includes a good representative sample of the types of data in use. The State Systems Development Initiative (SSDI) grant provides a good overview of data quality and data linkage capacity.

BFH has two epidemiology positions. Additional epidemiological support would be beneficial. The epi's serve as data analysts and resource persons for: Kansas' five year needs assessment, KDHE Healthy Kansans 2020, analysis of the National CYSHCN Survey, National Child Health Survey, birth defects data, and numerous ad hoc projects throughout the year. There is not sufficient capacity to conduct analyses of MCH data sets that go beyond descriptive statistics, although there has been some work in this area. BFH epidemiologists and other staff have compared health status measures across populations. The TVIS on the MCHB website is used often as a means of comparing health status measures for Kansas with those of other States.

The State has very limited capacity to generate and analyze primary data to address State and local knowledge gaps although there is some work in this area to generate CYSHCN data -- medical home, youth transition, and financial access. Information is needed beyond that available from the National CYSHCN Survey. Annual surveys are conducted to assess school nursing capacity. WIC conducts periodic family surveys. CYSHCN conducts regular surveys of family satisfaction with services.

Primary and secondary data are analyzed routinely and used in policy and program development across all BFH programs but the quality and consistency of the analyses varies based on staffing and other considerations. MCH grants to local agencies require local needs assessment to determine local priorities although capacity to provide training and technical assistance to the local agencies relating to the priorities is limited. Local agency epidemiological capacity ranges from highly sophisticated, primarily in urban areas, to very unsophisticated. Training of local staff to achieve some level of competence in use of data is ongoing. Training of State agency staff to achieve some basic level of competence across all BFH programs is ongoing as well. For the epidemiologists, specialized epidemiological training has been identified and completed. One such example is epidemiologist training in genetic epidemiology through the Sarah Lawrence College Public Health Genetics/Genomics certificate program.

Essential Service #2. Diagnose and investigate health problems and health hazards affecting women, children, and youth. BFH uses epidemiologic methods to respond to MCH issues and sentinel events. The Title V program engages in collaborative investigations and monitoring of environmental hazards (e.g., State schools for the deaf and blind, juvenile correction facilities, birthing centers) to identify threats to maternal and child health. The MCH epidemiologists participate in cross-bureau activities such as development of policies and procedures for cluster investigations to be observed by all programs.

The Title V program has been unsuccessful in applications to CDC for birth defects surveillance so the Title V program utilizes MCH Block Grant funds for some limited activities in this area. The Title V program continues to pursue federal funds to implement a law passed in the 2004 session giving the State agency statutory authority for birth defects surveillance. A formal request has been sent to CDC requesting on-site technical assistance to assess current efforts and to develop a plan and budget for future development efforts.

During the 2010 session, statutory authority to utilize birth certificate data to survey recent mothers was obtained largely through the efforts of the Blue Ribbon Panel on Infant Mortality. This legislation opens the way for Pregnancy Risk Assessment Monitoring System (PRAMS) and Fetal-Infant Mortality Review (FIMR) efforts in the state. Increasingly, the MCH epidemiologists serve as the State's expert resource for interpretation of data related to MCH issues. The Title V program is regularly consulted on MCH data issues and staffs participate as experts in planning

processes. The agency provides leadership for reviews of fetal, infant, child, and maternal deaths through its work with the Kansas Perinatal Council. Title V serves on the state Child Death Review Board and serves as interface in information sharing for implementing community-based interventions. Through the MCH needs assessment process, Title V uses epidemiologic methods to forecast emerging MCH/CYSHCN threats that can be addressed through planning processes.

Essential Service #3. Inform and educate the public and families about maternal and child health issues. Title V has no health education plan per se and no dedicated health educators. These functions are incorporated into the job duties of all Title V staff. There is no dedicated funding for health education activities, such as for print or media campaigns, although this may change with new priorities of MCH 2015. The CYSHCN program incorporates information and education to the public and to families about medical home, transition and other at specialty clinics as a routine part of its activities. Grants to local agencies and organizations encourage health education activities at the local level with the new focus on prevention/wellness, social determinants, life course perspective and health equity.

Title V engages in population based health information services, providing health information to broad audiences. Title V collaborated with Kansas Action for Children on a statewide media campaign to raise public awareness about the importance of oral health for pregnant women and children. MCH partnered with the March of Dimes on a public health education campaign on the importance of folic acid and also on prematurity. Title V partnered with early childhood programs on dissemination of information about text4baby, with WIC services on breastfeeding promotion. CYSHCN has expanded information resources available to families through the toll-free number and website.

The public information office of KDHE has new capacity and assists programs with public information through news releases, press events, print material development, website development, response to news reporters and related services.

Essential Service #4. Mobilize community partnerships with policy makers, health care providers, families, the general public, and others to identify and solve maternal and child health problems. The Kansas Title V program is strong in this area, responding to community MCH concerns as they arise, regularly communicating with community organizations. Needs assessments and planning activities engage community audiences on state and local needs. The Title V program supports the office of health care information to produce issue- and population-specific reports that are distributed widely in the state. Informal mechanisms are utilized to obtain input into the Title V program on MCH/CYSHCN needs.

The 5-year state needs assessment process is a formal mechanism for obtaining community input into the program. Funding and technical assistance are provided to local providers for services that are determined locally through a community needs assessment process. No additional funding is available for local programs to establish community advisory boards but grants to local health departments and other community organizations encourage liaison with city and county policy makers, school officials, and other local groups. Kansas Title V supports coalition and stakeholder groups primarily through technical assistance, although as in the case of the State Early Childhood Comprehensive Systems (SECCS) grant, funding may also be provided for planning activities. For the implementation phase of SECCS, Title V has maintained both supportive and leadership roles. The SAMHSA LAUNCH initiative builds a local coalition in the Finney county area with a focus on early childhood systems.

Title V has been assigned responsibility for coordinating the Governor's Child Health Advisory Committee (CHAC) charged with developing recommendations relating to immunizations, newborn screening expansion, school health education, and physical fitness/nutrition. The President of the Kansas Chapter of the AAP, heads the group of 18 appointees. CHAC recommendations to the KDHE Secretary translate to policy and program initiatives.

Essential Service #5. Provide leadership for priority setting, planning, and policy development to support community efforts to assure the health of women, children, youth, and their families. Title V assembled a Panel of Experts for the state needs assessment, MCH 2015. Title V plays a major role in development and implementation of the State Early Childhood Comprehensive Systems strategic plan, Bioterrorism planning, Continuity of Operations Planning, H1N1 planning, and planning for the Healthy Kansas 2020 process to determine priorities for the State agency. MCH/CYSHCN routinely lead and/or participate in data-driven decision making and planning activities. The annual and five-year Title V grant application and needs assessment cycle assures a systematic review of progress on objectives. Title V actively promotes the use of scientific knowledge bases in the development, evaluation, and allocation of resources for policies, services, and programs. A project underway for the MCH epidemiologists is production of the MCH Biennial Summary. The national and state performance measures serve as the basis for this report.

In 2009, the Secretary of KDHE convened a Blue Ribbon Panel on Infant Mortality to make recommendations on reducing Kansas' high infant mortality rate (2004-2006 MMWR Vo. 58, Number 17). Title V facilitated this effort. The Panel adopted a set of preliminary recommendations and agenda for the 2010 legislative session. Multiple organizations including March of Dimes and Kansas Action for Children advocated for these measures. The result was passage of amendments to the vital statistics statutes removing barriers to the use of birth certificates for MCH surveillance. Effective July 1, 2010, PRAMS or PRAMS-like surveys of recently delivered women will commence. The law will also facilitate access to data for FIMR projects in Kansas City and Wichita.

Formal advisory structures advise and assist KDHE on MCH/CYSHCN issues: the Kansas MCH Council, the CYSHCN Family and Youth Advisory Councils, and the Integrated Community Systems for CYSHCN grant council. Parents from Families Together, the State Affilliate Organization of Family Voices, participate. MCH/CYSHCN facilitates meetings of these groups throughout the year and solicits input on major issues impacting the health of mothers and children. MCH epidemiologists are available to support the deliberations of the groups.

Other groups convened are the Newborn Screening Advisory Council, the Sound Beginnings Advisory Council (newborn hearing screening), Genetics State Plan group, Nutrition and WIC Advisory Committee, Interagency Coordinating Council for special needs infants and toddlers, and the Family Planning Advisory Committee. Generally groups meet on a quarterly or as needed basis.

Kansas Title V regularly utilizes data available within the department as well as data from other agencies and organizations (state, local and/or national) to inform State MCH health objectives and planning. Recently, early childhood organizations requested MCH epidemiological support in developing the needs assessment for the Kansas application for federal home visiting funds. The annual MCH Block Grant utilizes a systematic process to produce an overview of the health of all mothers and children in the State.

Title V staffs are involved in multiple State-level advisory councils: Governor's Commission on Autism, Kansas Commission on Disability Concerns, Head Start, Kan-be-Healthy, Traumatic Brain Injury, Assistive Technology, and State Hunger Task Force. Routinely, staff partner with other agencies and programs listed in the collaboration section of this application. Title V has a number of formal interagency agreements for collaborative roles such as the agreement for the Individuals with Disabilities Education Act (IDEA) programs of Part C (located in the State health agency) and Part B (located in the State education agency); agreement with the Interagency Coordinating Council, agreement with KU's poison control center to assist in national certification efforts, KHPA/KDHE interagency agreement primarily focusing on Medicaid and SCHIP.

Title V has contributed to the planning processes of several State initiatives. Routinely, Title V staff are consulted by others needing guidance on MCH population services. Over time there

has been a pattern of a gradual shift towards other programs developing independent capacity to address traditional MCH issues. Two examples of this shift are: hiring of a staff person within the Bioterrorism program to address MCH issues and development of programs to address needs of school aged population by chronic disease through the CDC Coordinated School Health grant. Still, Title V serves as the representative of the State health agency at key meetings such as public/legislative hearings relating to MCH/CYSHCN issues.

Essential Service #6. Promote and enforce legal requirements that protect the health and safety of women, children, and youth, and ensure public accountability for their well-being. Title V has not coordinated a formal review of legislative and regulatory adequacy and consistency across all programs serving MCH populations for many years. Instead, there have been a number of reviews of specific legislation or regulations due to emergent policy or program issues.

Title V participated with child care licensing and the Kansas Perinatal Council in a review of outdated birthing center regulations. The group recommended that the State adopt national standards for birthing centers. The regulations have been finalized and are soon to be adopted. This year, newborn screening and birth defects reporting regulations were amended to account for the expansion of newborn screening testing.

Title V staff routinely provide oral and written briefings to policy makers on maternal and child health issues. Examples of these activities include testimony in legislative hearings, issue papers, and briefs. Subject matter may be on a wide range of issues and advisory committee members from university and clinical areas may be called on to participate.

As part of the KDHE budget process, MCH puts forward proposals for legislation, budgetary or regulatory changes each summer. In late summer, proposals are reviewed by an internal executive team and selected as priorities for the State agency. These are incorporated into the budget that is submitted to the Governor in early Fall. A new development for 2010 is a June retreat for directors in the division of health that will be used to select key priorities for the 2011 session.

Title V staff are encouraged to participate in professional organizations and to engage with other State agencies in the development of licensure/certification processes. Title V provides leadership to the development of quality standards of care for women, infants and children in collaboration with other agencies and organizations such as Medicaid's EPSDT Advisory Board, Hearing Screening Guidelines and Vision Screening Guidelines, birthing center regulations. Specialty clinic standards are another standard setting activity. The Title V program has collaborated with Medicaid and SCHIP to incorporate MCH standards and outcomes such as the low birth weight Pregnancy Improvement Project with First Guard, adoption of the CYSHCN definition in managed care contracts, and use of the CYSHCN program for consultation regarding care. MCH promotes Bright Futures as the standard for local MCH agencies throughout the State. MCH/CYSHCN staffs have been involved in policy and legislative initiatives for child passenger safety seats, child care health consultation, regulations relating to community-based and faith-based organizations that serve pregnant women.

MCH conducts on-site reviews of local agencies and allocates staff resources to provide technical assistance. Training and technical assistance are increasingly provided through new technologies such as on-line training (KS-Train) and Go to Meeting. The MCH aid to local program has initiated a risk-based schedule for reviews of local agencies to improve efficiency.

Essential Service #7. Link women, children and youth to health and other community and family services and assure quality systems of care. The Kansas Title V program develops, publicizes and routinely updates its Make a Difference Information Network (MADIN) toll-free line. The program uses the State language assistance contract to obtain interpretation services as well as Spanish-speaking staff. There are plans to use print materials, website and other means to publicize the line. At all points of contact with women, children, and families the Title V program

provides verbal information and/or print materials about publicly funded health services. The Title V program assists localities in developing and disseminating information and promoting awareness about local health services through such activities as community resource and referral lists that are maintained at each local service site. There has been no systematic effort to evaluate the effectiveness and appropriateness of efforts to link women and children with services.

Kansas Title V coordinates with managed care organizations (MCOs) on outreach and home visiting services for hard to reach populations. Innovative methods of providing services such as one stop shopping in Wyandotte County and CYSHCN involvement in Juniper Gardens have been encouraged although there has been no funding for these efforts. Technical assistance is provided at conferences and during on-site visits to local agencies, also to providers in identifying and serving hard-to-reach populations. BFH disseminates information on best practices to local agencies, providers, and health plans across the State.

Tracking systems for universal, high risk and underserved populations have been utilized for newborn metabolic screening and newborn hearing screening follow-up. There has been some use of the birth defects statutes that permit program information and brochures to be mailed to parents of children with high risk conditions noted on the birth certificate.

MCH and CYSHCN link families with services. Partial support for direct services is provided only when not otherwise available. Examples of these services are: child health assessments for school entry through local health departments for uninsured and underinsured children and CYSHCN medical specialty clinic services.

Resources are provided to strengthen the cultural and linguistic competence of providers and to enhance their accessibility and effectiveness. CYSHCN and other staff routinely authorize interpreters at out-patient appointments for families who have English as a second language and also for those who phone for assistance. Interpretation services are available within KDHE through the public information office and the farm worker health program. All staff participate in cultural competency training as well as continuing education opportunities as these are available. The Title V program assures that local health departments and other local agencies interface with culturally representative community groups and prepare outreach materials and media messages targeted to specific groups. When there are vacant positions, there has been an effort within MCH to recruit persons of color and bilingual staff in partnership with Human Resources.

Despite a number of challenges to MCH-Medicaid collaboration due to organization changes, the staffs of Medicaid and MCH continue a close working relationship. The update of the KHPA/KDHE Interagency Agreement (Title V/Title XIX) was finally completed in Fall 2009. Staffs meet with foundations, professional organizations and other potential partners regarding established and new ventures. Interagency agreements are routinely reviewed for effectiveness and appropriateness. Kansas works with the Medicaid agency and its contractors, and public/private providers on enrollment screening procedures, tracking of new enrollee utilization of services, and consumer information.

MCH/CYSHCN provides leadership and resources for a statewide system of case management and coordination of services by convening community providers and health plan administrators to develop model programs and linkages. The Title V program distributes best practices information through conferences, website, and program-specific training. Kansas provides leadership and oversight for systems of risk-appropriate perinatal and children's care and care for CYSHCN including: cross-agency review teams; developing and monitoring risk-appropriate standards of care; and, routine evaluation of systems.

Essential Service #8. Assure the capacity and competency of the public health and personal health work force to effectively address maternal and child health needs. A link between the Title V program, the school of public health, and other professional schools to enhance state and local

analytic capacity has been established. Internship/practicum students have been utilized. In 2009, a summer intern assisted with development of H1N1 and Pregnancy: FAQs that was posted on the KDHE Web site and utilized in training for Healthy Start Home Visitors during the fall regional training by MCH staff. For 2010, the CYSHCN program will have a summer intern for its Integrated Systems grant.

Academic partnerships, joint appointments, adjunct appointments, and sabbatical placements have been considered but not undertaken. Title V staff occasionally guest lecture at professional schools in the State such as the school of social welfare and the public health certificate program. MCH/CYSHCN collaborates with the primary care program to monitor changes in the public health workforce. Resource inventories of facilities and programs are also available through this source. Geographic coverage and availability of services and providers are monitored. The 5-year State needs assessment addresses to some extent workforce issues and workforce gaps as these pertain to overall program planning. Examples of activities to address workforce shortages include: Title V coordination with Medicaid, the Kansas School Nurse Organization, the Kansas Association of Local Health Departments, and others to assure statewide fluoride varnish training for nurses. Another example is coordination with Head Start, Early Head Start and other early childhood providers to adopt a quality curriculum for home visitors in the State and assure consistent training for home visitors across all programs.

Kansas MCH/CYSHCN builds the competency of its workforce through support for continuing professional education for staff. All staffs maintain an Individual Professional Development Plan (IPDP). They participate in orientation and training and in ongoing in-service education. Title V staff are encouraged to log on to mchcom.com archived materials to obtain information on emergent issues. Staffs participate in UIC Leadership Conferences, the annual AMCHP meeting, and other in-state and out-of-state education opportunities. In-service meetings are held each month. Topics and speakers are drawn from suggestions of participants. All supervisors collaborate with State human resources office in establishing job competencies and qualifications. If relevant, Title V includes job qualifications in contract requirements with local agencies as, for instance, in requiring multidisciplinary teams for prenatal care coordination services, or nursing/social work for case managers.

Essential Service #9. Evaluate the effectiveness, accessibility and quality of personal health and population-based maternal and child health services. MCH/CYSHCN evaluates outcomes of the services provided. This occurs through outcomes reporting and routine monitoring of all funded services. For some services such as Family Planning and Healthy Start home visiting, patient satisfaction with services is routinely assessed and there is a feedback loop with providers. For others there is submission of qualitative and quantitative data by local projects that is assessed and included in the grant application and the grant review. Some but not all require submission of an evaluation plan. For others such as the SAMHSA LAUNCH grant, a contract is secured with an outside evaluator in academia. Technical assistance may be provided to local agencies to design, analyze, and interpret their data depending on the program. State data is available to local agencies to facilitate implementation of their community assessments and evaluations through Kansas Information for Communities, Kansas Health Matters, and other data sources.

Consumer satisfaction is routinely assessed for all programs. Various mechanisms are used to assess satisfaction including mail-in postcards provided at the time of the service, phone surveys, family advocacy feedback, and focus groups. The Families Together contract includes a requirement for assessment of client satisfaction with services. Title V performs comparative analyses of programs and services when data are available across different populations or service arrangements such as for family planning or WIC. Special satisfaction surveys and focus groups have been conducted with families participating in CYSHCN and attending CYSHCN clinics. As requested, the results of monitoring and evaluation activities are reported to program managers, policy makers, communities and families/consumers. When there are deficiencies, corrective action is taken.

The Title V program disseminates relevant State and national data on "best practices." MCH plans quality improvement activities and communicates these to local agencies and other groups as needed. Information from evaluation and quality improvement activities does not necessarily translate into programs and practices. Interest groups outside the Title V agency are likely to influence program and policy development. Thus, there is a need for stakeholder involvement in all phases of planning, program development, operation, and evaluation.

The Title V program has not identified a core set of indicators for monitoring outcomes of private providers and is not currently at the table in discussions with insurance agencies, provider plans, and others about the use of MCH outcomes in their own assessment tools. An exception to this is the SECCS plan. MCH is a key partner in development of core indicators for early childhood health.

Essential Service #10. Support research and demonstrations to gain new insights and innovative solutions to maternal and child health related problems. The MCH program disseminates ZIPS, a monthly newsletter which abstracts current MCH research and reports to the readership. Staffs engage in research on a very limited basis. Examples of the types of research undertaken this year include an analysis of risk factors for newborn hearing screening loss to follow-up and loss to screening. An ongoing research project is that in partnership with Medicaid using hospital discharge data showing relative health status and health outcomes of women and children covered by public/private insurance plans. When research is undertaken, it is widely disseminated upon completion. MCH and KDHE are highly regarded for the availability of high quality data regarding many diverse health-related issues. Only very limited staffing resources are available for research, for local demonstration projects and special studies. Much of the research work is of a collaborative nature and done in consultation with other individuals inside and outside the agency.

/2012/ There have no major changes in agency capacity since last year's submission. //2012//

/2013/ There are no major changes in agency capacity since last year's submission. //2013//

/2014/ The Child, Adolescent & School Health Consultant position is vacant at the time of submission. Bureau of Family Health currently has only one of two epidemiology positions filled. Additional epidemiological support continues to be necessary and beneficial. //2014//

/2015/ Title V MCH is a leader in the agency in drawing on key players to inform the direction of the state. Through existing forums, Title V has engaged stakeholders in advocacy for improving the health status of women and children. Title V has provided or assisted in project management for special groups such as the Governor's Child Health Advisory Committee, Early Learning Coordinating Council, State Genetics Plan Stakeholders, Newborn Screening Advisory Council, Families Together, the Blue Ribbon Panel on Infant Mortality, the Kansas Perinatal Quality Collaborative, and the Kansas Breastfeeding Coalition. Title V has provided staffing and resource support to other emergent issues including H1N1, bioterrorism coordinating council, Developmental Disabilities Council, Autism Task Force, Food Security Task Force, State and Local Health Department Accreditation, and Healthy Kansans 2020 process (state health assessment and health improvement plan). The Kansas MCH Council (a merger of the Kansas Perinatal Council and the Kansas AAP Advisory Group) has served as a forum for policy and priority issues relating to the health of Kansas MCH populations. As the Title V agency, we act as the catalyst to build on the work of existing and new partners and provide staff support, technical assistance, and maternal and child health expertise. Kansas is practicing collective impact on many fronts--Kansas Children's Cabinet and Trust Fund, Early Childhood Comprehensive Systems, the Center for Disease Control's Safe, Stable and Nurturing Relationships project, and others. Stakeholders are increasingly understanding how small changes in one part of the system can lead to bigger rewards in other parts of the system. Capacity to promote and protect the health of all mothers and

children, including CSHCN is expanded on here.

The Kansas CoIIN Team list has been submitted for the July 2014 Summit for Region VII. Team members are: Robert Moser, MD, KDHE State Health Officer and Secretary; Aaron Dunkel, KDHE Deputy Secretary; Susan Mosier, MD, KDHE Medicaid Services Director and Interim Director for the Division of Health Care Finance; Rachel Sisson (Berroth), MS, KDHE Family Health Director and Kansas Title V Director; Jamie Kim, MPH, KDHE MCH Epidemiologist; Christy S. Schunn, LSCSW, Kansas Infant Death & SIDS (KIDS) Network, Inc. Executive Director; Dennis M. Cooley, MD, FAAP, Board-certified Pediatrician and Chair of the Kansas Infant Mortality Panel and MCH Council; Diane Daldrup, March of Dimes Greater Kansas Chapter State Director of Programs and Government Affairs. More information and state work plan to come.

AMCHP Compendium Project 2014-2015--Forging a Comprehensive Initiative to Improve Birth Outcomes and Reduce Infant Mortality: The Bureau of Family Health, in partnership with the March of Dimes and Association of Maternal & Child Health Programs (AMCHP), launched a national-state-local initiative in the Southeast Public Health Region aimed at improving the health of Kansas mothers and infants. More than 50 partners representing local and state public health departments, managed care organizations/KanCare, hospitals, primary care, Extension, and early childhood attended the working meeting. The areas of focus include access to quality care and services, social determinants of health, enhanced education and training, sustainability and accountability, and vulnerable populations. This work involves inventorying MCH programs/services (asset mapping) and aligns well with other public health efforts including: Primary Care-Public Health Integration, Healthy Kansans 2020, reducing infant mortality/improving birth outcomes, and other MCH activities. The project centers on the July 2012 compendium published by AMCHP. This initiative will be rolled out in the other five public health regions over the next year and involves: assessing current initiatives, identifying assets as well as service gaps, and developing recommendations/community action plan to address needs. AMCHP plans to complete an issue brief on this project and possibly highlight it at the 2015 AMCHP Conference. KDHE plans to debrief the pilot (southeast region) in the coming weeks, discuss changes/improvements to the project and timeline for rollout in the other five public health regions. State Extension and Medicaid as well as MCOs are committed to being present and participating in all regional projects.

KDHE Quality Improvement Efforts/Accreditation: At the state health department, the last year and coming year will be focused on renewing a culture of quality improvement (QI) across the state's health and environment infrastructure. KDHE has always worked to provide the highest quality of services to Kansans, but the agency is taking that a step further by gathering more meaningful baseline data and using standardized QI tools to help us better measure the performance of our programs. The agency submitted an application for accreditation to the Public Health Accreditation Board in May 2014. KDHE remains diligent in aligning its program activities with the agency's strategic priorities to achieve the most effective and efficient services for the state. Kansas' public health system -- including county health departments, clinics, hospitals, behavioral health centers, emergency management, etc. -- is committed to finding areas for continual improvement and working together to achieve success in the three core roles of public health - assessment, policy development and assurance. The agency implemented several new efficiencies during the second half of 2013, such as the online application for child care facilities. This supports small business operation and results in available child care for families. The online application features the option for child care providers to enroll with the Department for Children and Families to serve families receiving child care subsidy, eliminating the need to submit separate paper applications to each agency.

State Health Assessment/Health Improvement Plan (Healthy Kansans 2020 - HK2020): Family Health/MCH staff along with staff from all three divisions within the agency

(Division of Public Health, Division of Environment and Division of Health Care Finance)--as well as our health system partners--have participated in the HK2020 process, the state health planning process to identify priority actions for improving the health status of Kansans. The process is designed to identify and address objectives from Healthy People 2020 pertinent to Kansas and to support the agency's preparation for public health accreditation. This is a highly participatory strategic planning process emphasizing multi-sector collaboration to address selected priorities. In 2013, the HK2020 steering committee released the framework, outlining the three common themes and 11 priority strategies of the state health improvement plan. The plan, which was released in May 2014, provides organizations and agencies across the state a common set of priorities from which to work to improve the health of Kansans by 2020. The process addressed services of the health system as well as the role of both the individual and the community in improving population health. Themes and priorities include: Healthy Living -- Promote Physical Activity, Healthy Eating, Health & Wellness Programs, Tobacco Use Prevention, Supports for Social & Emotional Development of Children/Families; Healthy Communities -- Policies Promoting Healthy Food Choices, Making the Default Choice the Healthy Choice, Access to Clean and Safe Environments; Access to Services -- Address the Root Cause of Poor Health (food insecurity, homelessness, low education, income and health literacy), Manage Population Health through Health IT (electronic health records).

Promote Integration of Public Health and Primary Care Systems: The summer 2013 regional listening sessions with service providers to discuss the joint role of public health and primary care in improving health outcomes (titled "Impacting Population Health: A Statewide Conversation") highlighted successful partnerships and initiated discussion around the opportunities for public health and primary care. Many Kansas communities have since identified innovative strategies for collaboration. Examples of public health and primary care integration include facility-use agreements and sharing responsibility for community wellness programs. A second statewide listening tour is underway and will be followed by additional meetings, webinars and discussion sessions in conjunction with other events for public health partners through 2015 to explore current initiatives and opportunities to link public health and primary care service delivery in order to achieve better MCH health outcomes. The newly formed Center for Population Health within the Bureau of Community Health Systems is identifying opportunities for collaboration, activity planning, and opportunity exploration.

Workforce Development: An initiative to support incoming and advancing public health professionals is being led by the Bureau of Community Healthy Systems Local Public Health Program to lead the workforce assessment and development initiatives through leadership and collaboration with the Public Health Workforce Development Coordinating Council. There are plans to develop and deliver content to further knowledge and understanding related to MCH best practices, Core Public Health Functions, Essential Services, and PHAB Standards and Measures to entry-level and advancing public health professionals and governing bodies.

Becoming a Mom (BAM)/Comenzando bien(r) Programming in Kansas as of June 2014 (community collaboratives): The March of Dimes prenatal education curriculum was developed in 1998 (copyright 1998, 2011) by the March of Dimes Foundation in partnership with the National Alliance for Hispanic Health and the National Coalition of Hispanic Health and Human Services. It began as two separate curricula -- the Pregnancy Workshop - an English language curriculum for pregnant women and Comenzando bien -- a bi-lingual curriculum for Hispanic women. In 2010, the March of Dimes Kansas Chapter began development of community collaboratives bringing prenatal education and clinical prenatal care together to create the comprehensive Becoming a Mom program. There are currently four established sites with four new replication sites planned for 2014. To date, the March of Dimes financial Investment to develop community collaboratives, implement BAM and to develop a comprehensive evaluation system is $430,124. The Kansas

Department of Health & Environment has pledged $100,760 of Title V funding to launch two new sites in 2014. BAM partnerships have formed with the Kansas Department of Health and Environment, University of Kansas School of Medicine-Wichita, Wichita State University, county health departments, federally qualified health centers, private obstetric practices and hospitals serving women with demonstrated high birth disparities. Program evaluation tools were developed in partnership with the University of Kansas and Wichita State University and refined for improved outcome measurement in summer 2013. Preliminary birth outcome data shows statistically significant improvements including fewer preterm births and fewer low-birth weight babies. Sites are reporting increases in breastfeeding initiation rates and lowered infant mortality rates. The KDHE Family Health staff, Title V Director, and MCH staff have worked closely with the March of Dimes to plan for and launch replication sites.

The Title V Director is a member of the Kansas Perinatal Quality Collaborative (KPQC) Executive Committee as the state health department representative along with reps from hospitals, March of Dimes, higher education, Kansas Infant Death and SIDS Network, and others. The MCH perinatal consultant is a content expert, contributor, and backup. The KDHE Vital Statistics staff also contributes data and attends meetings as necessary. The Executive Committee continued work started by the Leadership Team in 2012 in response to the Team selecting the first QI project: exclusive breastfeeding. The first KPQC Executive Committee meeting was in January and included presentations from state breastfeeding experts, including WIC and Kansas Breastfeeding Coalition, for the KPQC increasing exclusive breastfeeding QI pilot project. Discussions began with REDCap representatives from KU Medical Center for the KPQC QI projects database. As of April 2014, database construction with REDCap at KU Center for Public Partnerships and Research was underway. The QI pilot project roll out meeting is set for June 6 at Children's Mercy Hospital. Upcoming work includes: Submission and approval of IRB application, construction of a database, development of collaborative quality improvement (CQI) pilot projects and teams from state perinatal QI priorities, assembly of stakeholders for statewide rollout in the fall of CQI projects with educational tool kits and resources from pilot project best practices; development of KPQC logo/branding and website. //2015//

C. Organizational Structure

The Secretary of the Kansas Department of Health and Environment (KDHE) is appointed by the Governor and serves on the Governor's Cabinet. The Secretary reports directly to the Governor. Previously four division diectors reported to the Secretary. In 2005, the four divisions were consolidated into two: Health and Environment. Health encompasses vital statistics and Environment now includes the state laboratory. The Director of Health, Jason Eberhart-Phillips, serves as the State Health Officer a position he has held since February of 2009. His background in chronic disease, epidemiology, and local health department management makes him uniquely qualified to serve in this role.

The Division of Health has eleven bureaus: Disease Control and Prevention (infectious disease); Bureau of Environmental Health (lead screening and abatement, radon, environmental tracking); Bureau of Family Health (maternal and child health); Bureau of Child Care Licensing and Health Facilities (child care & hospital regulation, credentialing); Bureau of Local and Rural Health (primary care, farmworker health); Bureau of Health Promotion (chronic disease); Bureau of Oral Health; Bureau of Public Health Preparedness; Bureau of Surveillance and Epidemiology; Bureau of Public Health Informatics; and the Bureau of Minority Health.

The Bureau of Family Health (BFH) administers the $4.7M MCH Services Block Grant. BFH has four sections: Nutrition and WIC Services; Children's Developmental Services, Children and Families Services(MCH); and Children and Youth with Special Health Care Needs (CYSHCN). The organization charts for the agency, the BFH and the four sections are attached as PDF files.

Also, refer to the website at www.kdheks.gov/bcyf.

Within the Bureau there are a number of cross-cutting initiatives such as nutrition, breastfeeding, oral health and epidemiology. The Bureau has two epidemiologists that serve as consultants to all programs. They interface with epidemiological work done in other Bureaus inside the agency and with other organizations and efforts in the state. One epidemiologist serves as the State Systems Development Initiative project coordinator. Both epidemiologists coordinate all data analyses for the MCH/CSHCN needs assessment with an outside contractor. Both assist programs with assessments and evaluations, conduct research, and address epidemiologic needs of the BFH. Each of the Sections is attempting to build data capacity through staff training and education and the rewriting of job descriptions to require data skills for new hires.

The Children & Families Section is responsible for: 1) Systems development activities for perinatal systems of care including coordination with Perinatal Association of Kansas; 2) Systems development for child, school and adolescent health care, in partnership with the Kansas Chapter of the American Academy of Pediatrics, Kansas School Nurse Association and others; 3) Maternal and Child Health grants to assist local communities to improve health outcomes for pregnant women and infants and for children and adolescents; 4) Women's Health Care and Family Planning - Systems of care and grants to communities to support the health of women in their reproductive years; 5) Other grants targeted to specific populations and needs - school nurse/public health nurse collaboration.

Children and Youth with Special Health Care Needs assumes the following responsibilities: 1) Systems development activities - promotes the functional skills of young persons in Kansas who have a disability or chronic disease by providing or supporting a system of specialty care for children and families including specialized services and service coordination, quality assurance, and community field offices; 2) Make a Difference Information Network (MADIN) - Assists children and adults including those with disabilities, their families and service providers to access information and obtain appropriate resources. MADIN serves as the MCH toll-free line; 3) State implementation grant for Integrated Community Systems for CSHCN; 4) Newborn Metabolic Screening - Assures identification and early intervention for infants with metabolic disorders.

The Children's Developmental Services Section includes the following programs: 1) Infant-Toddler Services (Part C of IDEA) - Promotes the early identification of developmental delay and disorders through child find, services coordination (case management), resource referral and development, and direct service provision for eligible infants and toddlers and their families; 2) Newborn Hearing Screening - Assures early identification of significant hearing loss in newborn infants including a hearing aid loaner program for young children; 3) Interagency coordinating Council - advisory committee to Part C of IDEA. Members are parents of children with special needs, legislators, early intervention service providers, state agencies, and community members. http://www.kansasicc.org/

The Nutrition and WIC Services Section includes the following programs: 1) Nutrition Services - Improves the health and nutritional well being of Kansans through access to quality nutrition intervention services including educational materials, consultation services, program coordination and referrals; 2) the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) - Provides nutrition education, breast-feeding promotion and support, substance abuse education, nutritious supplemental foods, and integration with and referral to other health and social services; 3) Breastfeeding -- Peer Education Program - small grants to local agencies to assist with peer-to-peer education. This unit also supports the State Breastfeeding Coalition.

The State health agency is responsible for the administration (or supervision of the administration) of programs carried out with allotments under Title V [Section 509(b)]. When funds are allocated to other programs outside the BFH, the Bureau maintains legal contracts for the use of the funds, or in the case of funds allocated to other programs within the KDHE MOUs clarify the nature of the work that is done in support of the MCH priorities.

Official and dated organizational charts that include all elements of the Title V Program and how it fits within the state agency, clearly depicted, are on file in the State Human Resources office and are available in the attachment.

/2012/ In January of 2011, Robert Moser MD was appointed by the new Governor to serve as both the Secretary of KDHE and the Director of Health. Dr. Moser graduated from the University of Kansas School of Medicine and served four years in a medically underserved rural area of the state after his residency. He then worked for 22 years as a family physician in a small western Kansas town in Greeley County.

Dr. Moser is Board Certified in Family Practice, a Fellow of the American Academy of Family Physicians, and holds Certificates of Added Qualifications from the American Board of Family Physicians in Sports Medicine and previously in Geriatrics. He is past President of the Kansas Academy of Family Physicians. Other service includes: Executive Board of Directors for the Kansas Practice-Based Research Network; senior delegate for KAFP to the AAFP congress on delegates; rural health committee for AAFP; Commission on Government Advocacy; AAFP liaison to the American College of Obstetrics and Gynecology Committee on Professional Liability. Dr. Moser is on the American Hospital Association Committee for Small and Rural Hospitals; special assistant to the Executive Vice Chancellor, University of Kansas School of Medicine; Chairman for the coordinating committee of the Kansas Primary Care Collaborative.

Dr. Moser will head the Executive Reorganization Order (ERO 38) merger of two state agencies: KDHE (State MCH Agency) with the Kansas Health Policy Authority (State Medicaid Agency). Officially this merger will take place July 1, 2011. Some preliminary work has been accomplished in merging the agencies with twelve individuals moving to Curtis building from Landon. Also, contractors are being interviewed who will guide key agency staff through strategic planning relating to the merger. //2012//

/2013/ An Executive Reorganization No. 41 which consolidates the financing arm of Medicaid as the third division, (Division of Health Care Finance) within the Kansas Department of Health and Environment. The reorganization renames the Department on Aging as the Department for Aging and Disability Services and consolidates all disability waiver and mental health services from the Department of Social and Rehabilitation Services into the Department for Aging and Disability Services. The reorganization renames the Department of Social and Rehabilitation Services as the Department for Children and Families.

Within the agency (KDHE), internal reorganization that includes merging the Bureau of Family Health and the Bureau of Child Care and Health Facilities takes effect July 1, 2012. Details of the process are fluid. The Acting Bureau Director of Child Care and Health Facilities, Rachel Berroth, will be the new Bureau Director. David Thomason, Acting Director of the Bureau of Family Health will be the new Deputy Bureau Director. An updated organizational chart is not available at this time. //2013//

/2014/ Effective July 22, 2012, in order to increase efficiencies and to improve communication, the Bureau of Family Health (BFH) was reorganized as listed below.

Significant changes within BFH include:

• Sound Beginnings Newborn Hearing Screening moved from the Children's Developmental Services Section to Children & Youth with Special Heath Care Needs Section to better support work between Newborn Screening and Newborn Hearing Screening.
• The Children & Families and Children's Development Services Sections merged, resulting in the Children & Families Section led by Sabra Shirrell.
• The Home Visiting Section staffed by Debbie Richardson merged with the Maternal and Child Health Unit in the new Children & Families Section.

The Bureau consists of six sections, three resulting from the merge with Child Care Licensing and three existing in the Bureau of Family Health.
• Administration & Policy (Mary Murphy, Director): Compliance & Regulation Development, Child Care Licensing Admin Professionals, Open Records/Policy
• Children & Families (Sabra Shirrell, Director): Infant-Toddler Services/Part C, Maternal and Child Health/Home Visiting/MIECHV, Reproductive Health, State Interagency Coordinating Council
• Special Health Services (Heather Smith, Director): Special Health Care Needs, Newborn Screening, Newborn Hearing Screening
• Child Placing Agency & Residential Programs (Daric Smith, Director) (24-hour residential care)
• Early Care & Youth Programs (Lori Steelman, Director) (out of home day/child care)
• Nutrition & WIC (David Thomason, Director)

Prior to the 2012 reorganization, the Maternal and Child Health Unit did not have a director/manager. This created issues with communication, oversight, and program integrity/performance. After the MIECHV Program was merged with the MCH Program, Debbie Richardson was named the MCH Unit manager, and this change has brought immense value to the programs: focus on integration, coordination, and quality has resulted. Strategic planning is in process, and several programs and processes are being reviewed including the MCH grant award monitoring and universal home visiting program. Debbie oversees the MCH unit staff of four as well as the MIECHV grant.

The updated organizational chart is provided as an attachment to this section. //2014//

/2015/ Dr. Robert Moser continues as the Secretary of KDHE, appointed by the Governor, and oversees three divisions: Public Health, Health Care Finance, and Environment. KDHE's Division of Public Health has a Center for Performance Management and seven bureaus: Bureau of Disease Control and Prevention (infectious disease); Bureau of Environmental Health (lead screening and abatement, radon, environmental tracking); Bureau of Family Health (maternal and child health, infant-toddler services, reproductive health, child care licensing); Bureau of Community Health Systems (local and rural health primary care, farmworker health); Bureau of Health Promotion (chronic disease); Bureau of Oral Health; and the Bureau of Epidemiology and Public Health Informatics (surveillance and epidemiology).

The Bureau of Family Health (BFH) consists of the same six sections as reported last year. The mission of (BFH) is to "provide leadership to enhance the health of Kansas women and children through partnerships with families and communities." The BFH has three goals: (1) Improve access to comprehensive health, developmental and nutritional services for women and children including children with special health care needs; (2) Improve the health of women and children in the State through prevention/wellness activities, a focus on social determinants of health, adopting a life-course perspective and addressing health equity; and (3) Strengthen Kansas' maternal and child health infrastructure and systems to eliminate barriers to care and to reduce health disparities.

The Maternal & Child Health Unit and Title V staff remain in the Children & Families Section; other grants and initiatives overseen by Unit staff include the Early Childhood Comprehensive Systems grant, the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, and Project LAUNCH. The Children & Families Section Director, Sabra Shirrell, resigned from KDHE in March 2014; the position remains vacant but recruitment is underway.A program analyst position remains vacant in the MCH Unit as well as one of the two epidemiologist positions.

In response to Sabra's resignation, the Bureau of Family Health identified another opportunity to align programming and improve services for children and families. The

Infant-Toddler Services Program (Part C/tiny k) was transferred from Children & Families to the Special Health Services Section to increase coordination and support shared resources, goals, and data. The SHS Section now includes the following programs: Special Health Care Needs, Newborn Metabolic Screening, Sound Beginnings Newborn Hearing Screening, and Infant-Toddler Services (Part C). Children & Families now includes Reproductive Health and Maternal & Child Health programs.

The updated organizational chart is provided as an attachment to this section. //2015//

D. Other MCH Capacity

The Bureau of Family Health (BFH) has 57.5 full-time equivalent (FTEs) positions. Four (4) FTEs including 2 epidemiologists are located in administration. CYSHCN has 11.5 FTEs plus 4 Newborn Metabolic screening. This includes three RNs. Children & Families Section has 11 FTEs including 5 RNs. Children's Developmental Services has 8 FTEs in Part C and 4 in Newborn Hearing Screening. This includes one audiologist. There are a total of 15 FTEs in Nutrition and WIC including 5 nutritionists. None of these positions are out-stationed in local or regional offices.

MCH Block Grant funds provide salaries for 22.5 FTEs or 40% of the staffing in the Bureau. This breaks out to 4.0 FTEs in Administration, 9.5 FTEs in CSHCN, 6.0 FTEs in C&F Section, 2.0 in CDS, and 1.0 in WIC.

Since 2000, Linda Kenney has served as Director of the bureau and Kansas Title V Director. From 1989-2000 she served as Director of the Children and Families Section in the Bureau. She served briefly as director of the state breast and cervical cancer screening program and director of a state mental hospital-community transition project, case management supervisor for a community disability organization, and director of a local family planning clinic. She has served on the Board of the Kansas Public Health Association (KPHA), and on a number of state and federal advisory groups relating to maternal and child health. She holds an MPH degree in Health Services Administration from the University of Pittsburgh, Pennsylvania and a bachelor's degree from Indiana University. In addition to the four Section Directors, three other staff report to her including the two epidemiologists. /2012/ The MCH/BFH Director retired in June 2011 after serving 25 years in state service. The position is vacant at the time of submission and a recruitment effrort is underway. The CYSHCN Director is serving as Acting MCH Director until a replacement is hired. //2012//

Marc Shiff serves as the State CYSHCN Director. He has a Master's of Public Administration degree from the University of Texas at Dallas with concentrations in Public Health and Resource Management. His Bachelor of Science degree in Management and Social Science is also from the University of Texas at Dallas. Prior to his current position, he served as Director of Operations and Services for the KDHE Bureau of Disease Control and Prevention and as Programs Manager for the University of Kansas Medical Center, Kansas City, providing medical, nursing, and allied health continuing education oversight. He was appointed to the Governor's Commission on Autism Task Force, and is a member of the Kansas Department of Social and Rehabilitation Services Traumatic Brain Injury advisory board, Kansas Developmental Disabilities Council, Kansas Families Together Advisory Council, and past State Co-Chair of the Kansas Community Planning Group. Shiff was selected to particpate in the MCH Leadership Development program. Fifteen CYSHCN/NBS Topeka staff report to him and he provides CYSHCN program support and guidance to 7 field contractor staff in Kansas City and Wichita. /2013/ Shiff is Region VII AMCHP Director and Chair of the AMCHP Governance Committee. //2013//

Ileen Meyer is a professional registered nurse with experience in services to the pediatric and young adult populations during her 35 year career in public health. She holds a Master of Science degree in Counseling Education from Emporia State University. She has extensive experience working with adolescent health and education issues. She joined KDHE as the

Director of Children & Families Section in 2000. She is involved with the Kansas Chapter of the American Academy of Pediatrics and its specialty subcommittees, Kansas Perinatal Council, Kansas Suicide Prevention Steering Committee, Early Childhood Stakeholders Advisory Committee, Head Start Collaborative Stakeholders, Kansas Safe Kids Coalition, Kansas Action for Children, Kansas Fatherhood Coalition, and Kansas Works Interagency Coordinating Council. Meyer manages a staff of 10 FTEs (5 nurses, 2 program planning and evaluation, 1 data entry and 2 clerical). /2013/ The Section Director of the Children and Families section retired in December 2011. The position is vacant at the time of this writing. //2013//

The Section Director of the Children's Developmental Services section retired in April 2010 after serving 10 years in her position. The position is vacant at the time of this writing and a recruitment effort is underway. /2012/ In June of 2010, Sabra Shirrell was hired to fill this Section Director position. Sabra has a BS degree in Family and Child Development, Community Services from Kansas State University. She has a Masters degree in Early Childhood and also certifications in Early Childhood and Early Childhood Special Education. Prior to assuming her current position, Sabra worked with the Part C of IDEA program in KDHE as a health consultant. She worked as the coordinator of Successful Connections in Shawnee County through Southeast Kansas Education Service Center serving as staff to the local interagency coordinating council among other duties. She has worked as an early childhood special education teacher, and Director of Children's Developmental Services at TARC, the Part C network in Shawnee County. //2012// /2014/ Since July 2012, Sabra has served as the Director of Children & Families Section. The Section includes Infant-Toddler Services/Part C, Maternal and Child Health/Home Visiting, Reproductive Health, and State Interagency Coordinating Council. //2014//

David Thomason is the Director of Nutrition and WIC services. He has served in that capacity since 1998. From 1989 to 1998, he managed fiscal services and reimbursement in the Kansas Medicaid Program. David holds a Master's degree in Public Administration from the University of Kansas and a Bachelor of Science degree in Human Service Agency Management from Missouri Valley College. Thomason has completed the Kansas Public Health Certificate Program. He has served as President of National Association of WIC Directors (NAWD). Thomason manages a staff of 15 FTEs (5 nutritionists, 1 RN, 2 information systems, 4 program analysts, 3 clerical). BFH staffs have been appointed to a number of Governor's Initiatives: State Hunger Team, Blue Ribbon Task Force on Immunization, Bioterrorism Coordinating Council, and State Developmental Disabilities Council. /2013/ Thomason is the Acting Director of the Bureau of Family Health and Director of Nutrition and WIC Services. //2013//

Other staff holds national offices: Sandy Perkins, WIC Nutritionist, is director of Association of State and Territorial Nutrition Directors; Jane Stueve is President of National Association of State School Nurse Consultants.

The only change to leadership in the BFH (the CDS Director) has been noted above.

The CYSHCN Family Advisory Council is comprised of parents and caregivers of children and youth with special health care needs. Efforts have been made to select families that represent geographical areas of the state, ethnic populations, and health categories supported by the state's training and information center for parents, Families Together Inc. The CYSHCN Family Advisory members are regarded as expert consumers as well as partners and their opinions are sought and incorporated on a variety of issues. Examples include the evaluation and implementation of the 5 year needs assessment, how to best disseminate/update information to families, and input on the design of the toll free information line and web-based companion. Family Advisory Council meetings occur in-person and via teleconferences throughout the year to maximize family's engagement.

The CYSHCN - HRSA D-70 Integrated Community Systems grant "Systems in Sinc" Advisory Council links families and youth with special health care needs with information and services for YSHCN. As members of the Advisory Council, parents of youth with special health care needs

are able to provide feedback and input on project activities to ensure that identified objectives are met. Consumers are the central focus of these efforts. Parents are also represented on the Quality Improvement team that will meet in Washington, D.C. in June 2010 to ensure parent participation and involvement on all levels of the grant project. Family members participated in the 8 regional town hall meetings and provided feedback and input on a variety of topics related to transition and health for youth with special health care needs. A Youth Advisory Council is in development to ensure youth participation and input is central to the project. Parents of our youth advisory members are provided with trainings or opportunities to share information and discuss important issues and topics related to their youth's transition and development.

/2014/ Changes to leadership in the BFH have occurred since last submission. David Thomason, previously Acting BFH/MCH Director, returned full time to his position as the WIC and Nutrition Services Director in July 2012 and Rachel Berroth has served as the Bureau of Family Health Director and Kansas Title V Director since that time. Her appointment was the agency's response to Kansas Executive Reorganization Order (ERO) 41 which merged programs remaining in the Division of Health Bureau Rachel was directing at the time (Child Care and Health Facilities) with Family Health. She has 13 years of experience managing statewide programs including Division of Public Health programs such as health occupations credentialing and human care regulation (hospitals and medical, child care, foster care). Prior to serving as Director of Family Health, she served as a Child Care Licensing Administrator and Director for six years and briefly served as the Program Analyst for the Newborn Hearing Screening Program. Rachel serves as a Board member for the Mother & Child Coalition of Greater Kansas City and Kansas Child Care Training Opportunities. She is a member of the Blue Ribbon Panel on Infant Mortality, Kansas Perinatal Quality Collaborative Leadership Team, and serves on a number of state advisory councils relating to maternal and child health and early childhood. She holds a Master's degree in Early Childhood Education and Bachelor's degree in Family Studies and Human Services from Kansas State University. Rachel manages a Bureau staff of 106.6 FTE. Direct reports include six Section Directors and an administrative professional.

Effective February 2013 Heather Smith was named CSHCN Director and Acting Director of the Special Health Services. She was appointed permanently in June 2013. Heather oversees a staff of 12 FTE's. From 2009 to 2013, she served as a Project Coordinator and Health Planning Consultant within the Kansas Children and Youth with Special Health Care Needs program. Prior to that, she worked as the Director of Children's Services for Children's Miracle Network in Springfield, MO. Heather has a Master's degree in Public Health and a Bachelor's in Child and Family Development, both from Missouri State University. In 2011, she was accepted to the Kansas Public Health Leadership Institute and completed that program in 2012. She serves as the Secretary of Health's designee on the Kansas Commission for Disability Concerns and a state representative on the Kansas Council for Developmental Disabilities.

Deborah L. (Debbie) Richardson, Ph.D., joined the KDHE Bureau of Family Health in February 2011 as the Program Manager of the Kansas Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant. In November 2012, she was also appointed as the Maternal and Child Health (MCH) Unit manager which includes supervising three MCH program consultants and one administrative assistant. Debbie oversees both the MIECHV and MCH programs. Prior to this, she served 10 years (2001-2011) as a parenting and child development specialist with the Oklahoma Cooperative Extension Service and Department of Human Development & Family Science at Oklahoma State University where she administered multiple grants and contracts, home visitation program sites serving families with children prenatal to five years, training and technical assistance for county Extension staff and other agencies, and program evaluation activities. Other previous positions include serving as a Senior Planner at the Oklahoma Commission on Children and Youth (1999-2001), as Executive Director of the Oklahoma Chapter of Prevent Child Abuse America (1990-1999), as well as a coordinator of community-based programs for low income mothers and pregnant and parenting teens and a youth and families services counselor (1984-1990). Dr. Richardson holds a Bachelor's degree in Psychology (1982), a Master of Science degree in Community Counseling (1984), and a Ph.D. specializing in Human

Development and Family Science (2009), all from Oklahoma State University. //2014//

/2015/ /2015/ Since last application, Jena Callen-Scholz and Kayzy Bigler joined the Special Health Services Section.

Jena Callen-Scholz was hired by the Bureau of Family Health in February 2014 as the Newborn Screening Educator. Her primary role consists of implementing the Critical Congenital Heart Defect (CCHD) screening program in all birthing facilities and midwives in the state of Kansas. She also will be preforming education and training regarding the newborn blood spot collection procedure and completing follow up recommendations for all newborns in Kansas. Jena has a BS degree in Family life and Community Service from Kansas State University. Prior to her current position, Jena worked as a Medical Investigator with the Bureau of Epidemiology and Public Health Informatics where she provided follow up and investigation on all vaccine preventable diseases reported in the state of Kansas.

Mrs. Bigler joined the Special Health Care Needs (SHCN) team in December 2013 as the new SHCN Program Manager. She is primarily responsible for overseeing program activities, family and youth engagement opportunities within the Bureau of Family Health, care coordination development and assisting with the SHCN Strategic Plan. Mrs. Bigler previously worked as a Parent Information Specialist and a Parent to Parent Coordinator. She worked closely with the State SHCN program as the liaison for the organization. One role as the liaison for the KS-SHCN program was to help rebuild the Special Health Service Family Advisory Council. As the Parent-to-Parent Coordinator for the state she rebuilt the Parent-to-Parent program developing policies, procedures, trainings, tools and collaborated in the building of an application tool; so matches could be made in a timely manner. Past experience includes co-ownership of a business for many years doing private Interactive Metronome Therapy. Prior to that Mrs. Bigler worked for a local school district for 15 years doing Applied Behavioral Analysis (ABA) therapy, speech therapy and assisting with occupational and physical therapies and classroom education for children with special health care needs. Ms. Bigler obtained her AA in Pre-Social Work from Allen County Community College in 2006. She is a Registered Interactive Metronome Certified Therapist and has obtained over 5oo in-services hours through the local school district and the State of Kansas. //2015//

E. State Agency Coordination

Coordination within the State Health Agency

MCH and CYSHCN work with a number of program areas on public health issues. Office of Local and Rural Health (Primary Care Cooperative Agreement, district nurse consultants, community health assessment coordination, Farmworker Health, Refugee Health, Trauma Registry), Bioterrorism and Preparedness, Bureau of Child Care Licensing (standards for health and safety in out of home care, inspections of residential facilities, state schools for deaf and blind and birthing centers), Bureau of Consumer Health (childhood lead poisoning and environmental tracking and birth defects), Bureau of Health Promotion (Breast & Cervical Cancer Screening, Injury/Disability Program, Youth Tobacco Prevention, Diabetes Control, Kansas LEAN, Arthritis, 5 A Day, Kansas LEAN 21), Bureau of Epidemiology and Disease Prevention (HIV/STDs, immunizations).

There is good coordination with the Division of Health and Environmental Laboratories: Inorganic Chemistry (Lead Screening), Neonatal Metabolic Screening. There is a close working relationship with Center for Health and Environmental Statistics (perinatal outcome data, adequacy of prenatal care, hospital discharge data, and data linkages with Medicaid).

Coordination with Other State Agencies

Education and Social Services are the two State Human Services Agencies with whom MCH/CYSHCN frequently has contact. MCH works with the State Department of Education on health related issues for preschool and school-age children including guidance for school nurses and administrators (see the BFH website). The school nurse role has been expanded to include preventive and primary health care at school for children and youth who are at risk including the underinsured and uninsured. Delegation of nursing tasks to unlicensed school personnel is an ongoing education issue. Title V staff assist the State Education agency and Kansas Board of Nursing with this issue. Title V staff serves on the Statewide Education Advisory Council and attends the special education administration staff meetings. This collaboration has served to strengthen the health services components for special health care needs students in local school districts.

The federal legislation on inclusion has necessitated the reeducation of school nurses and training for allied school personnel in the provision of care to medically complex children. "Guidelines for Serving Students with Special Needs Part II: Specialized Nursing Procedures," helps local education agencies provide services to CYSHCN students. This was a collaborative project between Title V and the State Department of Education. Standards for CYSHCN have been developed and are also underway for early childhood education programs and child care providers. Others areas of significant collaborative efforts include: Part B of IDEA, School Readiness, and School Nutrition.

Schools, health departments, and primary care providers are encouraged to use "School Nursing and Integrated Child Health Services: A Planning and Resource Guide" in tandem with Bright Futures as the standard for provision of public health services to children. Multiple professional development opportunities are provided utilizing the statewide Area Health Education Centers (AHECs) and local area education service centers as training sites. It is anticipated that a day long video conferencing format will become the norm with facilitators available at times and sites convenient for any school district.

MCH/CYSHCN staff have frequent contact with Medicaid and SCHIP (HealthWave). MCH/CYSHCN assists with outreach and enrollment efforts, reviews data relating to utilization patterns, assists with provider recruitment, promotes standards of care, and assures provider training. Local MCH agency dollars expended on Maternal and Child Health services are utilized as match for federal Medicaid dollars to provide prenatal case management, nutrition and social work service for high risk women as well as newborn postpartum home visits. These and other collaborative arrangements are formalized in the Interagency Agreement (updated in 2009 to include HIPAA and data sharing). MCH/CYSHCN staffs meet monthly with Medicaid and HealthWave staff to discuss mutual concerns and to plan for identified service needs. Medicaid includes information about the WIC program in its notices to clients reminding them of immunizations due. Medicaid and Family Planning did considerable work on a family planning waiver request that was never forwarded to CMS.

MCH/Infant-Toddler Services staff, in collaboration with Medicaid staff, has developed a Medicaid reimbursement fee for a service system of early intervention services (such as occupational therapy, physical therapy and speech-language therapy) through a specially designed Infant-Toddler early intervention Medicaid providership. Training was provided to teach the Infant-Toddler Networks how to use their providership numbers to bill for these services. In 1999, the Infant-Toddler Services Medicaid providership was enhanced to include targeted case management (service coordination) as a reimbursable service for eligible infants and toddlers. Steps were implemented to add developmental intervention services as a Medicaid reimbursable service as well.

For the high-cost services to special needs children, the interagency agreement directs mutual referrals, cross program education, fiscal responsibilities and case management services for

children participating in both Medicaid and CYSHCN programs. Title V implemented linkages with the Medicaid and EDS/MMIS System so that CYSHCN staff has direct access to Medicaid information on children eligible for both Title V and Title XIX/XXI.

An interagency agreement delineates mutual responsibilities between Title V and SRS focusing on referral of Supplemental Security Income (SSI) for children and youth between the two agencies. A third party, the Developmental Disabilities Center assists in the design of materials to improve reporting of reliable information to make an accurate determination of eligibility for SSI benefits, and recruitment and expansion of the SSI provider pool for SSI consultative examinations. Another development is training for providers who give consultative evaluations. CYSHCN staff has a B agreement in place that allows increased access to SSA data.

Through the Farmworker Health Program and with Medicaid coordination (described in the interagency agreement), children and families of migrant and seasonal farm workers receive primary, preventive, acute and chronic care services at seventy-five clinic sites. Title V staff coordinate with Farmworker Health staff in the Office of Local and Rural Health to identify methods to maximize use of individual program funds to assure access to prenatal care and specialty care/follow up for farmworkers and their families.

Title V works with Employment Preparation Services in SRS on issues such as teen pregnancy prevention and public health assistance for indigents. Title V has worked with Alcohol and Drug Abuse Services on a number of substance abuse issues including prevention programs for youth, identification and intervention for pregnant women, and treatment facility standards for pregnant substance abusers. Title V has worked with Mental Health on a state plan for adolescent health, youth suicide and other issues. MCH serves on the State Developmental Disabilities Council located in SRS. KDHE's Child Care Licensing works with Foster Care regarding quality of child placements. CYSHCN works with Rehabilitation Services (Vocational Rehabilitation), Disabilities Determination and Referral Services.

Other State agencies with whom MCH/CYSHCN collaborates include the following: Kansas Department of Insurance on issues of public and private insurance coverage for the maternal and child population. MCH works with the Kansas Department of Transportation (KDOT) and the Kansas Board of Emergency Medical Services through the Injury Prevention program on data and policy issues. MCH/CYSHCN has participated with the Kansas Advisory Committee on Hispanic Affairs and the Kansas African American Affairs Commission on cultural and linguistic competence issues. MCH has assisted the Kansas Department of Corrections on health standards for youth facilities, finding providers of prenatal care for pregnant inmates.

Coordination with Other Agencies and Organizations

University and other collaborations include the following: University of Kansas; Bureau of Child Research/Center for Independent Living; Life Span Institute; University Affiliated Programs, Kansas University Center for Developmental Disabilities, Lawrence and Parsons; Developmental Disability Center/LEND Program; School of Medicine; School of Social Welfare; Preventive Medicine; Mid-America Poison Control Center; Area Health Education Center; Wichita State University; Kansas State University; Cooperative Extension Kansas Nutrition Network; University of Kansas School of Medicine - Wichita, MPH Program; Heartland Regional Genetics Consortium (to develop State genetics plan).

MCH works with professional groups, private non-profit organizations and others such as: March of Dimes; American Academy of Pediatrics - Kansas Chapter; Academy of Family Physicians; Kansas Children's Service League; Children's Coalition; Kansas Adolescent Health Alliance; Dietetic Association of Kansas; Kansas Action for Children; Families Together, Inc; Kansas Hospital Association; Assistive Technology Project of Kansas; Kansas Medical Society; Kansas Lung Association; SAFE Kids Coalition; Kansas Immunization Action Coalition; Kansas Health Foundation (KHF); Sunflower Foundation; Kansas Health Institute; Kansas Public Health

Association; Perinatal Association of Kansas; SIDS Network of Kansas; Mexican American Ministries; Campaign to End Childhood Hunger; United Way; Kansas Head Start Association; Kansas Nutrition Council; Kansas Dental Association; Kansas Association of Dental Hygienists; United Methodist Health Ministries; Fetal Alcohol Syndrome pilot project; National School Readiness Indicators Workgroup; Missouri D70 project; Kansas Head Start Collaboration Project.

There is an interdependent relationship between the state and local public health agencies. Kansas' 99 local health departments (LHDs) serve all 105 counties. The local health departments are organized under city and/or county government. They are mostly reliant on county mill levy funding, although some modest per capita state formula funds are provided to each county. Contracts and grants from the state health agency provide a third significant source of funding. The staffs of the Kansas Association of Local Health Departments assure coordination with KDHE programs. LHD representatives serve on all KDHE workgroups and committees with potential impact on LHDs.

MCH Block Grant dollars support regional public health nurse activities: regional public health meetings that serve as a forum for updates; technical assistance to local health departments regarding administrative issues, including billing, grant writing, budget, human resources, information systems, policy/procedures, HIPAA; technical assistance to local health departments regarding public health practice issues, including public health performance standards and competencies, as well as the MCH Core Public Health Services; collaboration with Heartland Center for Public Health Preparedness and University of Kansas School of Medicine, Department of Preventive Medicine and Public Health, for training sessions on cultural competency and diversity, risk communication, informatics, and public health law, through Kansas Public Health Grand Rounds series; distribution of resource publications and information necessary to support practice, including Connections Newsletter, Kansas Rural Health Information Service (KRHIS), OLRH website, Public Health Nursing and Administrative Resources Manual, and Domestic Violence Manual. Public health nurses maintain ongoing partnerships to support education/training for public health with state and regional training partners, including: Heartland Center for Public Health Preparedness, St. Louis University School of Public Health, University of Kansas School of Medicine, KU Public Management Center, Professional Associations, and Kansas Association of Local Health Departments (KALHD). Ongoing training activities include the Kansas Public Health Certificate Program, and the Kansas Public Health Leadership Institute.

Newborn Screening staff work closely with Heartland Genetics and Newborn Screening Regional Collaborative funded by MCHB/HRSA. Staff serves on the Advisory Committee for the Heartland Collaborative and on the Newborn Screening committee. Heartland has provided funding for Kansas to complete a State Genetics Plan. Stakeholders participate in this planning process along with MCH/CYSHCN staff, Cancer Control and Prevention and Chronic Disease staff. The stakeholders have met for two face-to-face meetings and participated in conference calls. The plan will be finalized in 2010.

Coordination with other Kansas MCHB Grants

KDHE staff is involved in numerous ways with grants that are awarded by MCHB to the State of Kansas. MCH coordinates with the Kansas City Healthy Start awarded to the MCH Coalition of Greater Kansas City and with the Healthy Start Initiative awarded to the Wichita-Sedgwick County Health Department. The Directors of these two programs serve on the state Blue Ribbon Panel on Infant Mortality. The Kansas University Affiliated Program at the University of Kansas Medical Center works closely with the CYSHCN program staff and contract staff actually share office space with the program. Currently MCH staff serves on the advisory board for the Traumatic Brain Injury Implementation grant and have served in the past with the Healthy Child Care Kansas grant. Staff within the bureau directly administers the State Early Childhood Comprehensive Systems and the Universal Newborn Hearing Screening. MCH works closely with the Bureau of Oral Health on its grants, Emergency Medical Services for Children (EMSC)

Partnership and other grants.

Collaborative activities between newborn hearing screening (Sound Beginnings) and Part C of IDEA local agencies have decreased the loss to follow-up between diagnosis and early intervention. Collaboration with the KU Area Health Education Centers has facilitated ten regional trainings for over 150 nursing and laboratory staff who are involved in the collection of blood spot cards for newborn screening. Collaboration between SIDS Network of Kansas and Healthy Start Home Visitors has helped provide safe sleep environments for infants at risk of SIDS and other sleep related deaths. 'Cribs for Kids' were distributed through this joint effort. Collaboration with the data people in the state social service agency (SRS) has resulted in some program changes and explanation of the trends we see particularly for TANF. There has been ongoing sharing of data between SRS and KDHE and future meetings are planned with the possibility of MCH epidemiologists assisting with analysis of their data.

There has been strong collaboration among KDHE, KSDE, Kansas In-service Training System (KITS), local infant toddler networks and statewide school districts' Part B programs, to develop, implement, and provide user training for an outcomes web system that tracks a child's functional progress in three developmental outcomes.

CYSHCN and newborn screening have worked closely together during the expansion from four to 29 conditions. The newborn screening advisory council is a very strong group of specialty doctors, parents and staff that meet four times a year to assess program process and outcomes. Information about new conditions has been shared to assure families receive diagnoses and treatments for their infants. Collaboration with the federal Healthy Start projects in Kansas City and Wichita has helped bring the state up to date about the value of Fetal-Infant Mortality Review. Collaboration with the Perinatal Association of Kansas has enhanced multi-disciplinary expertise to the state agency's approach to perinatal care and education activities. Consultation is provided to the department to help improve state perinatal outcomes. The state MCH/CYSHCN agency and the Kansas Chapter of the AAP adopt strategies to improve child and adolescent health outcomes.

The Kansas Reconvene Team in which state health and education agencies obtained training through the National Alliance of State and Territorial AIDS Directors, National Coalition of STD Directors, and others was instrumental in advancing a plan for building capacity in the areas of disparities and peer education. The fatherhood summit was a collaborative activity in which JJA, Catholic Social Services, KPIRC, and others developed a common goal, shared resources, provided educational events for families and providers to help people better care for their children.

A strong ongoing collaboration exits between family planning and the breast cancer program, Early Detection Works. These two programs work together to help low-income women get follow-up care on their abnormal Pap smears. The child care health consultation training was an important collaboration among a variety of organizations/experts, Wichita State University, and KDHE. The project was a direct result of the collaboration between MCH and all the signators to the Kansas Early Childhood Comprehensive Systems State Plan. Another collaboration worth mentioning is that formed with the conveners of the SECCS Plan. This resulted in training for MCH/CYSHCN staff on Results-Based Accountability. A collaborative activity with K-State Research and Extension Department resulted in downsizing and redefining the activities of the Kansas Nutrition Network, the USDA State Nutrition Action Plan, and the annual MOU review and revision. The Kansas State Department of Education, Special Education Services and Children's Developmental Services have forged a close relationship attending each other's meetings. MCH participates in their annual Leadership Conference. Monthly meetings continue to build this important partnership.

Kansas business case for breastfeeding train the trainer grant has helped us build a coalition of partners committed to workplace reform and policies that better support families. The

Medicaid/MCH Interagency Agreement defines collaborative activities between the two programs as required by law. In 2009, an update to the document helped to strengthen our relationship. These are among the numerous collaborative activities and practices engaged in by the Kansas Title V.

/2013/ There are no major changes in agency coordination since last year's submission. //2013//

/2014/ Coordination within the State Health Agency has increased and improved over the last year since the agency reorganization. Within the BFH, Child Care Licensing is working more closely with other sections to identify how local health department surveyors visiting child care facilities can provide information to early care professionals serving children and families. The BFH is working closely with the Local Public Health program: presenting at the local public health regional meetings the last quarter of SFY13 and continuing through the first quarter of SFY14, sharing information about the current organizational structure, strategic planning, initiatives, and priorities for the coming year; working together on the AMCHP compendium pilot project, taking a comprehensive approach to improve birth outcomes, by using the regional public health meetings to inform health departments and collect input. The BFH worked with the Bureau of Health Promotion, providing strategies to incorporate into a CDC wellness grant to focus on nutrition, physical activity, and wellness in early care and education settings. The MCH program partnered with the KDHE Center for Health Equity (CHE) during SFY2013 to support three Preconception Peer Educator (PPE) community events (Wichita, Topeka, Kansas City) and continue the Healthy Babies Kansas online education campaign. The PPE program's core training topics include: health disparities and social determinants of health, causes of infant mortality and why it's a public health concern, racial and ethnic disparities in birth outcomes (life course perspective), preconception health and care for men and women, overcoming racism and its stress, men's health and fatherhood.

Coordination within the Department between the Divisions of Public Health and Health Care Finance (Medicaid) has improved during the last quarter of FFY13. The Secretary convened a workgroup with representatives from both Divisions to identify services not currently covered by Medicaid / Kansas MCOs which would reach a high number of individuals and result in cost savings (ex: prenatal education). The team has worked over the last several months to identify the recommended services and will be finalizing a proposal to present to leadership by October 1, 2013. The top priorities resulting from the group's research include: Asthma education and environmental assessment, Diabetes Prevention Program, Diabetes Self- Management Training, Tobacco Cessation Counseling (for all but Pregnant women, who are already covered), Prenatal education, Substance use disorder family counseling, Lead environmental assessment. This is a new approach and opportunity for Kansas--covered services have typically been mandated by the legislature or CMS.

Collaboration with the Greater Kansas Chapter of the March of Dimes (MOD) continues but has strengthened as a result of new initiatives. The KDHE MOD announced in March 2013 a joint initiative to reduce the rate of pre-term birth. Dr. Robert Moser, KDHE Secretary and State Health Officer, accepted a challenge from the Association of State and Territorial Health Officials (ASTHO) to reduce the rate of premature birth by 8% by the end of 2014. The March of Dimes 2012 Premature Birth Report Card shows that the premature birth rate in Kansas is currently at 11.2%. This 8% reduction will bring Kansas to 10.3%, which translates to roughly 350 babies. A number of agencies and organizations are working together on the following initiatives related to the Challenge: 1) A Statewide Public Awareness Campaign on issues related to infant mortality. The campaign, launched in 2010 and continuing, includes an informational website, Facebook and Twitter applications, and a virtual resource directory for local, state, and national resource access. National campaigns including "A Healthy Baby Begins with You" and the National Partnership for Action serve as key resources. Media outlets are leveraged in the months of September (Infant Mortality Awareness Month), October (SIDS Awareness Month), and November (Prematurity Awareness Month). The primary goal is to inform pregnant women and their health care providers that "Healthy Babies Are Worth the Wait." Through patient and

provider education, women are advised that if their pregnancy is healthy, it's best to wait for labor to begin on its own rather than scheduling an induction or cesarean section. 2) The Kansas Blue Ribbon Panel continues its work utilizing data to identify: leading causes for infant mortality in Kansas and communities with the combination of high infant mortality rates and significant birth numbers. Recommendations for possible interventions are developed and published (see attached). 3) Becoming A Mom/Comenzando bien Birth Disparities Programs developed by the Kansas Chapter of the March of Dimes was piloted and implemented in four targeted communities across the state (Saline, Sedgwick, Shawnee, and Geary counties). The philosophy is that every effort should be made to prevent the occurrence of preterm birth and reduce the associated infant mortality rate. The intent is to advance consumer education, assist and augment existing public health services, and clinically intervene in prenatal and pre/interconception periods. The primary goal was to decrease preterm birth by increasing awareness of causal factors while changing the attitudes and behaviors in order to impact community-specific risk factors and to implement prevention strategies. Programs are a community collaborative model which creates a long-term, sustainable public/private partnership among clinical and public health partners at the local and state level. 4) The Kansas Perinatal Quality Collaborative (KPQC) was formed in November 2012 to improve service quality and access to care for women and babies statewide. Among the top priorities will be hospital quality improvement projects related to preterm and early term births. One of the first projects of the KPQC will likely be the elimination of elective deliveries before 39 weeks of gestation. //2014//

/2015/ Coordination within the Bureau and within the State Health Agency: 1. Public Health Conference -The BFH and Title V/MCH directors/staff developed and presented a session titled "State-Local Initiatives Addressing Kansas Maternal and Child Health Priorities" for the 2014 Kansas Governor's Public Health Conference held April 30-May 1. The conference theme was "Connecting the Dots"; keynote presentations were delivered by Dr. Hani Atrash and Dr. Michael Lu (via video), HRSA MCHB. The session focused on state level coordination efforts and state-local initiatives. Presenters were Rachel Sisson (Berroth), BFH & Title V Director; Debbie Richardson, MCH & Home Visiting Program Manager; Linda Cottrell, Child Care Licensing Administrator; David Thomason, Nutrition & WIC Services Director; and Kayzy Bigler, SHCN Program Manager. Participants gained program-specific information related to priorities and initiatives, identified connections with local efforts, and provided input. 2. MCH Coordination Team - An MCH Coordination Team was convened in October 2013; meetings are held monthly. Members at this time are representatives from Title V/MCH, WIC, SHCN, Family Planning/Reproductive Health, Part C Infant Toddler Services/early childhood, Newborn Screening and Newborn Hearing Screening, and epidemiology. The purpose of the work/coordination/planning is to support the BFH mission and Title V MCH Purpose. Key concepts in mind include: Systems building, family involvement, population based, coordination systems of care, health equity, and life course. The Team goals are: Optimize Bureau resources, funding and personnel to maximize the impact of maternal and child health services, improving the health of Kansas women, children, and families; Align work and efforts with agency, Bureau and MCH missions, essential duties, and mandates with focus on MCH priorities and measures; Focus on the Life Course health perspective, taking into consideration factors impacting an individual's health in every stage of life, not just one (infancy, childhood, adolescence, childbearing age, elderly); Effectively use data to inform policy decisions and resource allocation, increase program impact, and apply continuous quality improvement; Focus on program and service integration where appropriate and necessary for moving work forward to support reaching and improving health outcomes; and Ensure Title V-funded projects "assure" services and are family-based, community centered, and integrated into the ongoing system of coordinated care for children and families. The meetings have resulted in improved communication, increased coordination across programs within the Bureau including MCH, and surveys/projects/agendas reflecting collective, broad input. 3. Medicaid-MCH: Title V Director met with Medicaid Director and Informatics staff in March to discuss the MCH data snapshot, specifically disparities between the Medicaid/nonMedicaid populations. Detailed information related to Title V,

legislation, and programming relevant to the Title V-Medicaid partnership, was shared. Leaders will meet again in June to continue the discussion and plan for Infant Mortality CoIIN. Focus will be on the Medicaid MCH data/linked data set and areas where measures and programming align--disparities in prenatal care and birth outcomes (including preterm birth and infant mortality) is feasible and will have the greatest impact on health and costs. Potential Projects with Medicaid include: Collaborate with state Medicaid staff and managed care organizations to ensure consistent reporting of low birth weight, understand current and planned initiatives to improve birth weight, and identify potential performance improvement interventions to improve birth weight for members using KanCare services. Examine the impact of maternal diabetes and pre-diabetes on birth weight, and identify potential performance improvement interventions to improve birth weight for members using KanCare services. Assist single state Medicaid agency to identify and address reporting and program requirements related to CMS Abstraction and Reporting Tool related to children's services issues, including childhood immunization status, live birth weight, well child visits, and chlamydia screening. MCH staff presented information to the group of Kansas Medicaid Outstationed Eligibility/Outreach workers March 2014. Medicaid Eligibility Supervisor presented to the MCH Coordination team April 2014, sharing changes in Kansas Medicaid as a result of health care reform. The outstationed worker list was distributed to all grantees to support referral and support for the application/eligibility process. The primary goal is targeting resources to activities and services that support what our most vulnerable and high-risk MCH populations need. The Managed Care Organizations (MCOs) have been engaged as well, May 2014, and actively participated in state-local projects aimed at improving MCH outcomes.

Coordination with other Kansas MCHB Grants: The Kansas Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program continued with both annual formula fund and competitive development grant funds administered by KDHE BFH. In the at-risk communities targeted for implementation - Wyandotte County (urban Kansas City, Kansas) and Montgomery, Labette, and Cherokee counties (rural southeast Kansas) - Early Head Start, Healthy Families America, and Parents as Teachers evidence-based home visiting programs and, in Wyandotte County specifically, a promising approach serving pregnant and postpartum women affected by alcohol or other drugs, the Team for Infants Endangered by Substance Abuse (TIES) Program, continued to scale up. A state level Home Visiting Workgroup composed of representatives from multiple state agencies, organizations, and programs developed a state strategic plan. In August 2013, KDHE BFH was awarded a new three-year Early Childhood Comprehensive Systems: Building Health Through Integration (ECCS) grant. Kansas selected strategy two with the goal to expand and effectively coordinate, improve, and track developmental screenings and referrals for infant and toddlers across early childhood support systems including home visiting and early education settings, pediatricians and medical homes, intervention services, and child care programs and families. The project has been named the Kansas Initiative of Developmental Ongoing Screening (KIDOS). There are substantial linkages between the MIECHV and ECCS initiatives. KDHE contracts with the University of Kansas Center for Public Partnerships and Research to coordinate and evaluate various aspects of both programs. Additionally, BFH/MCH staff is exploring ways to better coordinate and integrate MIECHV and KIDOS program activities with other BFH/MCH programs.

Coordination with Other State Agencies: Several KDHE/BFH staff, including the MCH/MIECHV/ECCS Program Manager, Part C Coordinator, and Child Care Licensing Director, are active members of the State Agencies Early Childhood Leadership Team. The team is a formalized group representing early childhood programs within state agencies including KDHE, Department for Children and Families (DCF), Department of Education (KSDE), and the Children's Cabinet and Trust Fund. It was created to represent Kansas state agencies as a collective voice on early childhood programs and services for children and families from birth to after kindergarten entry, and to plan and initiate cross-agency unified efforts and outreach directed toward development of a comprehensive early

childhood system. The team meets monthly to conduct strategic planning, identify priorities, and implement communication and coordination activities. In the past year, the team has worked to promote the Kansas School Readiness Framework, and identified the following priorities: developmental screening including the system for referral and follow up; family engagement practices and standards, use of the Kansas Early Learning Standards; and early childhood professional development system.

Coordination with Local Health Departments: The Perinatal Health Consultant and MCH epidemiologist in partnership with the Director of Vital Statistics Data Analysis (The Team - Three Amigos) have on-gong collaboration with local health departments to assist with their data needs. These include assisting with data requests, Perinatal Periods of Risk (PPOR) Analysis presentations, Fetal and Infant Mortality Review (FIMR) support, local public health system assessment, Pregnancy Risk Assessment Monitoring System (PRAMS) pilot project, State Health Assessment Report (Maternal, Infant, and Child Health Focus Area), etc. //2015//

F. Health Systems Capacity Indicators

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2012	matching data files	9.7	4.4	6.3

Notes - 2015
Data source:
Numerator: Linked death and birth file, 2012 death cohort. Bureau of Epidemiology and Public Health Informatics, KDHE.
Denominator: Live birth certificate (resident) data, 2012. Bureau of Epidemiology and Public Health Informatics, KDHE.

The "principal source of payment for this delivery" is based on live birth certificate data. Kansas' birth certificate includes an item inquiring about the "principal source of payment for this delivery" with the following check box items: Medicaid, Private/Employer Ins., Self-pay, Indian Health Service, CHAMPUS/TRICARE, Other government, Other (Specifiy), and Unknown. This does not indicate insurance coverage during pregnancy or imply the source of payment for prenatal care.

Medicaid population - includes live births records that checked as "Medicaid"

Non-Medicaid population - includes live birth records that checked as "private/Employer Ins., selfpay, Indian Health Service, CHAMPUS/TRICARE, other government, and other".

All population - includes all live birth records regardless of "principal source of payment for this delivery" status.

Narrative:
The Kansas Blue Ribbon Panel on Infant Mortality was formed in June 2009 with the charge to identify key issues contributing to Kansas infant mortality rates and to provide intervention

recommendations to the Secretary of the Kansas Department of Health & Environment. The identified leading causes for infant mortality in Kansas were premature birth/low birth weight, birth defects and Sudden Infant Death Syndrome (SIDS). The intervention recommendations covered four broad categories: 1) improve data and surveillance 2) expand research, 3) increase public awareness through education and 4) increase access to care and services through implementation of programs and targeted interventions. One key finding was that birth disparities in Kansas were significant with a 2:1 ratio for black/white infant death.

In response to the recommendations, stakeholders on the KBRP worked in partnership to develop resources and initiatives to address identified problems in the targeted communities. These initiatives include:
• Becoming A Mom/Comenzando bien Birth Disparities Programs
• SIDS Education Initiative
• Fetal Infant Mortality Review (FIMR)
• Kansas Perinatal Quality Collaborative (KPQC)
• Strong Start/ASTHO Challenge
• Statewide Public Awareness Campaign
• Perinatal Period of Risk (PPOR) Analysis
• Association of Maternal and Child Health Programs (AMCHP) Compendium Pilot Project: Improve birth outcomes and reduce infant mortality
• Pregnancy Risk Assessment Monitoring System (PRAMS) Pilot Project

Women enrolled in Medicaid have a higher rate of infant mortality than the state as a whole (6.3/1,000 live births, 2012) and the non-Medicaid population (4.4). Women enrolled in Medicaid are more likely to be younger, unmarried, have less than a high school education, or be of a racial or ethnic minority group. These factors may be contributing to higher rates of infant mortality among Kansas Medicaid population.

Two projects were completed utilizing the linked data:
• Using the linked the birth and Pediatric/Pregnancy Nutrition Surveillance System (WIC) data to determine the nutritional and health characteristics of Kansas Medicaid births who are also participants in the Supplemental Nutrition Program for Women, Infants and Children (WIC), compared to Medicaid births not in the WIC program.
• Using the linked the birth, Medicaid, WIC, and hospital discharge data to assess/evaluate/address Kansas women who are Medicaid participants but do not enroll in WIC during pregancy. With this information, state and local WIC programs in Kansas will have opportunities to "actively" colalborate with Medicaid, address gaps, and prioritize and develop an outreach campaign targeted where enrollment of WIC eligibe women is lowest.

IV. Priorities, Performance and Program Activities

A. Background and Overview

In Kansas, high standards of accountability apply to all maternal and child programs. This is due to scarcity of resources at the federal, state and local levels and through other funding sources such as foundations. Legislators and others require regular reports on best practices, performance and outcomes. Increasingly data is linked to funding decisions, mostly to achieve efficiencies but also to improve outcomes for certain target populations. The State budget including the BFH budget is based on performance and outcome measures linked to the spending plan. The Legislature requires strict accountability through annual reports and special reviews. An example of a special review is the Legislative Post Audit study on KDHE programs that address low birthweight. Other funding sources such as the Children's Cabinet which provides oversight of Tobacco Settlement funds requires each recipient of funds to provide an annual program evaluation summary including performance and outcome data.

Since 1999 BFH has included performance plans and performance information in its federal MCH budget submission. BFH submits annual reports to Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB) on the actual performance achieved compared to that proposed in the performance plan. This Section of the Kansas MCH Services Block Grant Application describes how the State-Local partnership will implement the federally-required performance reporting requirements.

The MCH Block Grant Performance Measurement System is an approach utilized by Kansas that begins with the state/local needs assessment and identification of priorities. Evidence-based strategies are identified to address each priority. The strategy(ies) selected are formalized in logic models and workplans. This culminates in improved outcomes for the maternal and child population.

After Kansas establishes its priority needs for the five-year statewide needs assessment, programs are developed based on best practices, assigned resources, and implemented to specifically address these priorities. Specific program activities are described and categorized by the four service levels found in the MCH Pyramid: direct health care services, enabling services, population-based activities, and infrastructure-building activities. Since there is flexibility available to Kansas in implementing programs to address priority needs, the program activities or the role that MCH plays in the implementation of each performance measure may be different from that of other states. Kansas tracks its individual progress on up to ten unique State performance measures and Kansas tracks its progress on all national performance measures. Kansas compares its performance with the performance of other states using the Maternal and Child Health Bureau's Title V Information System.

Accountability in BFH programs is determined in three ways: (1) by measuring the progress towards successful achievement of each individual performance measure; (2) by budgeting and expending dollars in each of the four recognized MCH services: direct health care, enabling services, population-based activities, and infrastructure-building activities; and (3) by having a positive impact on the outcome measures.

While improvement in outcome measures is the long-term goal, more immediate success may be realized by positive impact on the performance measures. These are measures of short term and intermediate term change, and they are precursors of long term change in outcome measures. It is important to note the change in performance measures because there may be other significant factors outside BFH control affecting the outcomes.

/2013/ There are no major changes since last year's submission. //2013//

/2014/ There are no major changes since last year's submission. //2014//

B. State Priorities

The Kansas comprehensive needs assessment, MCH 2015, was completed in 2009-2010. In all, ten priority needs were identified, four for pregnant women and infants and three each for children and adolescents and children/youth with special health care needs.

These are the resulting goals for each population group and the ten Kansas priority needs for 2011-2015:

Pregnant Women and Infants
Goal: Enhance the health of Kansas women and infants across the lifespan.

- All women receive early and comprehensive care before, during and after pregnancy
- Improve mental health and behavioral health of pregnant women and new mothers
- Reduce preterm births (including low birth weight and infant mortality)
- Increase initiation, duration and exclusivity of breastfeeding

Children and Adolescents
Goal: Enhance the health of Kansas children and adolescents across the lifespan.

- All children and youth receive health care through medical homes
- Reduce child and adolescent risk behaviors relating to alcohol, tobacco and other drugs (ATOD)
- All children and youth achieve and maintain healthy weight

Children and Youth with Special Health Care Needs (CYSHCN)
Goal: Enhance the health of all Kansas children and youth with special health care needs across the lifespan.

- All CYSHCN receive coordinated, comprehensive care within a medical home
- Improve the capacity of YSHCN to achieve maximum potential in all aspects of adult life, including appropriate health care, meaningful work, and self-determined independence
- Financing for CYSHCN services minimizes financial hardship for their families

This narrative will describe each priority need, Kansas' capacity and resources to address each need, and relation of each to the national and state performance measures.

PREGNANT WOMEN AND INFANTS

1. Kansas women need early and comprehensive health care before, during and after pregnancy.

This priority need was originally selected for MCH 2010 based on state and regional Perinatal Periods of Risk (PPOR) analysis. PPOR was used as a tool to identify excess mortality and to suggest reasons for excess mortality. It suggested which community interventions were most likely to result in improved health outcomes. Kansas data pointed to a need to target the area of Maternal Health/Prematurity and corresponding preconception health, health behaviors, and perinatal care.

MCH 2015 needs assessment stakeholders reviewed the data and concluded that more needs to be done in this area. MCH needs to redirect resources to health education and health promotion activities at both the state and local levels. In addition, through partnerships with stakeholders such as private physicians, March of Dimes, Medicaid, other programs, MCH can help guide policy decision-making relating to health care reform and coordinates public health efforts in support of positive changes in the health care system.

NPMs 8, 15, 18 and NOMs 1, 2, and 3 relate to this priority need.

2. The mental health and behavioral health needs of pregnant women and new mothers should be addressed.

This priority need was selected based on data showing that Kansas women have higher than average rates of cigarette smoking and other stress-related behaviors before, during and after pregnancy. Information needs to be readily available to the public and to women about the value of early/comprehensive health care for women of reproductive age and assimilated. There is a need to change the approach to women's health to a lifecourse perspective.

NPMs 8, 15, 18 and NOMs 1, 2, 3 relate to this priority need.

3. Kansas preterm births, low birthweight and infant mortality should be reduced.

This priority need was selected based on data that show continuing high rates of preterm birth, low birthweight and infant mortality for Kansas. MCH 2015 stakeholders concurred that all three are important and were unable to select from among the three.

Kansas has the capacity to address this priority through prenatal smoking cessation, improved nutritional status, and community-based prenatal case management and care coordination for low-income and high risk women. As well, through its wide array of stakeholder groups MCH can mobilize advocacy for policy changes needed to improve outcomes.

NPMs 8, 15, 18 and NOMs 1-3 relate to this priority.

4. Kansas women need support to increase initiation, duration, and exclusivity of breastfeeding.

The positive benefits of breastfeeding both for the mother and infant are provided in the discussions for NPM 11 and SPM 3. Kansas capacity to address this priority is significant due to partnerships forged across programs including WIC and women's health, due to the low cost of interventions and high yield in health benefits, and finally, due to a change in public attitudes and policy supporting breastfeeding mothers in the community and in the workplace. Kansas has devoted resources to peer education, health promotion and health education efforts, plus public information and education to address this priority.

NPMs 11, 15 and NOMs 1-3 relate to this priority.

CHILDREN AND ADOLESCENTS

5. All Kansas children and youth should receive health care through medical homes

This priority was held over from the last five year needs assessment due to data showing that the number of uninsured children is rising and that the problem of underinsured may be greater than uninsured. There was concern that more needs to be done in this area with the advent of national health care reform. MCH is in a unique position to support families and providers. MCH needs to engage in activities to educate families about the importance of care within a medical home. MCH needs to enlist the support of community partners to increase enrollment in Medicaid and Health/Wave for eligible children.

NPMs 7, 13, and 14 and NOMs 1 and 2 relate to this priority.

6. Child and adolescent risk behaviors relating to alcohol, tobacco, and other drugs should be reduced.

Youth Risk Behavior trend data show that Kansas youth continue to report higher than average

use of alcohol, tobacco and other drugs. These priority health risk behaviors are major contributors to morbidity and mortality trends including motor vehicle crashes, unintended pregnancy, HIV/STDs, and other. More effective school health programs and other policy and programmatic interventions are needed to reduce risk and improve health outcomes among youth. In particular, the state needs an Adolescent Health Plan that focuses on the needs of youth from a health perspective. MCH has the capacity to convene a group of stakeholders to address this need.

NPM 10, 16, and NOM 6 relate to this priority need.

7. Kansas children and youth need to achieve and maintain healthy weights.

This priority will be continued from MCH 2010. There is an increasing trend toward overweight even among very young Kansans and there is a strong association between overweight and health status. Many current efforts in the state focus on the needs of school-age and adult nutrition and physical activity. Kansas MCH not only joins in those efforts but also is in position through its public/private partnerships especially in the early childhood areas to address this priority. The Kansas breastfeeding priority also relates to this priority since breastfeeding has been linked with healthy weight in childhood.

NPMs 11 and 14 relate to this priority.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

8. All CYSHCN should receive coordinated, comprehensive care within a medical home.

This state performance measure holds for all children but in particular for CSHCN. Kansas capacity in this area is expanding to include development of data collection (new application form and survey systems), tracking systems (new CSHCN data system linked to Immunization Registry), parent/provider education about the medical home concept and practice, and linkages to other programs (Newborn Hearing Screening Learning Collaborative).

NPM 3 relates to this Kansas priority although NPM3 is broader and encompasses two concepts: family partnering in decision-making and care within a medical home. Kansas is developing interventions to address both and is developing capacity to track progress.

9. Kansas CYSHCN need early transition planning and services necessary to achieve maximum potential in all aspects of adult life, including health care, work and independence.

Kansas capacity in this area has improved considerably with the realignment of staff duties to include a focus on transition systems. This has resulted in new and enhanced partnerships with organizations in the disability community and a refocusing of state efforts on the needs of youth with special health care needs (YSHCN) as they transition to adult medical care.

NPMs 2-6 relate to this state priority.

10. Financing for CYSHCN services should minimize financial hardship for their families.

Kansas capacity in this area is enhanced through close working relationships with public programs (such as WIC and Farmworker Health) and public insurance (Medicaid and SCHIP). Direct financing of services through CYSHCN dollars has become more restrictive due to dwindling state and federal dollars and rising costs. Hospitals, labs and private providers continue to work with CYSHCN despite reductions in amount of coverage available. Private insurance coverage may only partially offset financial burden to the family or not at all. Rising numbers of uninsured and underinsured add to the ongoing challenge for the program. CYSHCN continues to engage in policy decisions to ration limited dollars.

NPMs 2-6 relate to this State of Kansas priority.

/2013/ There are no major changes since last year's submission. //2013//

/2014/ We were encouraged not to have duplicate measures between the state and national. We retired State Performance Measures (SPM) that no longer fit the priority needs of our State. They are SPM1, SPM 4, SPM8 and SPM10. We added a new measure: SPM11 - The percent of infants with Permanent Congenital Hearing Loss (PCHL) enrolled in early intervention services before 6 months of age. //2014//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	57	59	71	72	82
Denominator	57	59	71	72	82
Data Source	Kansas Newborn Screening data, 2009	Kansas Newborn Screening data, 2010	Kansas Newborn Screening data, 2011	Kansas Newborn Screening data, 2012	Kansas Newborn Screening data, 2013
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments

DS: Medical consultation for children with genetic/metabolic conditions was available statewide through the Special Health Care Needs (SHCN) contractual process. SHCN purchased metabolic formula and food products for individuals with phenylketonuria (PKU) and Maple Syrup Urine Disease (MSUD) along with treatment products for conditions identified through the newborn screening (NBS) program. SHCN continued to use a sliding fee scale with all families with children identified through the NBS process including those with cystic fibrosis. NBS follow-up staff works closely with SHCN staff to assure diagnostic testing is available for patients identified by the NBS program. Once the NBS program verifies that a patient is a resident of the state of Kansas and diagnosed with an eligible condition, an application for SHCN is sent to the family.

ES: Newborn Screening (NBS) staff participated in the Heartland Genetics and Newborn Screening Collaborative on both the advisory committee and standing committees. The NBS program worked in conjunction with the previous Kansas D-70 grant in order to place parent advocates in 2 genetic clinics (PKU and Hematology) in the Wichita area. The parent advocate worked with families seen at the clinics to increase compliance and lost to follow-up rates.

PBS: Kansas hospital personnel collected blood spot specimens from infants, usually between 24 to 48 hours of age. Specimens were sent by hospital staff to the Kansas Health and Environmental Laboratory (KHEL) for processing. Lab staff notified the NBS follow-up program of abnormal screening results. The NBS follow-up staff notified the primary care physician (PCP) of the abnormal screening test results and informed of consultation/referral available through the SHCN program. Parents were notified by letter of the need for follow-up with the PCP regarding abnormal screening results, if the infant was not a patient in a neonatal intensive care unit (NICU). The NBS follow-up program provided case management services to assure that infants had appropriate testing, diagnosis, referral and treatment services up to the point of diagnosis.

With implementation of new guidelines for infants in an NICU, the number of specimens collected under 24 hours of age had increased and a new reporting protocol was implemented. The laboratory system no longer reports out results for Congenital Hypothyroidism, Cystic Fibrosis or Congenital Adrenal Hyperplasia for those specimens taken under 24 hours of age. Those results are "Invalid". This provides less follow-up for those babies, as a later specimen will generally have normal results. Follow-up staff worked to ensure that a repeat specimen is received.

The NBS webpage on the KDHE website contains the information for both families and physicians. The section "Information for Parents" is available in both English and Spanish. Parent letters and information sheets have also been translated and used with parent mailings regarding abnormal or unsatisfactory specimens.

IBS: KDHE screened for 29 of the recommended conditions by the American College of Medical Genetics (ACMG). Although the recommendation from the NBS Advisory Council (NBS-AC) supported Kansas implementing a NBS fee, legislation as pass that allowed the Kansas NBS program to be funded with a user fee that is obtained from Medicaid Managed Care Organizations beginning in July 2014. The NBS-AC met twice last year to recommend critical NBS initiatives, including CCHD, fee for screening, protocols, and data collection.

The Vital Statistics information system exports birth certificate data into the Birth Defects Registry which is a component of the SHCN and NBS database. The registry continues to receive and monitor legislatively-mandated reports submitted by hospitals, birthing centers, and physicians regarding children under age 5 with a primary diagnosis of congenital anomaly or birth defect. MCH epidemiologists will continue to analyze birth defects data.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Provide nursing case management to families that have infants with abnormal newborn screens.		X		
2. Provide nursing case management to families that have infants with abnormal newborn screens.				X
3. Purchase and distribute treatment products to eligible individuals.	X			
4. Arrange transportation, as needed, for follow-up services.		X		
5. Manage data collection and reporting systems for NBS follow-up and birth defects information.				X
6. Provide information to policy makers on laboratory and follow-up procedures.				X
7. Notify parents and medical providers about abnormal lab results and follow-up recommendations.		X		
8. Provide educations materials such as pamphlets, handouts, DVD and website address to parents and medical providers.		X		
9. Participate in the newborn screening advisory committee to include QA activities.				X
10.				

b. Current Activities
Previous year activities continued as described in the previous section.

DS: In 2012, 72 newborns were confirmed with metabolic conditions received appropriate follow-up. In efforts to address the shortage of metabolic/genetic providers in the state, support for increased genetic counselors consultation was approved by KS-SHCN. An inability for unlicensed genetic counselors to bill prevents utilization of these services.

PBS: In April 2013, the NBS-AC recommended a quality initiative to provide training, education, and support for hospitals interested in implementing a CCHD screening program. Beginning in November 2013, a birthing facility survey was conducted to obtain data on screening activities.

IBS: A new laboratory information management system (LIMS) was implemented in December 2013. Transition to this new system has been challenging and has resulted in increased workloads and barriers to accurate and timely follow up. Programmatic changes have been made to accommodate for these barriers and have resulted in support for a new NBS follow up data management system, integrated with the hearing screening follow up data system.
This is expected to conclude late Summer 2014. The new system will allow: staff to verify specimen collection on all infants born in Kansas; work flow processes to be improved; and increased ability to obtain data from the LIMS.

c. Plan for the Coming Year
In addition to existing services, the newborn screening program is primarily focused on continuing efforts with regard to the CCHD Quality Initiative and the transition to a new data management system.

DS: Discussions regarding limited access to genetic/metabolic specialists will be continued. The University of Kansas Medical Center and Children's Mercy Hospitals have begun integration efforts for pediatric care provision between the two systems. This has resulted in a shared Director of Pediatrics. Discussions to support better provision of services for the SHCN population, including those identified through the newborn screen, will continue. Additionally, a new Director of Pediatrics at the KU School of Medicine in Wichita (KUSM-W) was recently named. There is a strong desire to increase genetic services in Wichita and ongoing discussions with KU, Children's Mercy, and the Arkansas Children's Hospital (where a dedicated geneticist

has been providing support and oversight of the genetic counselor through telemedicine) are taking place. It is anticipated that a proposal from the KUSM-W will be received later this fall for new funding processes that will provide stronger support for genetic services.

ES: A NBS Educator and Training Consultant was hired in February 2014 and will continue to expand outreach and training for birthing facilities related to newborn screening and CCHD activities. The quarterly newsletter will be reinstated to provide more guidance and support to facilities. An expansion to support providing the newsletter to private physician office staff is expected. With a new data system, this is expected to be easier to manage and support. In anticipation of interest to mandate CCHD and SCID screening, training for with staff and providers will be developed and available.

PBS: NBS staff will work with birthing facilities to encourage state-wide CCHD screening. Site visits will be made to facilities to verify accuracy of screening and review policies/procedures. Reporting can currently take place through a secured, online project data management system called RedCAP. Plans to integrate reporting through the Vital Statistics Electronic Birth Record have begun and will continue to be pursued over the next year.

IBS: NBS follow-up staff will continue regular coordination meetings with the KHEL. Bi annual meetings of the legislatively-mandated, NBS Advisory Council will continue to ensure coordination between the public and private sectors and to evaluate the program. The NBS Advisory Council CCHD subcommittee will continue with training in Kansas related to CCHD and work to develop the quality improvement program if it is accepted by the KDHE Secretary.

Training will take place with hospitals related to the new LIMS system. Further discussion will take place regarding the use of scanners for the bar codes on Neonatal samples, which would be used by the birth clerks.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**41163**					
Reporting Year:	**2012**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	41163	100.0	30	5	5	100.0
Congenital Hypothyroidism (Classical)	41163	100.0	36	30	30	100.0
Galactosemia (Classical)	41163	100.0	5	2	2	100.0
Sickle Cell	41163	100.0	10	10	10	100.0

Disease						
Biotinidase Deficiency	41163	100.0	2	1	1	100.0
Cystic Fibrosis	41163	100.0	46	9	9	100.0
Homocystinuria	41163	100.0	130	0	0	
Maple Syrup Urine Disease	41163	100.0	24	0	0	
Tyrosinemia Type I	41163	100.0	14	0	0	
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	41163	100.0	4	3	3	100.0
Citrullinemia	41163	100.0	2	0	0	
Isovaleric Acidemia	41163	100.0	13	0	0	
Carnitine Uptake Defect	41163	100.0	11	1	1	100.0
3-Methylcrotonyl-CoA Carboxylase Deficiency	41163	100.0	12	2	2	100.0
Methylmalonic acidemia (Cbl A,B)	41163	100.0	17	0	0	
Glutaric Acidemia Type I	41163	100.0	7	2	2	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	41163	100.0	9	1	1	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	41163	100.0	21	5	5	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	70	67	66	73	73
Annual Indicator	65.6	65.6	72.6	72.6	72.6
Numerator					
Denominator					
Data Source	National CSHCN 2005-2006.	National CSHCN 2005-2006.	National CSHCN 2009/2010.	National CSHCN 2009/2010.	National CSHCN 2009/2010.

	KS Estimate.	KS Estimate.	KS Estimate.	KS Estimate.	KS Estimate.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	74	74	75	75	75

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments

The 2009-2010 National Survey of Children with Special Health Care Needs (NS-CSHCN) showed that overall 72.6% of Kansas families of Children and Youth with Special Health Care Needs (CYSHCN) partnered in shared decision-making for child's optimal health, compared to 70.3% for the U.S. The Kansas outcome is higher than the U.S. but not significant, and ranks 23rd in the nation. Of the 72.6% of Kansas CYSHCN families that partnered in shared decision-making, 83.1% reported that doctors discussed range of health care/treatment options. Also 83.1% reported that doctors encouraged parents to ask questions or raise concerns and 86.3% reported that doctors made it easy for parents to ask questions or raise concerns. Nearly 87% reported that doctors considered and respected parents' treatment choices.

In Kansas, the "partners in decision-making" outcome was similar across the age groups, but slightly lower for school-aged children (age 6-11 years). CYSHCN in higher-income families were more likely to meet the outcome than CYSHCN in poverty. Nearly all CYSHCN who received services within a medical home met the outcome compared to CYSHCN without a medical home. A greater percentage of those with adequate insurance reported partnering in decision-making, compared to those without adequate insurance. By specific type of special health care needs, this outcome was achieved among nearly 82% with a need managed by prescription medication versus 60.8% of those with functional limitations.

The KS Resource Guide (KRG), a searchable resource directory, supports a comprehensive, multi-system approach to providing resources. The directory houses resources of all major systems impacting children and families, as well as the disability community. This directory can allow families to be better educated and more engaged, increasing those who feel comfortable and capable of being a partner in their child's health care needs. As a result of a targeted marketing effort the number of providers in the directory increased by 30% in the last year.

Through a partnership with the Families Together, the KS Family Voices and Family-to-Family Health Information Center (F2F-HIC), health care information notebooks were disseminated to families as a tool to help them organize their child's health records/needs and to engage providers and the health care team in a more effective, efficient partnership.

Last year's recruitment of a new KRG Administrator resulted in the hiring of a new bilingual staff member. This allowed for identified modifications and updates to the website to be completed, as well as a renewed effort for provider recruitment into the directory. Filling previous gaps in providing quality services to the Spanish speaking population, this staff person is capable of written and verbal translation and has been invaluable by increasing services and supports to our Spanish speaking clients.

A focus of the CYSHCN Advisory Council is placed on ensuring families from various cultural and geographical areas of KS are represented. CYSHCN materials and resources were developed in both English and Spanish and made available to families through community outreach efforts and partnerships with other organizations and agencies dedicated to supporting CYSHCN.

Support for the Parent Support Navigator (PSN) project decreased due to the completion of the D-70 Integrated Systems grant. This position continued to provide care coordination, follow-up, and support services to families and clinic staff in the PKU and Sickle Cell clinics.

Engagement of family and youth partners continued through the KS-SHCN Family Advisory Council. The council is central to supporting and ensuring the consumer voice is addressed and to provide opportunities for families become leaders and true advocates for themselves or their loved ones. FAC members offer guidance and feedback related to the KS-SHCN program

priorities.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Clinic staff meet with families at each multi-disciplinary clinic visit to assess and address family needs.	X		X	
2. Treatment plans are reviewed with youth and families to assure understanding and agreement.	X	X		
3. Families and youth are engaged and active participants in advisory councils.	X	X	X	X
4. Families and youth are financially supported to serve on advisory councils.	X	X	X	X
5. Parent surveys identify gaps and barriers to health care to support future program activities.	X	X	X	X
6. Expansion of resources through the KS Resource Guide and related activities.		X		X
7. Cultural diversity is addressed through accessible, bi-lingual materials and bi-lingual services in clinics.		X	X	
8. Partnership with Families Together, Inc. to support the use of personal health care notebooks and provision of trainings for parents and families.		X	X	X
9. Families are engaged in the KS-SHCN Strategic Planning efforts to support program enhancements and services.	X	X	X	X
10.				

b. Current Activities

Support for all previous activities continued. The KS-SHCN Program began strategic planning in July 2013, including the identification of five new program priorities: 1) care coordination; 2) training and education; 3) family caregiver health; 4) behavioral health; and 5) direct services. This process utilized quality improvement methods to obtain stakeholder and consumer input and identify opportunities for the program to improve upon and expand current services.

Families have been critical to the work that has been accomplished. Two strategic planning sessions have taken place, with another to be held in August 2014. The FAC has remained central to the planning and have provided guidance, assisted in developing key definitions and measurement needs for the new priorities, and recommended strategies supporting our goal of assuring families are partners in decision making at all levels.

A new care coordination program is being developed for the KS-SHCN program and the FAC has dedicated a good portion of their time on the council in assisting the program to identify potential care coordination services and at what level should services should be provided.

This past year, the FAC completed a series white papers, titled "Partner and Communicate with Families of Children with Special Health Care Needs," to educate providers about how important this partnership is. The paper is available on www.kdheks.gov/shcn/publications.htm.

c. Plan for the Coming Year

Families will continue to be central to the KS-SHCN Strategic Planning process. A survey was conducted on early 2014 to identify what families believe should be included services for the future of the KS-SHCN program. This survey was conducted through survey monkey and shared

with many partners across the state. Through this survey, we were essentially asking participants to help us plan and prioritize within each of the new priorities. A great response was received, with 80% of the respondents not currently members of the KS-SHCN FAC.

The survey allowed opportunities for us to identify potential members of the KS-SHCN FAC, in which we have 10 prospective members we are have communicated with regarding the August FAC meeting. This survey supported defining each of the five priorities for the program, including a collaborative model for care coordination. Specifically regarding care coordination efforts, we are working to assure services support families to feel supported, cared for and partnered with in all services offered. The activities being developed will support this and allow for families to provide input and comments to further support this objective.

Continued focus will be placed on addressing the identified unmet needs and major health concerns from the public input survey. The top major concerns for the CYSHCN birth to elven years old population included: family education and support; access to services; adequate health insurance coverage; chronic conditions (ADD/ADHD, asthma, autism spectrum, etc); and care coordination. The top major concerns for the CYSHCN, ages 12 -- 26, population included: access and/or referral to services; adequate health insurance coverage; behavioral and mental health; family education and support; and sexual behaviors (preventing STDs/STIs). These will be integrated into the KS-SHCN strategic plan and families will be provided opportunities assist in helping develop strategies to address these concerns.

In addition to the existing activities related to educating families and providers on how to partner together for the best care of the CYSHCN, the KS-SHCN has submitted an application for the new round of D-70 Integrated Systems for Medical/Health Homes, integrating new opportunities for families to learn more about how to best partner with their providers and for families to educate their peers and/or providers on the need to increase the percentage of families who feel they are partners in their child's health.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	60	60	60	50	51
Annual Indicator	55.3	55.3	49.4	53.8	53.8
Numerator					
Denominator					
Data Source	National CSHCN 2005-2006. KS Estimate.	National CSHCN 2005-2006. KS Estimate.	National CSHCN 2009/2010. KS Estimate.	NSCH 2011/2012. KS Estimate.	NSCH 2011/2012. KS Estimate.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average					

number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	54	56	58	60	62

Notes - 2013
For 2012 and 2013, indicator data come from the National Survey of Children's Health (NSCH), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2011-2012. The same questions were used to generate the NPM 3 indicator for both the 2009/10 NS-CSHCN and 2011/12 NSCH, therefore these two surveys are comparable.

All estimates from NS-CSHCN and NSCH are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2012 and 2013, indicator data come from the National Survey of Children's Health (NSCH), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2011-2012. The same questions were used to generate the NPM 3 indicator for both the 2009/10 NS-CSHCN and 2011/12 NSCH, therefore these two surveys are comparable.

All estimates from NS-CSHCN and NSCH are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments
The 2011/12 National Survey of Children's Health showed 53.8% of Kansas Children and Youth with Special Health Care Needs (CYSHCN) reported receiving care within a medical home, compared to 46.8% for the U.S. Families have become more familiar with the services available through medical homes, and although Kansas has shown improvements over the years and have been supported through efforts of the KS D-70 Integrated Systems (Systems in Sync) grant, there is still significant room for improvement.

Of the 53.8% of Kansas CYSHCN receiving care within a medical care, 94.8% reported that they had a usual source for both sick and well care and 94.2% had a personal doctor or nurse. About

95.1% of Kansas CYSHCN reported that they had no need of any referrals (80.6%) or no problems obtaining referrals when needed (14.5%). Approximately 72.1% of Kansas CYSHCN reported receiving family-centered care (i.e., doctors spent enough time with a child, doctors listened carefully to a child's parent(s), doctors were sensitive to family customs and values, doctors provided information specific to child's health, and doctors helped family feel like partners in care). About 45.6% of Kansas CYSHCN reported receiving effective care coordination when needed (i.e., received help to coordinate child's health care when needed, received extra help to coordinate child's health care if needed, satisfied with communication among child's doctors when needed, and satisfied with doctors' communication to school or programs when needed). About 32.6% of CYSHCN who received or needed specialist care and did not have a problem getting specialist care.

The KS-SHCN specialty clinics require that specialty evaluations and recommendations are sent to the PCP within 2 weeks of the clinic appointment in support of the medical home team approach. Support for the PSN project supported families attending selected SHCN-sponsored clinics. This project was developed as an opportunity to better assist families in partnering with their doctor to support improved quality health care and coordination with increased cost-efficiencies.

Partnership with the KS F2F grantee continues to educate families on medical home components and partnerships. A medical home presentation was developed to educate families on the medical home concept and provide information on how families can begin building a medical home for their families. This presentation was made available at multiple Families Together local and state-wide conferences. This presentation supports family and young adult skill-building in developing effective partnerships and active participation within the medical home. Resources for families and providers on effective partnerships among families and providers were developed by the FAC and made available in English and Spanish.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Clinic reports are provided to the PCP and other providers identified by the family.	X			X
2. SHCN promotes medical homes to clients seen in specialty clinics and assists families to obtain a primary care provider, if needed.	X	X	X	X
3. Infants identified with a positive Newborn Screening test are referred to the SHCN program and follow-up services are explained to families.		X	X	
4. Develop information & disseminate information about medical home for youth, families and professionals.		X		X
5. Conduct trainings for providers on medical home and how to partner with families.		X		X
6. Continue to expand the KS Resource Guide to provide additional medical home resources, tools and materials for youth, families and professionals.		X		X
7. Participate in the Heartland Genetics Collaborative medical home work group and related activities.		X	X	X
8. Support Family Advisory Council work group on medical home to support family leadership and advocacy.		X	X	X
9. Family-centered, cross-system care coordination activities are integrated into all aspects of the KS-SHCN Strategic Planning efforts.	X	X	X	X

10.				

b. Current Activities
The medical home approach continues to be central to the focus of the KS-SHCN program. While the strategic planning session did not highlight medical home explicitly, each priority addresses varying components of the medical home. Care coordination and direct health services are clearly aligned with the medical home approach. Additionally, family caregiver health addresses the family-centered care and comprehensive nature of a medical home. Training and education activities will include supporting increased knowledge of medical home services, building medical home partnerships, and where to access services. For the KS-SHCN program, behavioral and oral health providers are key partners to be integrated into the medical home team.

Medical home services were highlighted within the unmet needs section of the public input survey. Comments related to needs to improve: access to primary care, care coordination, early and periodic screening, diagnosis, and testing, integrated and comprehensive services, referral to community resources and supports, health education and care management supports, and health care transition. There are many other comments that address varying components within each of these items. While current SHCN program activities address some of these needs, this provides support for the strategic planning process.

c. Plan for the Coming Year
The focus of the strategic plan is to identify program needs for our target population. It was evident throughout the process that the program has room for improvement, most specifically building infrastructure and capacity for increased services, support cross-system care coordination, and stronger enabling and population based services. Upon feedback from clinic partners, it appears as though there may be a need to shift away from our previous 'way of doing business.' By shifting extensive support from direct services to address the wrap around services provided through a medical home, such as care coordination, resource referral, communicating among multiple team members, and assisting families with non-medical needs we believe we can better support families to meet the top health concerns and identified unmet needs identified through the public input survey.

As part of the strategic planning process, it was identified that a need to review funding allocated to direct clinical supports and the structure of the multidisciplinary services, it was identified that the need for these clinics varies across the state. Previously, clinics were held in both KC and Wichita, with occasional outreach. A clinic review indicated inconsistencies in the provision of services inequalities in funding allocation. Therefore a new process for clinic support allocation began in April 2014 and will continue for the coming years. This process required clinic partners to submit a proposal for services, demonstrate the need and anticipated health outcomes of clinic services, and outline how they provide and bill for services. Significant differences have been identified and costs savings are anticipated by shifting the funding and supporting an expectation of true partnership, including matched clinic partner funding supports and complete insurance billing practices.

Shifting away from only providing multidisciplinary clinic services, to an enhanced cross-system care coordination model, is believed to allow the program to serve more families across the state and assure support at the local level. There is also an interest from clinic partners to reduce support for facility-based clinics and increase support for telemedicine and outreach services. This is of great interest and excitement, especially to address the needs of our large rural and frontier population areas. The primary clinic partner in Kansas City submitted a funding proposal requesting support for development and capacity building of a medical home, assuring specialized services for the CYSHCN population. Although not knew ideas, this is new approach to utilization of Kansas CYSHCN Title V funds. Careful consideration is being made to assure these changes will increase/enhance services, not decrease them. The application submitted by

the SHCN program for the new D-70 Integrated Systems Medical/Health Home grant will greatly increase the level of support dedicated to this measure.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	64	64	65	61	61
Annual Indicator	62.9	62.9	60	75.2	75.2
Numerator					
Denominator					
Data Source	National CSCHN 2005-2006. KS Estimate.	National CSCHN 2005-2006. KS Estimate.	National CSHCN 2009/2010. KS Estimate.	NSCH 2011/2012. KS Estimate.	NSCH 2011/2012. KS Estimate.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	76	78	78	80	80

Notes - 2013
For 2012 and 2013, indicator data come from the National Survey of Children's Health (NSCH), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2011-2012. The same questions were used to generate the NPM 4 indicator for both the 2009/10 NS-CSHCN and 2011/12 NSCH, therefore these two surveys are comparable.

All estimates from NS-CSHCN and NSCH are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2012 and 2013, indicator data come from the National Survey of Children's Health (NSCH), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2011-2012. The same questions were used to generate the

NPM 4 indicator for both the 2009/10 NS-CSHCN and 2011/12 NSCH, therefore these two surveys are comparable.

All estimates from NS-CSHCN and NSCH are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments
The 2011/12 National Survey of Children's Health (NSCH) showed that 96.7% of Kansas children and youth with special health care needs (CYSHCN) currently had health insurance coverage of some type, compared to 96.8% for the U.S. Of the 96.7% of Kansas CYSHCN who reported currently having health insurance coverage of some type, 87.4% of CYSHCN reported having continuous health insurance coverage for at least one year, and 75.2% reported having (usually or always) adequate current health insurance for child's needs.

For Kansas, It is anticipated that those individuals who do not report having insurance coverage are most likely not eligible for supports through state Medicaid programs or support for affordable insurance through the exchanges. Therefore it is important that the SHCN program continue to provide eligible individuals services such as payment of direct health care costs, prescriptions, low protein food products/PKU formula, durable medical equipment, limited hospitalizations or therapy services, and other approved services. Medical and financial eligibility requirements are in place, based upon state statute and regulation. For those with metabolic conditions there is a sliding fee scale for services due to the high cost of treatment. As stated, large percentage of clients receiving these services do not have adequate insurance and often the SHCN funding is the only source of medical coverage.

The SHCN multidisciplinary clinics are available to anyone who meets the medical requirements for that particular clinic, regardless of financial eligibility to the SHCN program. The majority of patients that attend these clinics have some sort of medical coverage. Public (Medicaid) and private insurance is accepted and billed at these clinics, however patients are not billed for any clinic service.

SHCN staff continued to direct those in need to apply for public assistance (ie: Medicaid/CHIP, SSDI, etc). Expanded oral health services in select SHCN clinics were implemented to provide these services to families who are unable to obtain dental care due to lack of insurance or funding. The KS Equipment Exchange Program is utilized frequently by families of SHCN specialty clinics. This program provides an opportunity to "recycle" durable medical equipment when a child no longer has a need for it (or has outgrown the current equipment).

Medicaid coverage and Health Care Reform were key activities of many of our stakeholders. SHCN partnered with professional organizations and family partners to educate families and young adults about components of the Health Care Reform/Affordable Care Act that may impact their ability to maintain, gain, or expand insurance coverage.

This past year, the FAC completed a series of three white papers, one of which is titled "The Financial Impact of Raising Children with Special Health Care Needs," to help providers

understand some of the issues families experience that may cause non-compliance with medical treatment recommendations, or a lack of communication about the inability to follow through with certain services. The paper is available on www.kdheks.gov/shcn/publications.htm.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor Federal and State efforts related to the Affordable Care Act and educated families on specific elements that may impact access to services and coverage.		X		X
2. Coordinate with KanCare (KS Medicaid) on referrals to SHCN services.	X	X		
3. Route metabolic formula orders through SHCN for discounted rate to reduce out of pocket expenses for families.	X		X	
4. Authorize eligible services with contracted providers that take SHCN's negotiated rates to avoid/minimize family's liability.	X			
5. Assist families in identifying and connecting with private non-profit organization to fund medically necessary treatments and equipment not otherwise covered.		X		
6. Engage the FAC to provide feedback and guidance on insurance and financial impact for families of CYSHCN.		X		X
7. Utilize SHCN and KRG website to assist families of CYSCHN in understanding state and national financial supports available.		X	X	X
8.				
9.				
10.				

b. Current Activities

The purpose of the SHCN strategic plan is to support increased services, enhanced coordination, and stronger systems for CYSHCN. Central to this is providing support and accountability for the Title V and state funding received for these services. Clinical costs continue to rise, while the number of children served through clinics declines. With the increased availability of affordable health coverage and continued reduction of medical specialists in the state, dedicating the majority of funding to multi-disciplinary clinic services not appears to be an antiquated way of providing SHCN services. While some clinics continue to have patient support and operate cost-effectively, others are seeing a decline in attendance of clinics and demonstrating more cost-effective ways to support families.

The 3rd highest health concern for CYSHCN ages 0-11 years, as reported by the public input survey, was adequate insurance coverage; moving to 2nd for the 12-26 years CYSHCN population. This was also a consistent theme throughout the unmet needs responses as well. This year, program staff began researching new models of service delivery to better support families with accessing affordance, appropriate insurance coverage. Although families may be able to obtain affordable coverage, this does not always meet the needs of the CYSHCN. For example, an increase of insurance denials for medically indicated nutrition products, such as PKU formula, has been experienced.

c. Plan for the Coming Year

In additional to researching new models of service delivery, program staff have been meeting regularly to plan for the new KS-SHCN cross-system care coordination program. The first phase of this will include implementing care coordination within existing KS-SHCN Regional Offices,

expected to be rolled out in phases. The Kansas City regional office will be joining in the development and piloting process to assure this can work in both the state and regional offices. A major component of this will include assessing family needs, including financial support needs and ability to access adequate health insurance. Resources and supports will be provided to assist families in obtaining insurance coverage if they do not have it. Currently, the program primarily refers to appropriate programs, however this new model will include more individualized and personal assistance, as needed. Additionally, staff training will increase to assure all SHCN staff are familiar with how to access the health insurance exchanges and support families through that process.

Additionally, we plan to consult with the Catalyst Center to develop state-strategies designed to close funding gaps and enhance coverage for CYSHCN through the medical/health home approach. Evidence-informed best-practices will be considered and integrated into the KS-SHCN program efforts toward this outcome. We will also continue to partner with Families Together, Inc. and other partners to provide patient, parent, and family supports on obtaining affordable and adequate insurance coverage.

We plan to expand resources within the Kansas Resource Guide, and develop an interactive, electronic tool kit to help families better understand how to navigate state-wide service systems. This will include key information about the various programs available and the services offered from each, such as: how to access services; what documentation is required to apply; specific eligibility criteria; how to assure continuation of services once received; and any other information deemed important by state and family partners. The SHS-FAC will assist in developing the tool kit outline to further engage partners from each of the included service programs to assure accuracy and validity to the tool kit entry. This will also serve as a mechanism to assure notification of changes for ongoing monitoring and updates, as appropriate. The tool kit will be available primarily online through the expanded KRG website, downloadable as a printable PDF, and in hard copy (upon request).

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	95	99	93	67	68
Annual Indicator	92.5	92.5	66.8	66.8	66.8
Numerator					
Denominator					
Data Source	National CSHCN 2005-2006. Estimate KS	National CSHCN 2005-2006. Estimate KS	National CSHCN 2009/2010. Estimate KS.	National CSHCN 2009/2010. Estimate KS.	National CSHCN 2009/2010. Estimate KS.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over					

the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	68	69	69	69	69

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments
The 2009-2010 National Survey of Children with Special Health Care Needs (NS-CSHCN) showed that overall 66.8% of Kansas children and youth with special health care needs

(CYSHCN) families reported that community-based service systems were easy to use (i.e., no difficulties or frustration accessing services needed for their child in the past 12 months), compared to 65.1% for the U.S. The Kansas outcome is higher than the U.S. but not significant, and ranks 19th in the nation.

Of the 66.8% of Kansas CYSHCN families who reported that community-based service systems were easy to use, 66.9% reported that they experienced no difficulties or delays getting services. The table at right shows the results of the six subcomponent topics that describe difficulties with accessing care. About 64.3% of parents reported experiencing no frustration in getting services for their child.

In Kansas, achieving the "community-based services" outcome was similar across the age groups, but slightly higher for school-aged children. The proportions of CYSHCN achieving this outcome increased with family incomes. CYSHCN receiving care within medical homes were more likely to achieve this outcome than CYSHCN without a medical home. A greater percentage of those with adequate insurance reported achieving this outcome compared to those without adequate insurance. By specific type of special health care need, this outcome was achieved among nearly 80% with a need managed by prescription medication versus 43.4% of those with functional limitations.

This past year, the KS-SHCN funded a total of 20 specialty clinics in Kansas City and Wichita. From these clinics, approximately 6,206 patients were seen throughout the year. A dental hygienist was available to provide screening and preventative services to patients in the cerebral palsy, cleft lip/cleft palate, and spinal cord clinics. We continued to provide local resources within the SHCN health care plan and to the family, primary care provider, and authorized service providers along with community resources.

The Kansas Resource Guide (KRG) is maintained to provide a comprehensive, multi-system approach to providing resources. The directory houses resources of all major systems impacting children and families, as well as the disability community. This guide is intended to serve as a "one-stop-shop" for resources so families and professionals can find the resources and services they need in a more time-effective manner. A formal marketing and promotion campaign of the KRG was done as an effort to expand the number of providers listed in the directory. A translation widget was added to KRG to provide the searchable directory resources and services in languages other than English.

Interpretation services are provided to families for those who are not English-speaking and upon request. Follow-up screenings are provided to those who screen positively in the two newborn screening programs in KS (Hearing and Genetic conditions). Primary, specialty, dental and mental health services continue to be sparse in rural communities in KS and families continue to struggle with accessing these services.

KS-SHCN staff participated in a number of advisory councils and work groups to support collaboration and partnerships with the various community-based service systems. These include: Sound Beginnings, Newborn Screening Advisory Councils, Kansas Council for Developmental Disabilities, and serves on the Kansas Commission on Disability Concerns as the Secretary of Health's designee. Through participation in these meetings we can assure that the CYSHCN population is included in state policy and practices and that this population's voice does not go unheard. Additionally, these meetings provide opportunities for education, provision of information and networking to ensure our service systems are complimenting, not duplicating, each other's services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. Special needs outreach clinics are held in underserved areas of the state based on consumer need and staff capacity. Special clinics offered to local school systems, upon request.	X		X	
2. CSHCN (age 0-3) are referred to Part C Early Intervention networks that serve their community.	X	X	X	X
3. Interpreter services provided for visits with local and specialty providers, as needed.	X	X	X	
4. Provide care coordination and system support through the KS-SHCN.	X	X	X	X
5. Expand the KS Resource Guide to provide additional medical home resources, tools and materials for youth, families and professionals.		X		X
6. Serve and represent the CYSHCN population and their families at local, regional state level meetings and activities.				X
7. Conduct a survey to identify needs, gaps in services, and collect state-level data on access to community-based services and ease of use.		X	X	X
8. Develop a toolkit to support families in identifying resources and navigating the complex service system in Kansas.		X	X	X
9.				
10.				

b. Current Activities

The 2nd highest health concern for CYSHCN ages 0-11 years, as reported by the public input survey, was access to services and the 6th highest was referral services. For CYSHCN, 12-26 years, access and/or referral to services was the #1 reported health concern. As access to community-based services is closely tied to care coordination, it is not surprise this is a consistent theme throughout the unmet needs responses as well.

By including a variety of resources, information, documents and medical/health home provider listings in user friendly, accessible ways the KRG will help connect families, providers and others in order to assist in efforts to improve coordination of care across the state. Within the proposed D-70 grant activities, we also plan to enhance the KRG through mobile technology. The plan includes development a mobile application to allow access to the KRG directory and other resources through mobile site access and an application downloadable through the Android or iPhone app stores.

A new initiative with the Cerebral Palsy Research Foundation to host outreach clinics in the Western part of the state began this year. Outreach consultation and evaluation clinics were held in four semi-rural regions of the state. Typically these services have only been available in Kansas City and Wichita, the two largest metropolitan areas in Kansas. This was a successful initiative and is expected to continue, to expanded areas of the state in the coming year.

c. Plan for the Coming Year

In addition to the interactive, electronic tool kit, we will continue to expand and enrich the KRG by: conducting community outreach; providing informational webinars; recruiting more community-based provides; and adding additional enhancements, such as a stronger focus on outreach and provision of resources, information, and publications, including information about the various MCHB/HRSA National Centers and linkages to additional tools and resources available to families of CYSHCN. As new publications and reports are released, these will be linked on the expanded website. The SHCN staff will promote the KRG and electronic tool kit through outreach and social media to further support the ability for families to receive necessary information to obtain needed community referrals.

The KS-SHCN will be pursuing a new data system. We plan to integrate into the KS Early Hearing Detection and Information (EHDI)/Newborn Hearing Screening programs' data system. Currently, integration of the Newborn Metabolic Screening and Birth Defects Registry is underway. By enhancing this system further and integrating the KS-SHCN program data and care coordination efforts into the system, we will be better able to share data, make referrals, coordinate care from one program to the other, and assure timely follow up for patients and clients. The system will be developed to support: cross-system care coordination; assisting families to obtain services within a medical home; assessing and providing services based upon patient and family needs; increasing communication among medical and community service providers; automating program eligibility and service authorization processes; and stronger data collection/reporting capacity and capabilities. These benefits will greatly increase capacity to assure the SHCN program has access to services.

The KS-SHCN integration will begin in early 2015; however through the D-70 grant proposal, we plan to enhance this integration further by building in additional cross-system data sharing capabilities. Two primary enhancements will be considered as part of this grant project. The first include a patient/family portal for direct access to case information, care plans, and service authorizations. The portal will consist of a place for families to submit applications to the KS-SHCN program, request services, complete family and patient needs assessments, and access their information. The second is to build in interoperability within the health information exchanges to effectively share data with medical/health home providers (such as hearing and metabolic screening results, SHCN health care and service plans, care coordination efforts, and secured messaging directly to the provider).

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	53	55	53	53	54
Annual Indicator	50.3	50.3	52.7	52.7	52.7
Numerator					
Denominator					
Data Source	National CSHCN 2005-2006. KS Estimate.	National CSHCN 2005-2006. KS Estimate.	National CSHCN 2009/2010. KS Estimate.	National CSHCN 2009/2010. KS Estimate.	National CSHCN 2009/2010. KS Estimate.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and					

therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	54	55	55	55	55

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments
The 2009-2010 National Survey of Children with Special Health Care Needs (NS-CSHCN) showed that overall 52.7% of Kansas youth with special health care needs (YSHCN), 12-17

years, received the services necessary to make appropriate transitions to adult health care, work and independence. While Kansas outcome ranks 1st in the nation and is significantly higher (p-value<0.05) than the national average of 40.0%, this means that almost half of Kansas youth do not receive the necessary transitions services.

Of the 52.7% of Kansas YSHCN that received the services necessary to make appropriate transitions, 57.7% reported that they received anticipatory guidance for transition to adult health care. Among the 57.7% of Kansas YSHCN that received the anticipatory guidance, 59.8% reported that their health providers discussed the shift to adult health care providers, and 72.6% reported that their health providers discussed their changing health needs as they become an adult. About 66.5% reported that their health providers discussed health insurance as they become as adult.

In Kansas, achieving the outcome of receiving services necessary for transition was similar across the age groups. A greater percentage of those in higher-income families reported receiving services necessary for transition, compared to those in lower-income families. YSHCN within a medical home were more likely to receive services necessary for transition than YSHCN without a medical home. YSHCN receiving services with adequate current insurance were nearly twice as likely to report positively on this outcome compared to those without. By specific type of special health care needs, YSHCN with a need managed by prescription medication were more likely to receive services than YSHCN with functional limitations.

Through the previous D-70 Integrated Community Systems, Systems in Sync, grant, a web-based program for YSHCN was developed through partnership with the University of Kansas Center for Developmental Disabilities. An oversight in the development of an ongoing maintenance agreement with the University resulted in a delay in dissemination of the program. However, a contract with an external vendor has been completed and the necessary security updates have been deployed. The website hosting rights have been transferred to KDHE; however the administrative account access was deleted prior to transfer by the University. In order for KDHE to access the account and disseminate, additional modifications were needed for administrative access to be re-created. This is expected to be completed soon.

Partnership with Families Together, supports transition-related issues being addressed in regional and statewide conferences for parents/families, educators, community and health providers, and other interested parties. A strong focus on engaging youth early and providing resources to parents prior to the formal transition period was evident.

The Kansas Health Care Transition Model focuses on integrated and comprehensive supports for youth as they transition from pediatric to adult medical homes and into independent community living as an adult. This includes how youth, families and providers can be effective partners in this model. This model incorporates a variety of components to support capacity and infrastructure building in Kansas, including: the Parent Support Navigator project; the JumpStart project; a self-determination curriculum; partnership with the Heartland Genetics Collaborative; and individualized healthcare plans.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide transition resources to families, youth, and community service providers.			X	X
2. Coordinate with family and education partners' transition workshops.		X		X
3. SHCN staff participate in local, regional, state and national workshops to promote inclusion and increase awareness of the			X	X

needs of YSHCN.				
4. FAC members provide feedback and guidance on state transition efforts.				X
5. Dissemination of a youth-focused model for health care transition that includes a care coordination, provider policy development, system integration, partnerships, and resources/tools for youth, families and providers.		X	X	X
6. Expansion of the Kansas Resource Guide with the development of a transition navigational tool kit.		X		X
7.				
8.				
9.				
10.				

b. Current Activities
Although the KS-SHCN strategic plan has not had a specific focus on transition services, this is definitely a component of providing comprehensive care coordination and will be addressed through training and education for providers, families, and youth.

According to the public input survey, transition to adult health care is a major health concern for 48.5% of the people who responded to that question for the CYSHCN 12-26 age group. Additionally, when asked how well the respondent felt the state is doing with to address transition for YSHCN, the majority (66 of 107) responded "I don't know." Seven responses indicated "ineffective" or "very ineffective." This shows a clear need in raising awareness of the need for youth health care transition services and how to access available services. Additional data collection would be valuable to determine what services are felt to be ineffective; however the comments received through the public input survey did not provide the level of detail to know specifically what services are not effective.

c. Plan for the Coming Year
While the work on each component of the Kansas Health Care Transition Model has been finalized, additional work is needed to condense and compile the information in a way conducive to wide-spread dissemination. This will take place this year to support integration of this model and health care transition supports into the KS-SHCN Care Coordination Program. This model, consists of tools and resources for youth with special health care needs dedicated to supporting successful transition to independent living and adult health services. Components of this model integrate family supports, engaged healthcare providers, individualized healthcare planning, and youth self-directed health services.

With the new D-70 grant proposal, we are proposing a series of youth focus groups to review the health care transition model, provide feedback and input on the various components, and further pilot the tools and assessment developed in the Systems in Sync grant. Although provider and youth feedback were obtained during the development of the tool, further utilization and review is desired to support youth from a variety of backgrounds and use in additional settings, outside the doctor's office. It is anticipated that this tool could be initiated in by the school nurse as a way to support individualized health and education planning (IHPs/IEPs) as youth are reaching transition age and a transition plan is developed. This will support integration of health management skills into the IEP and provide opportunities for the school nurse to work with the youth to assure their health needs will be meet upon existing all service and support systems.

The SHS Director has been consulting with the Heartland Genetics Collaborative on projects related to individualized health planning for students with SHCN or genetic conditions. Through this work, and other projects within the Heartland Genetics Collaborative, there is an opportunity

for integration of IHPs and transition activities through the use of this tool and supports from various projects.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	90	79	79	83	85
Annual Indicator	77.5	80.1	77.7	68	68
Numerator					
Denominator					
Data Source	CDC National Immunization Survey 2009, KS	CDC National Immunization Survey 2010	CDC National Immunization Survey 2011	CDC National Immunization Survey 2012	CDC National Immunization Survey 2012
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	70	70	72	72	72

Notes - 2013
The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

Notes - 2012

DATA SOURCE: Centers for Disease Control and Prevention. Vaccination coverage for the 4:3:1:3:3 vaccine series among children 19 to 35 months U.S., National Immunization Survey, 2012. http://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/tables/12/tab03_antigen_state_2012.pdf

The 2012 coverage estimate is based on the new definition, 4:3:1 plus full series of Hib vaccine (3 or 4 doses depending on the brand) and 3 or more dosese of HepB vaccine. The 2011 and 2012 data not comparable to previous years.

In Kansas, Haemophilus Influenza type B (HiB) is not required for school entry but is required for public preschools or school operated child care for children under five years of age.

Notes - 2011
DATA SOURCE: Centers for Disease Control and Prevention. Vaccination coverage for the 4:3:1:3:3 vaccine series among children 19 to 35 months U.S., National Immunization Survey, 2011. Adhoc report.

The 2011 coverage estimate is based on the new definition, 4:3:1 plus full series of Hib vaccine (3 or 4 doses depending on the brand) and 3 or more dosese of HepB vaccine. The 2011 data not comparable to previous years.

In Kansas, Haemophilus Influenza type B (HiB) is not required for school entry but is required for public preschools or school operated child care for children under five years of age.

a. Last Year's Accomplishments
According to the 2012 National Immunization Survey (NIS), Kansas immunization rates for 4:3:1:3:3 combination (DTaP-Polio3-MMR1-Hib3-HepB3) was decreased from 77.7% to 68.0%. This was below the national average (73.2%) and did not meet the Healthy People 2020 goal of 80%. The coverage estimate is based on the new definition - 4:3:1 plus full series of Hib vaccine (3 or 4 doses depending on the brand) and 3 or more doses of Hep B vaccine. The 2012 and 2011 data are not comparable to previous years.

The statewide coverage levels at school entry (i.e., on the first day of school for the 2012-2013 academic year) for all vaccinations required for school entry (DTaP5, Polio4, MMR2, Var2, HepB3) were at or above 86%, with HepB3 having the highest coverage at 96%. HepB3 was the only vaccination to meet the Healthy People 2020 goal of at least 95% coverage for kindergarten immunizations. The complete series for all 5 required vaccinations (5-4-2-2-3) had a coverage level of 81% at school entry. Vaccination coverage levels for most immunizations increased within the first 30 days of school. Children enrolled in public schools had significantly higher coverage levels than children enrolled in private schools throughout Kansas for all required vaccines, except MMR2.

DS: MCH staff in local health departments provided immunizations, recorded data and reported to State MCH and Immunization Programs.

ES: None reported

PBS:
Kansas Immunization Program (KIP) provided Vaccines for Children (VFC) program on a sliding scale basis.
Kansas WIC interfaced with KIP to meet federal guidelines that WIC clinics check each client's immunization status. By checking WebIZ, local staff have accurate records allowing them to update immunizations or make a referral to do so. This has served a role to increase state immunization rates.

Medical home providers, the majority of schools, and local health departments across Kansas

have access to KSWebIZ to update demographics, historical vaccinations, and may track school immunization rates pending parental consent.

IBS:
The Maximizing Office Based Immunizations (MOBI) continued to train health providers to improve vaccine practices, administration, and storage for their pediatric and family practices.

KIP continued to expand the user base working with EClinic, NextGen, eMD, GE Centricity, and APRIMA and continue to work on interfaces that will allow providers to access and exchange information with the registry.

KIP interfaced with Kansas Vital Statistics to include on the birth certificate demographics and the birth dose of Hepatitis B -- thus beginning the baby's immunization tracking. KIP has also linked with Medicaid billing system to import into KIP data base (KSWebIZ) nightly.

KIP updated the annual retrospective immunization report that assesses the completeness of immunizations at 24 months of age in children enrolled in kindergarten during the 2012-2013 school years.

Immunization updates and training was provided at the Annual State School Nurse Conference and the Kansas Immunization Conference.

The Immunize Kansas Kids (IKK) coalition provided grants to support communities or agencies to improve immunization practices at the local level.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitor, evaluate and communicate provider vaccine management performance to reduce wasted, spoiled, expired or unaccounted-for vaccines			X	X
2. Conduct compliance site visits				X
3. Update and maintain list of participating health providers				X
4. Monitor and assess completeness and timeliness of case reporting to CDC for vaccine preventable conditions			X	X
5. Monitor and assess the accuracy , timeliness, and series completeness of vaccinations in children			X	X
6. Increase the number of health providers providing information to the immunization registry			X	X
7. Continue MOBI-KS project that has physician trainers educate and train providers on site at about immunization policies			X	X
8. Continue and expand the providers and families participating in 'Immunize and Win Prize' initiative			X	
9. Continue to assess immunization coverage for the 4-3-1-3-3 vaccine series for children enrolled in kindergarten using the retrospective immunization survey			X	X
10. Support immunization program staff by providing them opportunities to disseminate current immunization information to physicians, nurses and other health care staff in various settings		X	X	X

b. Current Activities

DS: MCH staff in local health departments provide immunizations, record data and report to State MCH and Immunization Programs.

ES: None

PBS: KIP continues Vaccines for Children (VFC) program.

Kansas WIC continues an interface with KIP to meet federal guidelines for WIC clinics to improve immunization rates.

KIP continues the Immunize and Win a Prize program. The family receives a prize each time their child is immunized between birth and two years of age. Once the child completes his/her primary infant immunization series, the family is entered in a drawing for $400 to be applied to a utility bill. One family will be drawn for each participating medical provider.

IBS:
KIP uses VTrckS developed by the CDC. VTrckS allows health care providers to input their vaccine requests (orders) directly online thereby improving efficiency and accountability of public dollars.

Immunization updates and training will be provided at the Annual State School Nurse Conference and the Kansas Immunization Conference.

The Immunize Kansas Kids (IKK) coalition provides grants to support communities or agencies to improve immunization practices at the local level.

IKK, and Kansas Chapter of the American Academy of Pediatrics, developed a new manual and provided trainings, webinars and a webpage on vaccinations and specifically addressed vaccine hesitancy. The resources and training were distributed statewide to health care providers, school nurses, MCH staff and others working with children and families.

c. Plan for the Coming Year
DS: MCH staff in local health departments will continue providing immunizations, recording data and reporting to State MCH and Immunization Programs.

ES: None reported

PBS: KIP will continue support of VFC program. WIC will continue to expand their services to increase referrals for immunizations. MCH will continue to support the VFC program and attend immunization update trainings as offered.

IBS:
The Kansas Immunization Conference will be held for all immunization providers with emphasis on best practices. On-line training will continue to be refined and offered on the KS TRAIN learning management system.

Collaboration and expansion of KIP work to maintain complete, accurate, and secure immunization records for all Kansas residents will continue.

Develop an intentional collaboration between MCH and KIP staff to identify strategies and find opportunities to update program information and engage stakeholders in a quality improvement process leading to improved immunization rates.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	20	20	20	18	15
Annual Indicator	20.6	19.1	15.5	14.5	14.5
Numerator	1162	1106	896	833	833
Denominator	56277	57952	57687	57341	57341
Data Source	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2012	Kansas Vital Statistics, 2012
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	14	14	13	13	12

Notes - 2013
The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

Notes - 2012
Data Source:
Numerator = Birth certificate (resident) data, 2012, Bureau of Epidemiology and Public Health Informatics, KDHE
Denominator = U.S. Bureau of the Census

Notes - 2011
Data Source:
Numerator = Birth certificate (resident) data, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE
Denominator = U.S. Bureau of the Census

a. Last Year's Accomplishments
The Kansas teen birth rate (ages 15-17) declined 18.8% from 2011 (15.5) to 2012 (14.5). The difference was not statically significant. In 2012, the birth rate for Kansas young teenagers was slightly higher than the national rate (14.1 per 1,000). There was a slight increasing trend over the interval 2003-2008, followed by a statistically significant decreasing trend from 2009 to 2012

with an annual percent change (APC) of -12.69. The declines in teen birth rates were observed by 2.9% for non-Hispanic white (from 10.3 in 2011 to 10.0 in 2012), by 8.3% for non-Hispanic black (from 19.3 in 2011 to 17.7 in 2012), and by 33.0% for Hispanic (from 38.5 in 2011 to 34.0 in 2012) teenagers from 2011 to 2012.

DS: Title X Family Planning services were offered in 61 of Kansas' 105 counties. All Family Planning clients receive STD prevention counseling at their initial and annual visits. Sexually active women < 25 years of age are offered Chlamydia screening annually.

ES:
KDHE continued to receive state general funds used to implement Teen Pregnancy Targeted Case Management (TPTCM) programs. Ten local programs were funded to support pregnant and parenting adolescents up to age 21 in order to reduce negative pregnancy outcomes and delay future pregnancies. In state fiscal year 2013, 980 adolescents were served.

Starting in 2011, KDHE received Section 510 Abstinence Education of Title V funds for the Kansas Abstinence Education Program (KAEP). KDHE contracted with the Children's Alliance of Kansas to provide abstinence education training to foster/adoptive/kinship care parents and youth in foster care ages 10-18. This information was added to foster care curricula and foster parents were given incentives to teach KAEP information to the foster children. The intent of the program is to normalize abstinence, healthy choices and positive behavior. In fiscal year 2013, 209 foster care providers were trained on working with teens and 843 teens received the curriculum.

KDHE Bureau of Disease Control and Prevention, STD Section, continued the Personal Responsibility Education Program (PREP) grant to provide evidence-based programming to adolescents (ages 13-18) on STDs, HIV/AIDS, teen pregnancy prevention and adulthood preparation topics. PREP was implemented in three urban counties which contain about 42 percent of the state population. PREP served 1,453 participants. Preliminary evaluation indicates participants have a significant increase in knowledge at post-test.

PBS:
Teen pregnancy prevention messages were sent to all MCH grantees and school nurses (approximately 800) during Teen Pregnancy Prevention Month to provide public information to promote teens making healthy choices.

Due to the direct relationship between alcohol and teen pregnancy, Fetal Alcohol Spectrum Disorder (FASD) training was provided to teens and groups that work with teens. MCH staff trained 49 community members on the dangers of alcohol and pregnancy.

IBS:
MCH partnered with Kansas State Department of Education (KSDE) to provide AIDS/HIV/STD education for teachers and nurses; topics included the technical world of teen sexuality, current trends in adolescent sexual behavior, human trafficking, abstinence programs, and staying safe online.

MCH staff served on DCF Kansas Child Welfare Quality Improvement Committee which addressed coordination, policies, and legislation to improve the permanency of teens in the foster care systems that are pregnant or parenting.

MCH staff continued active participation with the Kansas Fatherhood Coalition which included training activities focused on adolescent males.

KDHE continued to partner with the KSDE and other KDHE sections to maximize and assure access to information and resources.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide family planning and STD prevention/treatment services to adolescents.	X	X	X	
2. Continue to develop and promote evidence based teen pregnancy prevention programs.		X	X	X
3. Promote the prevention of Fetal Alcohol Spectrum Disorder (FASD) in teen's children though education and participation in FASD prevention campaigns.		X	X	X
4. Serve on Department for Children and Families (DCF) Kansas Child Welfare Quality Improvement Committee to improve the permanency of teens in the foster care systems that are pregnant or parenting.				X
5. Actively look for opportunities to address teen pregnancy disparity issues such as speaking opportunities and program committee involvement.		X	X	X
6. Serve on committee with DCF to provide education and support male involvement programs and resources.		X	X	X
7. Plan and participate with KSDE and surrounding states to offer a regional training on HIV/STD/AIDs prevention conference.				X
8.				
9.				
10.				

b. Current Activities

DS: Title X Family Planning services have been provided in 62 of Kansas' 105 counties. All Family Planning clients receive STD prevention counseling at their initial and annual visits. Sexually active women < 25 years of age are offered Chlamydia screening annually.

ES:
Ten local TPTCM programs continued with state general funds. From July 2013 through March 2014, 886 adolescents were served.

From October 1, 2013 through March 31, 2014, the KAEP provided training to 67 foster care providers on working with teens and 439 youth received the curriculum. There were 35 new trainers.
The KDHE STD Section continued the PREP grant implemented in three urban counties.

PBS: Teen pregnancy prevention messages are sent to all MCH grantees and school nurses (approximately 800) to provide public information to promote teens making healthy choices.

IBS:
MCH partnered with KSDE to provide AIDS/HIV/STD education for teachers and nurses.

KDHE continues to partner with the KSDE and other KDHE sections to maximize and assure access to information and resources.

Using state general funds for teen pregnancy prevention activities, KDHE established a contract with Kansas State University to conduct a state level needs assessment addressing adolescent health including teen pregnancy prevention and develop a Kansas Adolescent Health Strategic Plan which will also inform the next state MCH five-year needs assessment.

c. Plan for the Coming Year
DS: Title X FP services will continue in an estimated 61 of Kansas' 105 counties, including STD prevention counseling and screening.

ES:
Ten local TPTCM programs will continue supported by state general funds.

KAEP will continue to provide foster parents tools to help foster teens make responsible choices. It is anticipated the program will serve 1,011 students next year and train 77 foster parents.

The PREP grant will continue to provide training to target high population areas in Kansas using proven effective curricula.

KDHE will continue to identify and support evidence-based teen pregnancy prevention programs.

PBS: Public education information will continue to be distributed to all MCH grantees, school nurses, and other partners regarding teen pregnancy prevention and related topics.

IBS:
MCH will continue collaborations with KSDE and school nurses to provide training on adolescent health issues, including human trafficking, pregnancy and STDs.

MCH staff will continue involvement with the Kansas Fatherhood Coalition including an emphasis on adolescent males.

KDHE will continue to collaborate with other state agencies and programs to maximize funds.

The KDHE will continue the contract with Kansas State University to complete a state level needs assessment and Kansas Adolescent Health Strategic Plan which will also inform the next state MCH five-year needs assessment.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	40	40	40	41	38
Annual Indicator	38.2	38.2	35.7	35.7	35.7
Numerator	13176	13176			
Denominator	34506	34506			
Data Source	KDHE. Smiles Across Kansas: 2007	KDHE. Smiles Across Kansas: 2007	KDHE. Smiles Across Kansas: 2012	KDHE. Smiles Across Kansas: 2012	KDHE. Smiles Across Kansas: 2012
Check this box if you cannot report the numerator because 1.There are fewer than 5					

events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	38	40	40	42	42

Notes - 2013
Data Source: KDHE. Bureau of Oral Health. Smiles Across Kansas: 2012.

Notes - 2012
Data Source: KDHE. Bureau of Oral Health. Smiles Across Kansas: 2012.

Notes - 2011
Data Source: KDHE. Bureau of Oral Health. Smiles Across Kansas: 2012.

a. Last Year's Accomplishments
The Bureau of Oral Health (BOH) is in year three of a state-wide public health program designed to reduce dental disease in Kansas children. The Kansas School Sealant Program partners with local dental professionals and schools to bring preventive oral health services to children that may have limited access to dental care. The Kansas School Sealant Program has seen tremendous growth since its inception during the 2010-11 school year. This program is bringing access to preventative care to thousands of children who may not have obtained services without it. In 2013, 77 percent of these children were receiving Medicaid services or had no dental insurance. The Kansas School Screening Program reported data for more than 150,000 kids. Eighty-three of the state's 105 counties have a school sealant program in at least one of their schools.

Direct Health Care Services:

The Kansas Bureau of Health does not provide direct dental health care services.

Enabling Services:

Oral Health Education/ Outreach:
1. Regional Dental Hygienists provide oral health information and one and one dental hygiene instruction to parents and caregivers of Children and Youth with Special Health Care Needs. Working through contractor Oral Health Kansas, these parent educators meet with children and parents as well as the support service providers to raise awareness about the importance of oral health in overall health improvement.

2. Collaboration with the Primary Care Association - the Bureau provides the Primary Care Association with assistance on educating their dental providers about pediatric and special needs patients. We also collaborate on dental recruitment and workforce issues.

Support Services:

1. The Bureau has contracted with eighteen clinics or programs to create and maintain school sealant programs. Last school year (12-13) those that participated in the Kansas School Sealant Program placed 21,914 sealants on 5,274 students. The Bureau provides funding and technical

assistance.

Population Based Services:
Oral Health Screening - Kansas law requires each child to have a yearly oral health screening. The Bureau of Oral Health assists schools in complying with this statute. Bureau staff trains screeners and helps schools organize screening dates. Screening data is collected and housed at the Bureau. In the 2012-13 school year, over 150,000 children were screened.

Infrastructure Building Services:

Policy Development:
1. Co-facilitate Early Childhood Oral Health Advisory Council (ECOHAC) with Oral Health Kansas.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Establish school oral health screenings and referrals.		X	X	X
2. Provide consultation and technical assistance to school based dental sealant projects.		X		X
3. Provide support and technical assistance to the Medicaid Agency on dental matters.				X
4. Provide leadership to the Oral Health Kansas Coalition.				X
5. Provide leadership to the Kansas Public Health Association Board Oral Health Section.				X
6. Provide education and dental access to Children and Youth with Special Health Care Needs.		X		X
7. Collaborate with private dentists and safety net clinics to provide technical assistance and education about underserved populations.				X
8. Targeted education and outreach to families to improve the oral health of children across Kansas.		X	X	X
9.				
10.				

b. Current Activities
Enabling Activities:

Education:
1. Conduct calibration training for nurses in Johnson County School Districts to aide in a county level initiative to have dental screenings offered in all elementary schools in the county by 2017.
2. Conduct an educational seminar for the eighteen sealant sites for administrative and technical support for the Kansas School Sealant Program.
3. Provide training for Early Childhood Staff on Oral Health with the Cavity Free Kids Oral Health curriculum.

Population Based Services:
1. The school based screening initiative screened over 150,000 children in the 2012-2011 school year.
2. The Kansas Oral Health Burden Document released in 2013.

c. Plan for the Coming Year
Continue to recruit volunteer screeners to expand the number of children offered screenings in school.

Collect data from the eighteen sealant sites on services performed in the 2013-14 school year and evaluate the program.

Continue to locate and secure funds to continue and expand the Kansas School Sealant Program with an emphasis in rural communities and urban schools with a Free Reduced Lunch participation rate of 50% or higher. This program will increase the proportion of African American and Latino children with dental sealants. Partners will also create or expand outreach dental preventive services/collect data for the pre-k and nursing home population.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	3.6	3.6	2.5	3.6	2.6
Annual Indicator	2.7	4.0	2.8	3.3	3.3
Numerator	16	24	17	20	20
Denominator	588523	606823	605120	606608	606608
Data Source	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2012	Kansas Vital Statistics, 2012
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	2.6	2.4	2.4	2.2	2.2

Notes - 2013
The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

Notes - 2012
Data Source:
Numerator = Death certificate (resident) data, 2012, Bureau of Epidemiology and Public Health

Informatics, KDHE
Denominator = U.S. Bureau of the Census; 2012 estimates.

Notes - 2011
Data Source:
Numerator = Death certificate (resident) data, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE
Denominator = U.S. Bureau of the Census; 2011 estimates.

a. Last Year's Accomplishments
In 2012, the mortality rate for children ages <= 14 because of unintentional injury-motor vehicle crashes was 3.3/100,000 children, a 17.9% increase from 2011 (2.8). Overall, there is a significant decreasing trend observed over the 10 year period, 2003-2012. The APC (annual percent change) was significant (-6.89).

According to the 2013 Annual Report (2011 Data) of the Kansas State Child Death Review Board, 33 children died in Kansas due to a motor vehicle crash (MVC). This is the lowest number of MVC fatalities since the Board's inception. Of those deaths, 45% were not using a safety restraint; 30% were rear-seat passengers; 48% were less than 10 years of age; and 49% of the fatalities occurred from 3 p.m. to midnight.

DS, ES: None reported.

PBS:
Healthy Start Home Visitors (HSHV) in local health departments continued to serve and be certified as child passenger safety (CPS) technicians. Child passenger safety seats installation/inspection continue with training offered by Kansas Traffic Safety Resource Office (KTSRO).

MCH works with KTSRO, the Kansas Highway Patrol, local law enforcement, the Kansas Drivers Safety Education Association, AAA, Kansas Safe Kids Coalitions, the Kansas Family Partnership, Students Against Destructive Decisions (SADD), and others to provide an assortment of traffic safety education through newsletters, web mail, education programs and public service announcements. MCH staff continues to support and promote these training and prevention programs, and write prevention articles for publication in MCH, KDHE, and other newsletters.

Registered CPS inspection stations receive periodic disbursements of car seats from the Kansas Department of Transportation to provide at no cost to families. KTSRO trains 60-80 child passenger safety technicians a year. Some of these technicians are from car dealerships, schools and other community members.

IBS: Safe Kids has 28 local coalitions covering 74% of Kansas children age 0-14. A State MCH staff member serves on the Safe Kids Advisory Committee. Safe Kids and MCH are looking closely at car crashes in relationship to where the occurrences happen, race of victims, and the age and gender of the driver of vehicle involved in the crash.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH Title V staff collaborates with Safe Kids, KTSRO and the Emergency Medical Services for Children Coalition to coordinate delivery of motor vehicle injury/death prevention information and resources.			X	X
2. Link local health departments to data resources that provide			X	X

information of motor vehicle unintentional injury to facilitate development of regional/community strategies targeting specific populations/injuries/deaths.				
3. Local MCH staff provide installation expertise, education and instruction to families with infants and young children on Child Passenger Safety Seats.			X	
4. Encourage community collaboration to seek out resources to assist in injury prevention programs such as Booster to Belts, Cycle Smart, Walk This Way, Spot the Tot and Safe Routes to School.			X	X
5. MCH provides education/resources for developing/delivering targeted MCH services for specific populations through annual orientation session for new MCH staff, the monthly MCH newsletter, and participation on statewide coalitions/committees.			X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
DS, ES: None reported.

PBS:
HSHVs with local health departments continued to serve and be certified as CPS technicians. One was recognized as CPS Technician of the Year and another as Station of the Year.

Child safety seats installation/inspection continue with training offered by KTSRO. CPS technicians promote "Choosing the right seat" and are aware of product safety recalls.

MCH works with KTSRO, Kansas Highway Patrol, local law enforcement, Kansas Drivers Safety Education Association, AAA, Kansas Safe Kids Coalitions, Kansas Family Partnership, SADD, and others to provide traffic safety education through newsletters, web mail, education programs and public service announcements.

Registered CPS inspection stations receive periodic disbursements of car seats from the Kansas Department of Transportation to provide at no cost to families.

IBS:
Safe Kids has 28 local coalitions covering 74% of Kansas children age 0-14.

KTSRO trains 60-80 child passenger safety technicians a year.

Safe Kids formed an Injury Priority Workgroup focusing on child passenger safety to develop an action plan of strategies for training, media, partnerships, policy and evidence-based programs. They completed an online Child Care Transportation Safety Training that covers car seat usage, safe transportation policies, and identifying tools and resources to ensure children are traveling safely.

A state MCH staff member serves on the Safe Kids Advisory Committee.

c. Plan for the Coming Year

DS, ES: None reported.

PBS:
Child safety seats installation/inspection will continue with additional training offered by KTSRO.

MCH will continue to promote and provide education on child safety and encourage HSHVs to be certified CPS Technicians.

State MCH staff will serve on the Safe Kids Advisory Committee and KEMSC Coalition.

IBS:
MCH will continue to collaborate with outside sources and develop objectives to decrease accidental morbidity caused by motor vehicle crashes.

The Safe Kids Injury Priority Workgroup focusing on child passenger safety will continue to develop and implement an action plan of strategies for training, media, partnerships, policy and evidence-based programs.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	45	45	50	42	47
Annual Indicator	47.4	41	45.1	41.8	41.8
Numerator					
Denominator					
Data Source	National Immunization Survey, 2007 birth cohort	National Immunization Survey, 2008 births	National Immunization Survey, 2009 births	National Immunization Survey, 2010 births	National Immunization Survey, 2010 births
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving					

average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	44	44	46	46	48

Notes - 2013
The 2013 column is populated with 2012 data (provisional data, 2010 births). Data will be available in 2015.

Notes - 2012
Data Source: National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services.

Breastfeeding Report Card - United States, 2013
http://www.cdc.gov/breastfeeding/pdf/2013breastfeedingreportcard.pdf

Notes - 2011
Data Source: National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services.

Breastfeeding Report Card - United States, 2012
http://www.cdc.gov/breastfeeding/pdf/2011BreastfeedingReportCard.pdf

a. Last Year's Accomplishments
In the 2013 Breastfeeding Report Card, breastfeeding at 6 months decreased from 45.1% in 2009 to 41.8% in 2010 (provisional). This compares to 49.0% for U.S children born in 2010 (provisional). This estimate remains below the national Health People 2020 objective (60.6%). Over the 10 year period (2001-2010), there was a significantly increasing trend in the proportion of Kansas infants breastfed at 6 months of age. A similar trend was observed at the national level. The survey also shows that low income mothers are less likely to breastfeed than their higher income counterparts.

According to the 2011 Pediatric Nutrition Surveillance System (PedNSS), which assesses nutritional status of children from low-income families (below 185% of poverty level) participating in WIC, 18.9% of Kansas WIC infants were breastfed at least 6 months, 9.2% higher than in 2010 (17.3%). However, this was 27.3% lower than the percent for U.S. WIC infants (26.0%). This is well below the Health People 2020 objective (60.6%). In recent years (2002-2011), the prevalence of Kansas WIC infants breastfed at 6 months of age has declined. A similar trend was observed at the national level since 2008.

Infrastructure Building Services:

Provided financial support to the Kansas LaLeche League 2013 spring conference for all health professionals.

Provided financial support to encourage LHD staff to attend trainings on breastfeeding promotion and support.

317 local WIC program staff attended the spring 2013 Kansas WIC Conference. Breakout sessions on breastfeeding included the topics: Everybody Has a Role in Breastfeeding; To Have and To Hold (kangaroo care); Overcoming Barriers to Exclusive Breastfeeding; Baby Behavior

Campaign- History, Results, and Expansion of a WIC-based Obesity Prevention Intervention.

Supported evidenced-based breastfeeding related training of researchers and practitioners with a bi monthly electronic newsletter.

Supported Certified Breastfeeding Educator Training in September 2013.

Provided twice a year breastfeeding training based on the USDA "Using Loving Support to Grow & Glow in WIC" curriculum for all new WIC employees and other interested LHD staff.

Developed webinar "How to Run an Effective Breastfeeding Support Group

Population Based Services:

Kansas WIC continues the peer counseling program in 43 of the 105 counties in the state.

Participated in a workgroup for "High 5 for Mom and Baby" hospital education campaign to improve Kansas breastfeeding statistics through policy and practices changes developing a High 5 handout to support WIC client participation in this program.

Developed a Kansas Baby Behavior staff training based on the University of California Davis Human Lactation Center model. This program improves exclusive breastfeeding rates.

Enabling Services:

Kansas Breastfeeding Coalition (KBC) in partnership with KDHE conducted several Business Case for Breastfeeding workshops for breastfeeding advocates. KBC also provided presentations to employers and Society of Human Resource Managers groups in support of working women who breastfeed.

KBC and the Kaw Area Breastfeeding Coalition implemented a local breastfeeding support group for minority populations.

KBC fostered the development of local community breastfeeding coalitions with a kick off coalition building summit and follow up quarterly coalition support calls.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Support state agencies, LHD and private businesses to implement new or enhance existing breastfeeding friendly worksite policies.				X
2. Build and enhance relationships among community, public, non-profit and private sectors at the community, county and state level that support breastfeeding.		X		
3. Provide or support evidence-based continuing education on breastfeeding promotion and support.				X
4. Support breastfeeding credentialing efforts of LHD staff for both MCH and WIC programs.				X
5. Sustain a statewide public awareness campaign that supports breastfeeding.			X	

6.				
7.				
8.				
9.				
10.				

b. Current Activities
Infrastructure Building Services:

Provide financial support to LHD to attend trainings that improve staff competencies related to breastfeeding.

Provide financial and in-kind support to organizations organizing education on breastfeeding promotion and support to health professionals and the general public including the Kansas LaLeche League conference.

Provide financial support to LHD to attend local breastfeeding coalition meetings and 2nd Annual Breastfeeding Coalition Building Summit.

Provide breastfeeding training for new WIC employees and other LHD employees twice a year.

Collaborate with federally funded nutrition programs and community organizations to identify opportunities for coordination to promote and support breastfeeding with participation in Nutrition and Physical Activity Collaborative (NuPAC.)

Participate in workgroup to plan and implement the Kansas Breastfeeding Summit to develop a roadmap for future breastfeeding promotion and support activities.

Population Based Services:

Sustain WIC Breastfeeding Peer Counselor programs in existing counties.

Support World Breastfeeding Week activities.

Provide evidenced-based breastfeeding related information via bi-monthly electronic newsletter to breastfeeding health professionals and advocates.

Enabling Services:

Support working breastfeeding mothers using Business Case for Breastfeeding and breastpump program.

Support development of local breastfeeding support groups for minorities.

c. Plan for the Coming Year
Infrastructure Building Services:

Provide financial support to LHD to attend trainings that improve staff competencies related to breastfeeding.

Provide financial and in-kind support to organizations organizing education on breastfeeding promotion and support to health professionals and the general public.

Provide twice a year breastfeeding training for all new WIC employees and other LHD employees.

Collaborate with federally funded nutrition programs and community organizations to identify opportunities for coordination to promote and support breastfeeding.

Population Based Services:

Sustain Breastfeeding Peer Counselor programs in existing counties.

Support World Breastfeeding Week activities.

Provide evidenced-based breastfeeding related information via bi-monthly electronic newsletter to breastfeeding health professionals and advocates.

Enabling Services:

Work with local Breastfeeding Coalitions, LaLeche League and others to promote breastfeeding friendly employee policies.

Foster development of local breastfeeding coalitions.

Foster development of local breastfeeding support groups for minority populations.

Support working breastfeeding mothers using employer support, "Breastfeeding Welcome Here campaign" and breastpump programs.

Participate with the "High 5 for Mom and Baby" hospital education campaign to improve Kansas breastfeeding statistics through policy and practices changes.

Provide follow up to Kansas Baby Behavior Campaign trainings at the Kansas WIC Conference.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	98	98.2	98.2	99	99
Annual Indicator	98.0	98.5	98.7	98.7	98.6
Numerator	41645	40962	39908	40636	39207
Denominator	42515	41593	40452	41177	39771
Data Source	KDHE. Kansas Newborn Screening program, 2009	KDHE. Kansas Newborn Screening program, 2010	KDHE. Kansas Newborn Screening program, 2011	KDHE. Kansas Newborn Screening program, 2012	KDHE. Kansas Newborn Screening program, 2013
Check this box if you					

cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	99	99	99	99	99

Notes - 2013
DATA SOURCE:
Numerator= KDHE. Bureau of Family Health. Kansas Newborn Screening program for Calendar Year 2013.
Denominator= KDHE. Bureau of Epidemiology and Public Health Informatics. Kansas Live Birth by Occurrences.

Notes - 2012
DATA SOURCE:
Numerator= KDHE. Bureau of Family Health. Kansas Newborn Screening program for Calendar Year 2012.
Denominator= KDHE. Bureau of Epidemiology and Public Health Informatics. Kansas Live Birth by Occurrences.

Notes - 2011
DATA SOURCE:
Numerator= KDHE. Bureau of Family Health. Kansas Newborn Screening program for Calendar Year 2011.
Denominator= KDHE. Office of Health Assessment. Kansas Live Birth by Occurrences.

a. Last Year's Accomplishments
SoundBeginnings (SB) Newborn Hearing Screening (NBHS) program's purpose is to improve the health and quality of life of children with hearing loss and their families in Kansas. The goal of the program is to screen all babies before one month of age, to identify permanent hearing loss before three months of age and if identified with hearing loss to receive the appropriate services for normal development of speech and language. Screening is implemented at the local level by hospitals, birthing centers or other obstetrical/newborn services licensed facilities. SB administered the statewide system for newborn Early Hearing Detection and Intervention (EHDI) including data management tracking and surveillance. Screening and diagnostic evaluation results received through direct database input, fax, mail and email. Follow-up was completed on missed, NICU, and failed screens by staff and by EHDI Coordinator for confirmed hearing loss to medical home providers, Part C local networks and families.

Kansas birthing hospitals and facilities screened 99% of the babies before one month of age and have continued to screen at 98% or better since 2009. 53% of the infants who failed the hearing screen were diagnosed with normal hearing or hearing loss before 3 months of age. This is 19% higher than the 2011 national average. 65% of the infants who were identified with hearing loss received infant toddler early intervention services before 6 months of age. This too is higher than

the national average by 22%. The percent of infants who are Lost to Follow-Up/Lost to Documentation (LFU/LTD), those infants who never completed the hearing screening process, is 27% for 2011. This is a decrease of 15% from the previous year. In 2008, Kansas' NBHS Program reported that 84% of the infants who failed the newborn hearing screen never completed the hearing screening process and/or it was not reported to the state. Great measures have been implemented throughout the past several years that have proven to be indicators in reducing the LFU/LTD.

SB developed and distributed Quality Improvement Reports to birthing hospitals and facilities to assure that the hospital refer (not pass) rates were kept within normal limits indicated by the equipment manufacturer and the Joint Committee on Infant Hearing (JCIH) recommendations. A letter was developed and distributed to Audiologists and other outpatient screening facilities that outline the reporting requirements and guidelines as mandated by the state of Kansas. Hospitals with the highest refer and lost to follow-up rates were mapped out per county. SB provided those hospitals with ongoing technical assistance in the use of the equipment, reporting of screening results not captured by the birth certificate system, and providing any information to the program that will assist in decreasing their rates.

The SB Advisory Committee meets quarterly to review, endorse, provide guidance and promote elements of the state EHDI program. Advisory Committee activities continued and site visits were made to hospitals and Audiologists. Information and technical assistance was provided to all stakeholders on program via phone and/or email. Continued work with support through grants was ongoing for reducing loss to follow-up and loss to documentation and tracking, surveillance and integration.

Dedicated staff attempts to resolve issues that lead to the reduction of Kansas' overall loss to follow-up rate. Staff continued to focus on: maintaining the national JCIH goals for EHDI, improve understanding of the hearing screening process and the benefits to professionals touching the lives of our children, and to improve the health and quality of life for children with hearing loss and their families in Kansas. Staff are constantly reviewing and recommending potential enhancements to the current SB database allowing hospitals and audiologist to manually enter hearing screening data was implemented.

Staff and parent representatives and national conferences to assist with the development of family support infrastructure and services for children and their families. Information resources to outpatient and diagnostic Audiology Providers were provided. Collaboration and funding continued to be provided for assistance with parent-to-parent support, and continual work to develop the parent-driven Kansas Hands & Voices Chapter family support organization.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue data submission through the web-based birth certificate (VRV) reporting system.				X
2. Continue quarterly meetings of the SoundBeginnings Advisory Committee				X
3. Continue the education training to professionals on early intervention				X
4. Collaborate to assist Kansas Hands and Voices chapter enabling parental input and parent to parent support			X	
5. Continue dissemination of Newborn Hearing Screening brochures for families to hospitals, etc				X
6. Support to hospitals to enhance screening equipment				X

7. Family and Audiologist Consultants to assist reduce loss to follow-up				X
8. Formalization of a regional program to assist newly identified families at first contact.				X
9. Collaborate with private dentists and safety net clinics to provide technical assistance and education about underserved populations.				X
10. Continued attendance at EHDI, parent support and deaf education focused meetings				X

b. Current Activities
In additional to all previous activities, the program developed a list of approved centers, categorizing the level of testing each facility administers and services they provide. This list will be made public on the SoundBeginnings website and will be distributed to physicians, early intervention agencies, and families of young children with hearing loss.

The public input survey indicates that the top five major health concerns for newborns and infants 0-1 year of age include parenting education, growth and development, newborn care in home, developmental screenings, and safety and injury prevention. The screenings and follow up provided by the EHDI program directly impact 3 of the 5 concerns. As the newborn hearing screening is a developmental screening and hearing loss can significantly impact an infant and toddler's growth and development, we can increase the number of babies who receive timely and accurate follow up through parent education about the importance of newborn screenings. The other two concerns are relatively related to the screening and a delay or decline of newborn screening can pose safety and home care hazards in the future.

A training curriculum developed for Parents as Teachers (PAT) Otoacoustic Emission Hearing screenings was developed and PAT networks are being trained and will have the hearing screening protocols in place by June 2014.

c. Plan for the Coming Year
The program will continue providing technical assistance and education for all providers, staff, and parents and ongoing outreach for program services and supports. Continued collaborations with the Kansas School for the Deaf, Infant Toddler Services, the University of Kansas Deaf Education program, tiny-K networks, WIC, Healthy Start Home Visit programs, Hartley Family Center will continue to: 1) provide assistance and training for personnel at tiny-K networks and 2) develop a regional program to assist in first contacts with families.

The SB Advisory Committee continues to meet quarterly to provide guidance and promote elements of the state EHDI program. The members of the advisory committee represent a varied group including parents and family members of deaf and hard of hearing children, community and medical providers -- such as early intervention, educators, pediatric speach language pathologist and audiologists, hospital staff, and a pediatrician -- and representatives from state agency partners such as Children's Developmental Services, the State Part C program, Newborn Metabolic Screening, Children and Youth with Special Health Care Needs, Special Education Services, the Kansas Commission of the Deaf and Hard of Hearing, and the Kansas School for the Deaf. The Committee has established goals including parent communication and family concerns; education to all members involved in early intervention, including a focus on the family perspective; and information sharing of legislative issues or advocacy. Support will be provided to hospitals that have a Level II or III NICU to purchase Automated Auditory Brainstem Response (AABR) equipment.

Staff, parents, and Pediatric Audiologists continue to attend conferences focusing on Early Hearing Detection and Intervention (EHDI) issues, family support and Deaf Education.

SoundBeginnings and Newborn Metabolic Screening will hold a one day conference for midwives on the metabolic and hearing screenings by December 2014. Staff, parents, and Pediatric Audiologists continue to attend conferences focusing on Early
Hearing Detection and Intervention (EHDI) issues, family support and Deaf Education.

Continue quality improvement methodology to reduce the percentage of Kansas birthing facilities with refer rates higher than 10% which has an impact on Kansas' LFU/LTD rates. Continue submission of hearing screening results through the web-based birth certificate system and the SB database to accept the required Healthy People 2020 data fields including race, ethnicity, language spoken in the home, birth defects, and transferring hospital.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	7	10.5	8	7.5	9.2
Annual Indicator	7.3	7.5	9.4	6.1	6.1
Numerator					
Denominator					
Data Source	US Census. ASEC supplement. Table HI05	US Census. ASEC supplement. Table HIB-5	US Census. ASEC supplement. Table HIB-5	US Census. ASEC supplement. Table HIB-5	US Census. ASEC supplement. Table HIB-5
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	5.9	5.9	5.7	5.7	5.5

Notes - 2013
Data for 2013 is not available. 2012 data was used to pre-populate this performance measure. Data for 2013 will be available in Fall 2014

Notes - 2012
Data Source: U.S. Census Bureau and Bureau of Labor Statistics. Current Population Survey. Annual Social and Economic (ASEC) supplement. Table HIB-5. Table HIB-5. Health Insurance Coverage Status and Type of Coverage by State--Children Under 18: 1999 to 2012. http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html

Notes - 2011
DATA SOURCE: U.S. Census Bureau and Bureau of Labor Statistics. Current Population Survey. Annual Social and Economic (ASEC) supplement. Table HIB-5. Table HIB-5. Health Insurance Coverage Status and Type of Coverage by State--Children Under 18: 1999 to 2011. http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html

a. Last Year's Accomplishments
Data from the U.S. Census Current Population Survey (CPS) show that the percentage of Kansas children under 18 years old without health insurance decreased from 9.4% in 2011 to 6.1% in 2012, a 35.1% decrease. The U.S. percentage also decreased slightly from 9.4% in 2011 to 8.9% in 2012. Over the 10 year period (2003-2012), the percentage of Kansas children without health insurance increased, while the US percentage significantly decreased.

DS:
State general funds were provided for the development and operation of "safety net" clinics to improve access to health care with an emphasis on community-based services and reducing health disparities for underserved populations. These provide services on a sliding fee scale to zero fees.

The Kansas Statewide Farmworker Health Program coordinated a statewide case management system for migratory/seasonal farm workers. Covered health services vouchers from state-funded access point agencies are made available to assist workers in obtaining needed services.

ES:
KanCare was formed as the state's managed care program provided to Medicaid and Children's Health Insurance Program (CHIP) consumers. Kansas contracted with three health plans, or managed care organizations, to coordinate health care for nearly all beneficiaries.

MCH continued to work with state/local partners to assist MCH staff in locating insurance coverage and access to care for children.

PBS: MCH supported/promoted outreach and enrollment activities in local agencies and schools for KanCare-eligible women/children encouraging health services in a medical home and referred ineligible families to safety net clinics.

IBS: Kansas Medical Assistance Program (KMAP) website provided information to KanCare beneficiaries and providers. Links are available to the health plan providers, questions and answers, and eligibility criteria and information.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide information to MCH programs related to location and services available in safety net clinics.		X	X	X

2. Provide MCH clinics with KanCare Program information and application assistance.		X	X	X
3. Assist families with KanCare in establishment of a medical home.	X	X	X	X
4. Link students with KanCare coverage through school health services.		X	X	X
5. Promote local coordination and collaboration between agencies to link hard-to-reach and disparate populations to KanCare Programs.				X
6. Assist local health agencies to create a community plan for linking families to safety net clinics/dental hubs and in providing care for those uninsured children who remain ineligible for KanCare Programs.		X	X	X
7. Develop strategies to inform the public of implications of health reform and Patient Protection and Affordable Care Act.				X
8.				
9.				
10.				

b. Current Activities
DS: Local MCH programs continues to provide immunizations, well child checks and MCH services on a sliding fee scale to families unable to afford care at full price.

ES: Local MCH programs continue to screen and assist with enrollment for KanCare services. Healthy Start Home Visitors (HSHVs) help mothers and their children enroll for KanCare services. MCH works with state/local partners to assist families in locating insurance coverage and access to care for children.

PBS: MCH continues to support and promote outreach/enrollment activities in local agencies and schools for Medicaid-eligible women/children encouraging health services in a medical home or safety net clinic.

IBS: MCH continues to work with KMAP and KanCare health plan providers to link them to potential clients. MCH is utilizing federal technical assistance resources regarding the implications and implementation of the Affordable Care Act to inform local MCH agencies and determine needs, roles, and strategies for MCH services/programs.

c. Plan for the Coming Year
DS: Local MCH clinics will continue to provide immunizations, well child checks and MCH services on a sliding fee scale to families unable to afford care at full price.

ES:
Local MCH clinics will continue to assist families with KanCare enrollment for services. HSHVs will provide health education and make referrals as necessary for pregnant women and postpartum women and their babies and help them enroll for KanCare services.

MCH will continue to work with state/local partners to assist families in locating insurance coverage and access to care for children.

PBS: MCH/HSHVs will continue to support and promote outreach/enrollment activities in local agencies and schools for Medicaid-eligible women/children encouraging health services in a medical home or safety net clinic.

IBS:
MCH will continue to work with KMAP and KanCare health plan providers to link them to potential clients.

MCH will utilize federal technical assistance resources regarding the implications and implementation of the Affordable Care Act to inform local MCH agencies and determine needs, roles, and strategies for MCH services/programs.

MCH/HSHVs that are trained will provide the book "What to Do When Your Child Gets Sick" to new mothers in partnership with Health Literacy Kansas.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	29	28	28	28	27
Annual Indicator	29.8	28.7	28.4	28.4	28.4
Numerator	11013	10860	10657	10657	10657
Denominator	36956	37838	37524	37524	37524
Data Source	Kansas PedNSS, 2009	Kansas PedNSS, 2010	Kansas PedNSS, 2011	Kansas PedNSS, 2011	Kansas PedNSS, 2011
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	27	27	26	26	25

Notes - 2013
The 2012 and 2013 columns are populated with 2011 data. CDC discontinued operation of the PedNSS and PNSS in the Fall of 2012 after production of the 2011 reports.

Notes - 2012
The 2012 and 2013 columns are populated with 2011 data. CDC discontinued operation of the PedNSS and PNSS in the Fall of 2012 after production of the 2011 reports.

Notes - 2011
Data Source: Pediatric Nutriton Surveillance System (PedNSS), 2011(Kansas WIC database).

a. Last Year's Accomplishments
According to the 2011 Pediatric Nutrition Surveillance System (PedNSS), which assesses nutritional status of children from low-income families (below 185% of poverty level) participating in WIC, 28.4% of low-income children ages 24-59 months in Kansas were overweight (at or above 85%) or obese (above 95%). Kansas prevalence was significantly lower than the prevalence nationally (30.4%). Over the 10-year period (2002-2011), there was a significant increasing trend during 2002-2004, since 2004 the trend has decreased significantly. For both periods, the annual percent changes (APCs) were significant (8.15, -1.17, respectively).

Infrastructure Building:

Trainings, websites and other resources that promote good nutrition and physical activity were published in the Zero to age 21: Information for Promoting for Public Health Professionals working with Kansas Kids (ZIPS) newsletter and WIC Information Memos throughout the year.

Assisted LHDs in identifying funding mechanisms and partnerships to support initiatives at the community level.

Four state staff attended the 2013 Annual Meeting of the Association of State and Territorial Public Health Nutrition Directors (ASTPHND).

University of California Davis Human Lactation Center Baby Behavior train-the-trainer attended by 48 state and local WIC staff and other Kansas health professionals. This program discourages overfeeding and future overweight. This program discourages overfeeding and future overweight.

Kansas Baby Behavior Campaign training planned and developed.

Population Based Services:

317 local WIC program staff attended the spring 2013 Kansas WIC Conference. Breakout sessions on breastfeeding included the topics: Everybody Has a Role in Breastfeeding; To Have and To Hold (kangaroo care); Overcoming Barriers to Exclusive Breastfeeding; Baby Behavior Campaign- History, Results, and Expansion of a WIC-based Obesity Prevention Intervention; and Nutrition Update.

Enabling Services:

Promoted the use of existing online staff educational programs that promote good nutrition and physical activity.

Enhanced and expanded existing partnerships with federally funded nutrition programs for coordination to meet the overall maternal and child health nutrition goals with participation in Nutrition and Physical Activity Collaborative (NuPAC).

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Assure access to a food supply and healthy food choices.			X	
2. Assure access to safe, affordable opportunities to be physical active.			X	
3. Identify funding resources and partners.		X	X	

4. Utilize and improve data systems.		X	X	X
5. Use and communicate results of program and policy interventions that contribute to evidence-based strategies.		X		X
6. Increase the number of well-trained MCH personnel who support healthy eating and physical activity.				X
7. Promote consistent messages with best evidence available.		X	X	
8.				
9.				
10.				

b. Current Activities
Infrastructure Building:

Provide child care providers education on health and physical activity for young children and their families. Work with the Kansas Breastfeeding Coalition to train child care providers on how to support a breastfeeding infant/family.

Work with KU School of Medicine and KDHE epidemiologists to study infant feeding behaviors and weight.

Work with KDHE epidemiologists to produce reports comparable to former PNSS and PedNSS reports.

Collaborate with federally funded nutrition programs to identify opportunities for coordination to meet the overall maternal and child health nutrition goals.

Population Based Services:

Support continuing education opportunities on nutrition and physical activity from credentialing organizations, member associations, academic institutions and other groups.

Provide Kansas Baby Behavior Campaign trainings to all local KS WIC clinic staff and other interested health professionals at 15 sites around Kansas.

Enabling Services:

Promote use of existing online staff educational programs that promote good nutrition and physical activity.

c. Plan for the Coming Year
Infrastructure Building:

Advocate for policies and environmental changes that support daily physical activity opportunities in all settings.

Provide child care providers education on health and physical activity for young children and their families.

Utilize and improve data systems to measure the development and impact of community-based policy and program interventions at the individual, organizational and community level.

Strengthen partnerships related to healthy eating, nutrition and physical activity.

Coordinate with federally funded nutrition programs to identify opportunities for collaboration to meet the overall maternal and child health nutrition goals.

Population Based Services:

Work with Bureau of Health Promotion (BHP) and other stakeholders to design and promote consistent and culturally appropriate nutrition and physical activity messages.

Support continuing education opportunities on nutrition and physical activity from credentialing organizations, member associations, academic institutions and other groups.

Enabling Services:

Promote use of existing online staff educational programs that promote good nutrition and physical activity.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	13	13	12.5	12.5	12
Annual Indicator	12.7	12.7	12.2	11.5	11.5
Numerator	5246	5005	4795	4624	4624
Denominator	41210	39409	39441	40212	40212
Data Source	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2012	Kansas Vital Statistics, 2012
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	12	11.8	11.8	11.6	11.4

Notes - 2013
The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

Notes - 2012

Data Source: Birth certificate (resident) data, 2012, Bureau of Epidemiology and Public Health Informatics, KDHE

Denominator: Live birth records with unknown/missing values for smoking status were excluded from analysis.

Notes - 2011
Data Source: Birth certificate (resident) data, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE

Denominator: Live birth records with unknown/missing values for smoking status were excluded from analysis.

a. Last Year's Accomplishments
Cigarette smoking during pregnancy adversely affects the health of both mother and child. It increases the risk for adverse maternal conditions and poor pregnancy outcomes. Infants born to mothers who smoke weigh less than other infants, and low birth weight (<2,500 grams) is a key predictor for infant mortality. In 2012, 11.5% (4,624) of women reported smoking during the last three months of pregnancy, a slight decrease from 2011 (12.2%). Over the eight year period (2005-2012), there was a statistically significant decreasing trend detected. The annual percent change was significant (APC=-2.93). Among women who reported smoking during the last three months of pregnancy, 70.2% reported Medicaid as principal source of payment for this delivery, a slight decrease from 2011 (70.8%).

DS: Pregnant women are referred to the Kansas Tobacco Quitline (Quitline) and local tobacco cessation services for tobacco cessation assistance by MCH grantees. MCH grantees trained in the 5 A's counseling method of smoking cessation provided brief interventions to pregnant women. Activities focused on cessation were provided by community coalitions and youth organizations at schools and health fairs to support families' ability to quit.

ES: MCH grantees were provided education on referral and web resources for evidence-based tobacco cessation like the Quitline and counseling methods that include the 5 A's method of smoking cessation.

PBS: KDHE served as a state partner in the text4baby free text messaging program for pregnant women and new moms. Health messages discouraging smoking during pregnancy and around children are included. The Kansas text4baby Partnership consists of 42 state-wide member organizations, the State health department, all three Managed Care Organizations for KanCare, a large bi-state children's hospital and a large private health care insurance company.

IBS: Birth outcomes and smoking rates were monitored in relation to local agency efforts in prenatal smoking prevention and cessation. Kansas TUPP and MCH staff provided education and encouragement to local agencies and support use of the Quitline and other materials to aid in smoking cessation efforts. MCH grantees and prenatal providers were encouraged to use CDC and March of Dimes tobacco cessation web resources and promote text4baby to support the health and well-being pregnant women, new mothers and infants up to one year of age. The Kansas TUPP and MCH staff provided support, training and technical assistance to local grantees.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH grantees receive tobacco cessation training, support and technical assistance in prevention efforts.				X
2. MCH grantees refer pregnant women to the Quitline.	X			

3. MCH grantees provide a linkage for pregnant women to local tobacco cessation services.		X		
4. MCH grantee staff trained in the use of the 5 A's counseling approach to smoking cessation provide brief interventions to assist pregnant women to quit smoking.	X			
5. MCH staff link grantees and partnering perinatal health care organizations to web resources provided by the CDC and the March of Dimes.		X	X	X
6. MCH staff provides grantees and partnering perinatal health care staff with other relevant tobacco cessation resources via the Web, educational conferences, newsletter articles and through routine communications.		X	X	X
7. MCH staff educate local health departments and perinatal health care staff to routinely screen pregnant women for smoking behaviors and tobacco use, provide information on benefits of quitting and links to local smoking cessation services.		X		
8. MCH staff will monitor for changes in tobacco-related legislation. Landmark legislation: Kansas Clean Air Act of 2010.				X
9. Kansas continues to serve as state-level text4baby partner through MCH staff leadership.			X	X
10. Surveillance of smoking during pregnancy through Kansas Health Matters by local partners and by State programs through BRFSS.				X

b. Current Activities

DS: Local grantee staff continues to utilize the Quitline as a referral source for pregnant women to encourage them to quit smoking as well as local tobacco cessation resources.

ES: MCH grantees are provided education on use of the Quitline and web resources through the March of Dimes and CDC. Training in the 5 A's method of tobacco cessation counseling is encouraged for grantee staff.

PBS: Use of the free health text messaging service, text4baby, continues to be a highly valued resource for local partners across sectors to positively impact the health of pregnant women and encouraging them to quit smoking.

IBS: Coalition building efforts continue with a focus toward involving more businesses, hospitals and local health care providers. Training of local grantees and interested partners continues through efforts by Kansas TUPP and MCH staff. State and federal government and national partner web resources, the Quitline and the Kansas Clean Indoor Act of 2010 legislation serve as a solid foundation of support and resources to increase smoking cessation efforts. MCH grantees will use Kansas Health Matters dashboard surveillance tools to monitor indicators on women who reported smoking during pregnancy in their service area.

c. Plan for the Coming Year

DS: MCH grantees will provide referrals to the Quitline and evidence-based information on the health benefits associated with smoking cessation to pregnant women. MCH grantees trained in the 5 A's counseling method of smoking cessation will provide brief interventions to pregnant women. Perinatal collaboratives located in several communities will begin to screen for tobacco use and provide education to women served in these settings as part of a comprehensive prenatal education approach.

ES: MCH and Kansas TUPP staff will provide evidence-based information on tobacco cessation

via Web links, newsletter articles and routine communications to local grantees and partnering organizations. Local grantee Healthy Start Home Visitors will link pregnant women to smoking cessation resources, make referrals to the Quitline, and provide education and supportive services.

PBS: Work with Kansas TUPP to identify communities with high rates of pregnant women that smoke and identify strategies to more effectively reach out and provide appropriate cessation education. MCH local grantees will be encouraged to utilize existing evidence-based smoking cessation resources for pregnant women and women of childbearing age like the Quitline and information from the CDC and March of Dimes websites. MCH and Kansas TUPP staff will provide on-going technical assistance to MCH grantees to increase efficiency and effectiveness in providing outreach, support and tobacco cessation services to clients.

IBS: MCH staff will monitor for changes in local and State policy regarding smoking cessation. MCH staff will participate with existing advisory councils on implementing strategies to decrease smoking in pregnant women in women of childbearing age. MCH staff will monitor for changes in smoking cessation-related data.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	9.3	11	9	10	10
Annual Indicator	9.1	10.1	10.5	13.8	13.8
Numerator	55	61	64	84	84
Denominator	602256	604262	608906	609260	609260
Data Source	Kansas Vital Statistics, 2007-2009	Kansas Vital Statistics, 2008-2010	Kansas Vital Statistics, 2009-2011	Kansas Vital Statistics, 2010-2012	Kansas Vital Statistics, 2010-2012
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	12	12	10	10	8

Notes - 2013

The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

Notes - 2012
Data Source:
Numerator = Death certificate (resident) data, 2010-2012, Bureau of Epidemiology and Public Health Informatics, KDHE

Reporting years were combined to calculate 3 year rolling averages due to small sample size.
ICD-10 coding: U03, X60-X84, Y87.0.

Denominator =U.S. Bureau of the Census
2010-2012 data are U.S. Census estimates (Bridged-Race Vintage data set); 2010 data are actual Census counts, not estimates.

Notes - 2011
Data Source:
Numerator = Death certificate (resident) data, 2009-2011, Bureau of Epidemiology and Public Health Informatics, KDHE

Reporting years were combined to calculate 3 year rolling averages due to small sample size.
ICD-10 coding: U03, X60-X84, Y87.0.

Denominator =U.S. Bureau of the Census
2009-2011 data are U.S. Census estimates (Bridged-Race Vintage data set); 2010 data are actual Census counts, not estimates.

a. Last Year's Accomplishments
In 2010-2012, the suicide rate among Kansas youth ages 15-19 was 13.8 per 100,000. This was higher than 2000-2011 (10.5). For the period 2003-2012, using rolling 3 year averages, overall, there was an increasing trend observed in completed suicides by Kansas youth (15-19) during 2003-2005 and 2010-2012. The annual percent change (APC) was not significant (3.71).

According to the 2011 Kansas Youth Risk Behavior Survey (YRBS), 11.8% of Kansas high school students had seriously considered attempting suicide during the 12 months before the survey, a slight decrease from 12.6% in 2009. The percentage of students who made a plan about how they would attempt suicide during the 12 months before the survey was 9.9% in 2011, a slight increase from 9.5% in 2009. The percentage of students that attempted suicide one or more times during the 12 months before the survey was 5.9% in 2011, a decrease from 6.1% in 2009. The percentage of students that attempted suicide resulted in an injury, poisoning, or overdoses that had to be treated by a doctor or nurse during the 12 months before the survey was 2.5% in 2011, an increase from 1.8% in 2009. Often the youth who attempt suicide have associated mental health or other behavioral concerns such as depression, substance abuse, and a sense of hopelessness, increased stress and a lack of family support.

DS: None reported.

ES: Kansas schools used the Telemedicine network, their regional mental health centers, and KU to provide mental health services to rural areas of Kansas.

PBS: Kansas school nurses were provided technical assistance on how to develop a Yellow Ribbon
Suicide Prevention Program in their schools and communities. Articles on suicide awareness and prevention were published in MCH newsletters to local health department and school nurse staff.

IBS: A MCH staff member served on an advisory board for the federal Garrett Lee Smith Suicide Prevention grant awarded to the Headquarters Counseling Center, Inc. (HCC) in Kansas, a

statewide collaboration to reduce the number of suicide attempts and deaths among Kansans10-24 years of age.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participate in the Governor's Mental Health Services Planning Council and Suicide Prevention Subcommittee (SPS) to promote statewide suicide prevention strategic plan.				X
2. Work with the SPS to develop culturally appropriate, effective suicide prevention strategies for adolescent populations in Kansas.			X	X
3. Support the activities offered by Headquarters Counseling Center as they implement activities from a Garrett Lee Smith grant.				X
4. Develop infrastructure and provide awareness of mental health/suicide specialists so referral sources will be available when needed.		X		X
5. Assist making linkages from Kansas schools to regional mental health centers for counseling and mental health services to decrease suicide ideology.		X		X
6. Ask school nurses for feedback if they are implementing a suicide prevention program in their schools through a school nurse survey to evaluate program implementation.				X
7. Support the first statewide conference on Kansas Youth Suicide Prevention offered with Garrett Lee Smith grant funding.				X
8.				
9.				
10.				

b. Current Activities
DS, ES: None reported.

PBS: MCH and school nurses continue to support prevention of suicide occurrences.

IBS:
KDHE continues to promote goals and strategies of the Kansas Suicide Prevention Plan and HCC to decrease 10-24 year olds' suicide attempts and deaths. The HCC offered Local Activities Grants and Coalition Development Grants toward the goal of preventing suicide attempts and deaths and decreasing suicidal behavior in Kansas youth. The HCC partnered with the Fort Hays State University Department of Psychology to host the first statewide conference that addresses youth suicide prevention.

MCH staff and school nurses were trained on suicide prevention and intervention. The HCC is working to offer school nurses Applied Suicide Intervention Skills Training (ASIST). MCH staff is helping facilitate training activities with school nurses.

The Governor signed a proclamation for Suicide Prevention Week in September. The Governor's Mental Health Services Planning Council, Suicide Prevention Subcommittee (SPS), pursued changes for general practitioners to have additional mental health training in order to treat suicidal patients more effectively and requested the Behavioral Sciences Regulatory Board to increase certification requirements for professionals specialized in suicide prevention.

KDHE will support efforts through consortiums, such as Safe Kids initiatives, to reduce access to lethal means and methods of self-harm.

c. Plan for the Coming Year
DS, ES: None reported.

PBS:
For the 2014/2015 academic year (August 1, 2014 -- July 31, 2015) KU will accept an unlimited number of eligible students into the Yellow Ribbon Program.

Materials will be obtained from the National Yellow Ribbon Suicide Prevention Program and distributed to students by the school nurses.

IBS: HCC will conduct a Statewide Suicide Prevention Conference in September.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	86	86	87	87	88
Annual Indicator	80.8	82.3	86.6	87.1	87.1
Numerator	437	377	425	438	438
Denominator	541	458	491	503	503
Data Source	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2012	Kansas Vital Statistics, 2012
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	88	89	89	90	90

Notes - 2013

The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

Notes - 2012
Data Source: Birth certificate (resident instate births) data, 2012, Bureau of Epidemiology and Public Health Informatics, KDHE

Hospitals with level III nurseries are Irwin Army Community Hospital, Menorah Medical Center, Olathe Medical Center, Overland Park Regional Medical Center (Overland Park), Shawnee Mission Medical Center (Kansas City), St Luke's South (Overland Park), Stormont-Vail Regional Health Center (Topeka), University of Kansas Medical Center (Kansas City), and Via Christi-St Joseph and Wesley Medical Center (Wichita).

Notes - 2011
Data Source: Birth certificate (resident instate births) data, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE

Hospitals with level III nurseries are Irwin Army Community Hospital, Menorah Medical Center, Olathe Medical Center, Overland Park Regional Medical Center (Overland Park), Shawnee Mission Medical Center (Kansas City), St Luke's South (Overland Park), Stormont-Vail Regional Health Center (Topeka), University of Kansas Hospital (Kansas City), and Via Christi-St Joseph and Wesley Medical Center (Wichita).

a. Last Year's Accomplishments
In 2012, the percent of very low birth weight infants delivered in subspecialty perinatal care facilities was 87.1%, a slight increase from 2011 (86.6%). Over the ten year period (2003-2012), there was a statistically significant increasing trend detected in the percent of VLBW infants delivered at facilities for high-risk deliveries and neonates. The annual percent change was significant (APC=0.86). The Healthy People 2020 goal of VLBW infants born in level III hospitals or subspecialty perinatal centers is 90 percent.
From 2012 resident in-state data on VLBW live births born at Level III hospitals by peer groups of residence (i.e., those living in frontier, rural, densely-settled rural, semi-urban and urban areas), the data suggest that babies born in the less densely settled areas of Kansas (frontier, rural and densely-settled rural) were less likely to be born at Level III hospitals than those residing in semi-urban and urban areas.

DS: Services for VLBW infants were only available in subspecialty perinatal care facilities (hospitals with self-designated Level III nurseries) in the Wichita, Topeka and Kansas City metropolitan areas.

ES:
Obstetrical providers in public and private practice settings continued to utilize a variety of methods to identify women at risk for preterm delivery or other complications that are associated with the delivery of very low birthweight infants and provide treatment or referral to services that will reduce this likelihood.

Education on a broad range of perinatal health topics, including where VLBW babies should be born, was provided to perinatal health care providers in hospitals with Level II and below nurseries by physician teams from hospitals with Level III nurseries.

MCH staff instructed and provided resources to local MCH grantees to educate pregnant women on the signs and symptoms of preterm labor and when to seek further medical care.

The University of Kansas Hospital in the Kansas City area and Wesley Medical Center in Wichita both have neonatal transportation services available for high-risk obstetrical cases in outlying areas.

PBS: None reported.

IBS:
MCH staff worked with the Kansas Maternal Child Health Council (KMCHC) on advocating to obstetrical care providers for the delivery of VLBW infants in subspecialty perinatal care facilities. The KMCHC continues to serve as a multidisciplinary panel with expertise in maternal and child health issues in an advisory role to the MCH Program.

Kansas has maintained its system of provider-driven referrals to facilitate access to consultation across various jurisdictions between primary obstetrical care providers and specialty maternal-fetal medicine professionals. This system includes several hospitals that are self-designated subspecialty perinatal care centers that provide both in-patient and out-patient high risk obstetrical/fetal and neonatal services and education mentioned previously. All of the subspecialty perinatal care centers are located in the Wichita, Kansas City and Topeka metropolitan areas.

Since its formation in 2013, the Kansas Perinatal Quality Collaborative (KPQC) has met to decide on its organizational structure, policies and by-laws and has begun to prioritize possible quality improvement projects. The KPQC's overarching goal is to improve service, quality and access to care for women and babies in Kansas.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Perinatal outcome data is provided in an electronic format to delivering hospitals who request data about their hospital or hospital group.				X
2. Sub-specialty perinatal health care services in Wichita, Kansas City, and Topeka metropolitan areas.	X			
3. KMCHC advises KDHE on MCH issues and advocates for practice that supports VLBW infants are born in Level III hospitals.				X
4. Local OB providers identify women with high-risk pregnancies.	X			
5. KPQC work on QI projects to improve best practice.				X
6. MCH staff work with perinatal experts to promote birth of VLBW infants in Level III hospitals to OB providers in local communities.		X		X
7.				
8.				
9.				
10.				

b. Current Activities
DS: Subspecialty perinatal care services are provided in Wichita, Kansas City and Topeka metropolitan areas. Local obstetrical care providers identify women at high-risk for premature birth and delivery of LBW and VLBW infants.

ES: Kansas promotes the use of the national Healthy Mothers, Healthy Babies text4baby free text messaging service for new moms and pregnant women.

PBS: MCH staff shares perinatal education web resources and links with grantees and interested stakeholders.

IBS:
KDHE maintains an electronic database of perinatal data and provides data to hospitals upon request.

Kansas Health Matters interactive website with data useful for communities working on community health assessment and community health improvement projects is available through KDHE.

MCH staff monitors hospitals that self-designate as Level III and those hospitals providing maternal/infant transport.

The KMCHC now includes a member from KanCare the State's Medicaid Program and is beginning a process of self-evaluation with the intention of linking their goals with identified state MCH health priorities and issues identified in the Healthy Kansans 2020 process.

c. Plan for the Coming Year
DS: Subspecialty perinatal care services will be provided in Wichita, Kansas City and Topeka metropolitan areas. Local OB providers will continue to identify high-risk pregnancies related to premature delivery and delivery of LBW and VLBW infants.

ES: MCH grantees will provide prenatal education topics related to identifying preterm labor and when to call the physician.

PBS: MCH staff will work on providing links to web resources on healthy pregnancy and conditions related to healthy pregnancy and childbirth. MCH will continue to partner with the text4baby program to provide healthy messages to pregnant women and new mothers.

IBS:
Principles of the life course and social determinants of health theories will be utilized as a lens when approaching local community health needs.

KMCHC will advise Kansas MCH in addressing the need to provide focused professional education and consultation to obstetrical delivery facilities as well as to advocate for delivery of very low birthweight infants in subspecialty perinatal care facilities.

MCH will maintain and update a list of delivering hospitals with levels of NICU to better describe Kansas' system of hospitals that self-designate their level of perinatal health services.

KDHE will provide perinatal health information to hospitals via electronic means upon request.

MCH provides staff and resources to support meetings and activities of the KPQC and Kansas Blue Ribbon Panel on Infant Mortality that are working to promote system changes to positively impact the health of women of reproductive age and infants. A project, in collaboration with the Kansas Health Care Collaborative (Hospital Engagement Network) project, to reduce the number of early elective deliveries will continue.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and	2009	2010	2011	2012	2013

Performance Data					
Annual Performance Objective	79	79	80	80	80
Annual Indicator	74.1	75.1	77.3	78.9	78.9
Numerator	29244	29552	29618	31457	31457
Denominator	39481	39362	38296	39871	39871
Data Source	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2012	Kansas Vital Statistics, 2012
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	80	80	82	82	84

Notes - 2013
The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

Notes - 2012
Data Source: Birth certificate (resident) data, 2012, Bureau of Epidemiology and Public Health Informatics, KDHE

Notes - 2011
Data Source: Birth certificate (resident) data, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE

a. Last Year's Accomplishments
In 2012, 78.9% of infants were born to pregnant women receiving prenatal care in the first trimester, a slight increase from 2011 (77.3%). The U.S. data for 2010 (the most recent year for which data are available) on this measure was 73.1%. Kansas exceeded the U.S. on this measure by 2.7% in 2010 (75.1%). However, this was below the Healthy People 2020 goal of 77.9%. During 2005-2011, Joinpoint regression analysis showed a decreasing trend over the interval 2005-2007 followed by a significantly increasing trend from 2007-2012. Kansas 2012 data shows that Hispanic and non-Hispanic black mothers are most likely to enter prenatal care late. Older mothers are most likely to begin prenatal care early regardless of race and ethnicity. In general, women in rural areas are less likely to get prenatal care.

DS: In 2013, 85 MCH grants were awarded to local agencies/organizations that provided prenatal and postpartum services to 8,402 women and medical services to 10,375 infants. Direct prenatal medical care services continued to be provided in Lyon, Reno, Ford, Finney, Seward, Montgomery, Bourbon, Crawford and Johnson counties due to a lack of available providers of these services and for persons who are underinsured or uninsured.

ES:
MCH grantees provided linkages to local prenatal care services.

Healthy Start Home Visitors (HSHV) in local health agencies conducted outreach and home visits with pregnant women, and provided support and referrals for prenatal care.

KDHE continued to receive state general funds targeted to provide services to low-income, high risk families in Geary and Wyandotte counties, identified as high-risk in terms of poor birth outcomes. These "Healthy Family Services" grants continued to be provided to health departments in both counties to provide intensive prenatal and postpartum case management services.

MCH staff provided professional education to HSHVs and supervisors on effective communication and engagement with families, identifying and responding to concerns during home visits, documenting home visits and improving program effectiveness and efficiency. Focus groups were held to elicit input from local programs about home visitation services programming.

Outreach and services to a primarily Hispanic migrant population, speaking Low German and Spanish, were provided services in collaboration with the Kansas Farm Worker Health Program.

MCH grantees provided prenatal care services to women at risk for no prenatal care or late entry into prenatal care using community-specific approaches adapted from national evidence-based programs (e.g., Centering Pregnancy Model and Nurse Family Partnership and others).

PBS: Local MCH grantee staff used the online Kansas Resource Guide and the state hotline number to link clients to services.

IBS:
MCH staff assisted in planning educational conferences with partners from a variety of organizations in the health care sector involved in caring for pregnant women. Emphasis was placed on the benefits of early and comprehensive prenatal care and how to reach women in high-risk situations utilizing culturally sensitive practices and lower literacy level materials.

MCH staff worked with the KDHE Center for Health Equity to develop and disseminate accurate health care information and special events to improve health of women in high-risk communities through social media and other channels. The Center conducted a Healthy Babies Kansas campaign using a Facebook presence as part of this collaboration. The Center for Health Equity also closed due to no support funding.

MCH staff monitored trends in data for prenatal care usage via the annual Adequacy of Prenatal Care Index and used county and state data from the Kansas Health Matters website. These results were shared back to MCH grantees locally and to the KMCHC that provides expert advice to the MCH Program on significant health issues.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MCH grantees provide prenatal care and care coordination services.	X	X		
2. Identify women at risk for late entry into or no prenatal care.	X	X		
3. Grantees use evidence-based prenatal care models.	X	X		
4. Use of prenatal, delivery and postpartum resources.		X	X	
5. Encourage use of Kansas Resource Guide at KDHE.		X	X	

6. Greater use of readily available data systems (e.g., KIC, Kansas Health Matters, etc.) documented.				X
7. Provide messages on prenatal care using social media resources.			X	X
8. Promote optimal health during the (pre-) interconception period.			X	X
9. Support/encourage local efforts to overcome disparities in provision of prenatal care using current practice theories.		X		
10.				

b. Current Activities
DS: Local health departments, Federally Qualified Health Centers, hospitals, and local obstetrical and perinatal health care providers comprise the comprehensive prenatal care coordination system.

ES:
Local MCH agencies use care coordination and case management models to provide prenatal services.

Family Planning, WIC and MCH programs coordinate prenatal care outreach and help clients in navigating the health care system and KanCare (Medicaid/SCHIP).

PBS: The Kansas text4baby Partnership increased to 48 organizations. There were 10,836 participants in Kansas that receive text4baby health messages. MCH staff promotes use of text4baby by new mothers and pregnant women.

IBS:
MCH staff works in collaboration with the Kansas Fatherhood Coalition and assists with providing fathers accurate and reliable health care information in regard to promoting healthier pregnancies.

MCH grantees have increased use of the Kansas Health Matters website when looking at local needs and services. The site provides tools and resources for community health assessment and community health improvement activities.

MCH staff in concert with the March of Dimes has helped several targeted communities establish and maintain perinatal collaboratives to create a system of coordinated and comprehensive prenatal care in an effort to reduce infant morbidity and mortality.

c. Plan for the Coming Year
DS: Local agencies will assist in linking clients to or facilitate direct prenatal medical services.

ES: Fund and support outreach and case management services such as HSHVs and other programs to improve engagement in early prenatal care.

MCH, Family Planning, WIC, and KanCare will improve coordination efforts engaging local grantees in prenatal outreach and offering clients assistance to navigate the health care system. Local staff will refer clients to health navigators.

PBS:
Encourage Kansas text4baby partners to promote and fully engage in the national enrollment event.

Seek collaboration with the Kansas Fatherhood Coalition and provide educational resources for

fathers to increase their ability to make appropriate health care decisions and serve a supportive role for their families.

Promote use of the Kansas Resource Guide and other resources to MCH grantees, the public, and perinatal care providers for information on access to local services and accurate health care information.

IBS:
Provide professional education and technical assistance to MCH grantees promoting systems of comprehensive prenatal care coordination and case management services.

Collaborate with the Kansas Fatherhood Coalition and Kansas Children's Service League to reach more fathers with accurate and helpful information to support their family role.

At least two additional perinatal collaborative sites will be established to improve the system of coordinated and comprehensive prenatal care services.

D. State Performance Measures

State Performance Measure 2: *The percent of women in their reproductive years (18-44 years) who report consuming four or more alcoholic drinks on an occasion in the past 30 days.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			14.4	13.5	13
Annual Indicator	14.5	14	17.7	15.7	15.7
Numerator					
Denominator					
Data Source	Kansas BRFSS, 2009	Kansas BRFSS, 2010	Kansas BRFSS, 2011	Kansas BRFSS, 2012	Kansas BRFSS, 2012
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	12.5	12	11.5	11	10.5

Notes - 2013
The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

Notes - 2012
Data Source: Kansas BRFSS 2012
Note: The 2011 and 2012 BRFSS dataset included modifications of weighting methods and modes of data collection. Raking weighting was used, and cellular telephone surveys were incorporated into the data. These changes affect state-level estimates of health risk behaviors and chronic disease. Trend analyses might show artifactual differences between 2011 data and data from previous years. Changes caused by changes in methods from real changes cannot be distinguished. Estimates before 2011 and after 2011 are not comparable and should not be compared.

Notes - 2011
Data Source: Kansas BRFSS 2011
Note: The 2011 BRFSS dataset included modifications of weighting methods and modes of data collection. Raking weighting was used, and cellular telephone surveys were incorporated into the data. These changes affect state-level estimates of health risk behaviors and chronic disease. Trend analyses might show artifactual differences between 2011 data and data from previous years. Changes caused by changes in methods from real changes cannot be distinguished. Estimates before 2011 and after 2011 are not comparable and should not be compared.

a. Last Year's Accomplishments
According to the Kansas BRFSS, in 2012, 15.7% of women ages 18-44 years old reported consuming four or more alcoholic drinks (i.e., binge drinking) on an occasion in the past 30 days. White women ages 18-44 years old reported the highest levels of binge drinking (18.0%), compared to black women (9.8%) and Hispanic women of all races (8.2%). Healthy People 2020 recommends all pregnant women, as well as women who may become pregnant, completely abstain from alcohol. Healthy People 2020 Objectives MICH -- 11.1 and 11.2 propose to increase abstinence from alcohol among pregnant women to 98.3% and from binge drinking to 100%.

DS:
Screening for alcohol and tobacco use is routinely conducted during initial and annual Title X Family Planning visits. Local agencies have been provided with sample/template Female and Male History Forms which include screening questions. Education and counseling appropriate to the client's history is provided. If problems are identified which are beyond the scope of the clinic, appropriate referrals are made.

MCH grantees provide education to women about substance and alcohol use and make referrals for any women reporting use to local and regional counseling and treatment resources.

ES:
Parts of a voluntary, incentive-based program (Health in Pregnancy) to help pregnant women abstain from alcohol and drugs were maintained in local Department for Children and Families (DCF) Services programs.

An MCH staff serves on the state-level Fetal Alcohol Spectrum Disorders (FASD) speakers' bureau providing education and resources to statewide stakeholders.

PBS:
KDHE tracked and monitored BRFSS data on binge drinking of reproductive age women (18-44 years old).

MCH tracked the incidence of Fetal Alcohol Syndrome (FAS) through the birth defects information system.

IBS:
MCH staff participates in the National Association of Fetal Alcohol Spectrum Disorders State

Coordinators (NAFSC) group in quarterly meetings and at the state-level with the Kansas Leadership to Keep Children Alcohol Free Coalition to support educational efforts and system maintenance activities to prevent alcohol-exposed pregnancies in women and underage drinking in children in Kansas.

The Kansas Chapter of the American Academy of Pediatrics maintained affiliate status with the National Organization of Fetal Alcohol Spectrum Disorders (NOFAS) in support of statewide prevention efforts.

MCH maintains a birth defects information system that tracks FAS.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide local health care practitioners and MCH grantee staff with professional education on the science behind the effects of alcohol during pregnancy.				X
2. Develop, disseminate and promote use of evidence-based information on reducing alcohol consumption in the perinatal health population using web links and raising awareness of the need to abstain from alcohol during pregnancy.		X	X	X
3. KDHE will report data on the occurrence of binge drinking during pregnancy from the BRFSS.				X
4. MCH will facilitate discussions of strategies to approach binge drinking during pregnancy with Kansas Leadership to Keep Children Alcohol Free, Mental Health and Alcohol and Prevention Services in Department for Aging and Disability Services (KDADS),				X
5. Title X Family Planning clinics screen clients for alcohol and tobacco use provide education and counseling and make referrals to treatment and cessation services as appropriate.				X
6. KDHE tracks number of FAS cases through the birth defects information system.				X
7. Kansas Leadership to Keep Children Alcohol Free annually present facts on underage drinking impacts to legislators.				X
8. “No safe amount of alcohol during pregnancy” message and other alcohol prevention messages from the U.S. Surgeon General’s Office and CDC are promoted by MCH and other stakeholders.		X	X	
9. MCH and KDADS staff create plans to educate local health care providers on use of SBIRT in practices with women of childbearing age at risk for use of alcohol, tobacco and other substances.				X
10.				

b. Current Activities

DS: Screening for alcohol and tobacco use is routinely conducted during initial and annual Title X Family Planning visits. Education, counseling, and referrals appropriate to the client's history are provided.

ES:

MCH grantees educate pregnant women and women of reproductive age they serve with messages to abstain from alcohol and other substances during pregnancy and breastfeeding and make referrals as needed. They provide outreach, education and resources from the FASD Center for Excellence and FAS Community Resource Center websites to women served.

MRFASTC-trained staff provides professional education on the prevention of FASD to MCH grantees, health care providers and other stakeholders.

MCH staff is working with Kansas Department on Aging and Disability Services on a plan to

educate health care providers on benefits of providing screening, brief intervention, referral and treatment (SBIRT) process to women of childbearing age regarding use of tobacco, alcohol or other substances. Planning has continued, but funding wasn't obtained.

PBS: KDHE tracks BRFSS data on binge drinking of reproductive age women (18-44 years old). MCH reports the incidence of FAS through the birth defects information system.

IBS:
MCH provides leadership and education to bring awareness to the importance of preconception health, abstaining from alcohol, its negative effects and direct impact on birth outcomes.

MCH staff participated in first annual FASD prevention bi-state conference in Kansas City.

c. Plan for the Coming Year
DS: Screening for alcohol and tobacco use during initial and annual Title X Family Planning visits will continue. Education, counseling, and referrals appropriate to the client's history will be provided.

ES:
MCH will refer women to local services to assist them in maintaining abstinence from alcohol and other substances prior to and during pregnancy. MCH grantees provide education and resources to women of reproductive age and pregnant women to abstain from alcohol and other substances during pregnancy.

MCH staff will work with partners in the Kansas Department on Aging and Disability Services on a plan to educate health care providers on benefits of providing screening, brief intervention, referral and treatment (SBIRT) process to women of childbearing age in their practices with respect to those who may be using tobacco, alcohol or other substances.

PBS:
MCH staff receives annual MRFASTC training to help maintain capacity to provide quality education on the science behind FASD prevention. MRFASTC-trained MCH staff will provide annual trainings on the identification, diagnosis and treatment of FASD's in Kansas.

MCH will provide access to evidence-based research, FASD awareness and prevention resources from the FASD Center for Excellence and FAS Community Resource Center websites to all interested stakeholders.

MCH will promote awareness for the prevention of FASD statewide in a variety of settings with stakeholders.

MCH will encourage local grantees to participate in an FASD Awareness Day event for September 9 to elevate awareness of FASD to enlist more support for statewide prevention efforts in concert with NAFSC member states.

MCH staff will collaborate with Kansas Leadership to Keep Children Alcohol Free Coalition in promoting underage drinking prevention efforts in schools and other settings and in preparing briefs for legislators on the impacts of underage drinking.

MCH will promote use of text4baby and other free and low cost social media tools to reach women with the message that no amount of alcohol use during pregnancy is safe.

IBS:
KDHE will report FAS in its birth defects information system with ongoing improvements being

made to the system. KDHE will monitor binge drinking data for women of reproductive age using BRFSS data.

MCH staff will work toward developing uniform screening activities like those undertaken by the WIC and Family Planning Programs for use with MCH grantees.

Planning for the second annual FASD prevention conference will be undertaken by Regional MRFASTC.

Develop collaboration with KDHE Teen Pregnancy Targeted Case Management Program and the Foster Care Program to assess alcohol and drug use issues and to provide education and supports as needed.

State Performance Measure 3: *The percent of live births that are born preterm less than 37 weeks of gestation.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			9.1	8.6	8.6
Annual Indicator	9.2	8.8	9.1	9.0	9.0
Numerator	3804	3534	3598	3629	3629
Denominator	41313	40381	39593	40282	40282
Data Source	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2012	Kansas Vital Statistics, 2012
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	8.4	8.4	8.2	8.2	8

Notes - 2013
The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

Notes - 2012
Data Source: Birth certificate (resident) data, 2012, Bureau of Epidemiology and Public Health Informatics, KDHE; Births for which gestational ages (i.e., obstetric estimate of gestation, completed weeks) are not reported are excluded from the computation of percentages.

Notes - 2011
Data Source: Birth certificate (resident) data, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE; Births for which gestational ages (i.e., obstetric estimate of gestation, completed weeks) are not reported are excluded from the computation of percentages.

a. Last Year's Accomplishments
Reducing premature births is a Kansas MCH priority in MCH 2015, the current 5-year MCH Statewide Needs Assessment. In 2012, the rate for preterm births, those occurring before 37

weeks gestational age, has been lower in Kansas (9.0%) than the U.S. (11.5%). The Kansas prematurity rate met the Healthy People 2020 goal of 11.4%. Among racial/ethnic groups, the black non-Hispanic prematurity rate (13.0%) was 51.2% higher than the white non-Hispanic rate (8.6%). Both non-Hispanic white and Hispanic premature births (8.6%) were lower than the State average. During 2003-2012, a statistically significant decreasing trend was observed (Annual Percent Change = -0.76).

DS: Pregnant women who screened positive for tobacco use across MCH, WIC, and Family Planning Programs received referrals to the Kansas Tobacco Quitline (Quitline) and available local tobacco cessation and clinical provider services.

ES:
MCH grantees continued a partnership with the Kansas Tobacco Use Prevention Program (TUPP) to screen and make referrals to locally available tobacco cessation services for pregnant women and women of reproductive age. Use of the Quitline, local tobacco cessation services, and activities of local community coalitions helped assure education and support to help pregnant women quit using tobacco.

MCH grantee home visitation staff (Healthy Start Home Visitors) provided outreach services to pregnant women and their families offering support, education and referrals to smoking cessation resources.

KDHE's Center for Health Equity (CHE) continued using social and other electronic media to promote a theme of healthy babies in Kansas by presenting health information to women and communities in an engaging manner.

MCH supported the March of Dimes promotion of the National Birth Defects Prevention Network's campaign to increase use of folic acid.

Kansas' partnership with the national Healthy Mothers, Healthy Babies Coalition's program "text4baby" continued with a successful membership campaign drive as part of a national contest. As a result, Kansas' text4baby Partnership experienced doubling of the number of participating organizations including the state's three Managed Care Organizations that oversee KanCare (Kansas Medicaid and State Children's Health Insurance Programs).

PBS:
MCH staff continued to promote use of text4baby and other outreach efforts to women in typically hard to reach communities with positive messages that promoted healthy pregnancies.
MCH participated with KDHE's CHE in efforts to target and work with disparate populations in Kansas on topics that will positively impact the prematurity rate. The campaign was called "Healthy Babies are Worth the Wait" with a Facebook page. The CHE web resources are still available, but the CHE was discontinued due to lack of a funding stream.

IBS:
MCH staff provided links to prenatal risk assessment tools and other online resources for local grantees.

MCH continued to monitor local and state-wide smoking/tobacco cessation ordinances and legislation.

MCH continued to support the March of Dimes (MOD) on-going Prematurity Awareness Campaign and participated in activities of the Kansas Perinatal Quality Collaborative (KPQC) that is coordinated by the Kansas MOD and the Kansas Blue Ribbon Panel on Infant Mortality. MCH supported efforts in partnership with MOD to increase the number, quality and impact of local perinatal disparity collaboratives and encouraged the activities of four active Fetal Infant Mortality Review teams in Kansas. Gradual progress continues to proceed in terms of capacity

development with respect to Perinatal Periods of Risk (PPOR) and FIMR activities.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH grantee agencies and local prenatal care providers provide screening, counseling and referral services for pregnant women and women of reproductive age.	X			
2. MCH Healthy Start Home Visitors provided outreach, education and support to women to promote healthy pregnancies.		X		
3. Kansas promotes text4baby free healthy text messaging service for outreach to pregnant women in high-risk populations.		X	X	X
4. Public and health care providers are provided information and education resources that identify contributing factors leading to preterm birth, low birthweight, and infant mortality.			X	X
5. MCH participates in KPQC, Kansas Blue Ribbon Panel on Infant Mortality, and Healthy Kansans 2020 to decrease number of infants born prematurely and infant mortality.				X
6. MCH participated with the KDHE Center for Health Equity in efforts to target and work with disparate populations in Kansas where prematurity is an issue.		X	X	X
7. Pregnant women who use tobacco utilize services of the Kansas Tobacco Quitline.		X		
8. MCH staff and partners provide local health care professionals with links to tools on prenatal risk assessment and other information to improve the health of women of childbearing age.		X		X
9. KPQC develops plans to address prematurity that consider various quality improvement initiatives.				X
10. Continued local capacity development in PPOR and FIMR.				X

b. Current Activities

DS: Pregnant women who use tobacco are referred to the Quitline and to local tobacco cessation clinical provider services across programs.

ES:
The Kansas text4baby partnership has grown in capacity to 48 organizations statewide that have so far reached 10,836 pregnant women and new moms with health-related messages focused on pregnancy and women's health, child health and safety.

MCH grantee staff provides outreach, support and education to families and makes referrals to the Quitline for tobacco cessation issues.

PBS: MCH utilizes web materials developed by KDHE's CHE in efforts to target and work on topics that will positively impact the prematurity rate for disparate populations. The current campaign is called "Healthy Babies are Worth the Wait" with a Facebook page.

IBA:
MCH and other KDHE staff participated in efforts with local communities working on infant mortality issues using PPOR and FIMR methodologies.

MCH supports the work of the MOD, Kansas Blue Ribbon Panel on Infant Mortality, and KPQC in raising awareness of prematurity issues in Kansas.

MOD coordinated formation of the KPQC that is dedicated to improving perinatal health in Kansas in a multi-stakeholder effort to improve service quality and access to care for women and infants.

KDHE's Kansas Health Matters and other data resources are used to support community health assessment and health improvement activities to address preterm birth.

c. Plan for the Coming Year

DS: Pregnant women screening positive for tobacco use across MCH, WIC, and Family Planning Programs will receive referrals to the Quitline and available local tobacco cessation and clinical provider services.

ES:
MCH will promote the text4baby program to physicians and other local health care practitioners and participate in the annual national enrollment contest with its partners.

MCH grantee staff will continue to provide outreach, support and education to families and make referrals to the Quitline for tobacco cessation issues.

PBS: MCH will continue its work in providing website updates to include more comprehensive and user-friendly information and tools for local health care providers, the public and other stakeholders interested in reducing prematurity.

IBS:
In collaboration with the Kansas Maternal and Child Health Council, the MCH multidisciplinary advisory council, MCH staff will discuss the feasibility of proceeding with plans of the former KDHE CHE to promote the development of a peer-to-peer mentor network to provide education and support to young women in communities experiencing high rates of low birth weight and infant mortality.

MCH staff will participate with Kansas TUPP on strategies to increase smoking cessation among women of childbearing age and pregnant women.

MCH will partner with the Kansas Fatherhood Coalition and Kansas Children's Service League in promoting the message that there is "no safe amount of alcohol use during pregnancy" and other health-related messages in regard to how fathers can support the women in their lives to make healthier choices.

MCH staff will continue work with KPQC to move forward with quality improvement projects.

MCH staff in concert with the March of Dimes has helped several targeted communities establish and maintain perinatal collaboratives in the development of a system that promotes coordinated and comprehensive prenatal care in an effort to reduce infant morbidity and mortality.

State Performance Measure 5: *The percent of children age 0 to 17 who received coordinated, ongoing, comprehensive care within a medical home.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and	2009	2010	2011	2012	2013

Performance Data					
Annual Performance Objective			63	63	62
Annual Indicator	61.3	61.3	59.1	59.1	59.1
Numerator					
Denominator					
Data Source	National Survey Of Children's Health, 2007	National Survey Of Children's Health, 2007	NSCH, 2011/2012. Kansas Estimate.	NSCH, 2011/2012. Kansas Estimate.	NSCH, 2011/2012. Kansas Estimate.
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	62	64	64	66	66

Notes - 2013
For 2011-2013, indicator data come from the National Survey of Children's Health (NSCH), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2011-2012.

All estimates from NSCH are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2011-2013, indicator data come from the National Survey of Children's Health (NSCH), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2011-2012.

All estimates from NSCH are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2013, indicator data come from the National Survey of Children's Health (NSCH), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2011-2012.

All estimates from NSCH are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments
According to the 2011/2012 National Survey of Children's Health, the care received by 59.1% of Kansas children met this medical home standard, compared to 54.4% for the U.S. This varies substantially by household income in Kansas: 42.6% of children in households with incomes at less than 100 percent of the Federal poverty level ($22,350 for a family of four in 2011) had a medical home, compared to 69.2% of children in households at or above 400 percent of the Federal poverty level. Receipt of care from a medical home also varies by race and ethnicity. Non-Hispanic white children are the most likely to receive care in a medical home (67.3%), followed by non-Hispanic black children (43.0%). Hispanic children are the least likely to have a medical home (35.4%).

Direct Services:
MCH grantees assessed each client they served for medical home. If none reported, then grantees would either assist clients in filling out medical insurance applications or refer them to DCF outreach workers for this service.

Enabling Services:
MCH grantees linked clients to local mental health, medical, dental and social services through Healthy Start Home Visitors (HSHV) who provided outreach to families in their communities. MCH staff provided technical assistance to local grantees in how to measure medical home as an outcome objective for reporting purposes. MCH grantees worked with Farmworker Health programs to link pregnant women with health resources.

Population Based Services:
The Kansas Head Start Association provided two annual Basic Home Visitation trainings for new HSHV and other State home visitation program staff. Medical home and the facilitation of linkages and referrals to local services for their clients was one focus of these trainings.

Infrastructure Building Services:
KanCare, the Kansas Medicaid Program, including SCHIP was rolled out this year. All three Kansas MCO's were fully engaged in a process of making sure physicians in all parts of Kansas were signed up with them. As part of the program rollout, listening tours were provided across the State to get out information about KanCare and to hear back from various parts of the State about any concerns or comments they might have. MCH staff collected data that served as a proxy measure for medical home from local grantees.

Direct Services:
MCH grantees assessed clients served for medical home and provided assistance in linking them with local health and family services.

Enabling Services:
HSHV works with clients to help them gain an understanding of and navigating the health care system and in gaining access to health care services. MCH staff provides technical assistance to local grantees in working toward increasing the percentage of clients served in a medical home.

Population Based Services:
Basic Home Visitation trainings are provided by the Kansas Head Start Association to train HSHV and other State home visitation program staff on the importance of medical home and the facilitation of linkages and referrals to local services for their clients.

Infrastructure Building Services:
Kansas has legislation (KSA 75-7429) that defines medical home that became effective July 1, 2008. MCH collects proxy medical home data in its data system to assist in the measurement of grantees' progress on this objective.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Adapt resources within KDHE to measure medical home.				X
2. MCH grantees assess clients served for medical home and provided assistance in linking them with local health and family services.	X	X		
3. Kansas promotes text4baby free healthy text messaging service for outreach to pregnant women in high-risk populations to promote medical homes.		X	X	

4. Healthy Start Home Visitors work with clients to help them gain understanding of navigating the health care system and in gaining access to health care services.		X		
5. Kansas has legislation (KSA 75-7429) that defines medical home that became effective July 1, 2008.				X
6. MCH collects proxy medical home data in its data system to measure grantees' progress on this objective.				X
7. MCH staff provides technical assistance and professional education homes to local MCH grantees and health care providers on the importance of access to medical.				X
8. MCH staff will reassess how its data system collects medical home data and implement any improvements that are feasible.				X
9. MCH grantees worked with Farmworker Health programs to link pregnant women with health resources.		X		X
10.				

b. Current Activities
DS: MCH grantees continue to assess clients for medical home and provide assistance in linking them to local medical and family services according to need.

ES: MCH staff continue to: provide technical assistance to local grantees in working toward the objective of assisting clients they serve in obtaining a medical home; assist clients in filling out KanCare application forms or in referring them to DCF outreach workers for same; provide technical assistance; and provide professional education on the importance of access to medical homes to local MCH grantees and health care providers.

PBS: KanCare serves as the Medicaid/SCHIP program for Kansans who qualify for its services. Local school districts will assist in promoting KanCare to parents who may qualify for services during Kindergarten round-up and school enrollment events.

MCH staff provides a list of pregnant women on Medicaid to its grantees in an effort to provide targeted outreach to populations at high-risk for poor birth and health outcomes.

IBS: MCH staff monitors and evaluates data from the National Survey of Children's Health on medical homes. MCH staff participates in meetings with various statewide partners to strive for a system that provides outreach, identification and referral services for eligible children in KanCare.

c. Plan for the Coming Year
DS: MCH grantees, primarily consisting of local health departments, will continue to address medical home by screening clients for a consistent provider of medical care and health care insurance. If a client is determined to not have either a consistent provider for medical care or health care insurance, then a process is begun to assist clients to obtain one or the other as their needs dictate on balance with available local resources. Some grantees provide a list of local health care providers from which the clients may choose a provider with guidance from local staff and a varying degree of assistance in filling out health care insurance forms. Other grantees with greater resources assist clients in making appointments and go so far as taking the clients to the provider.

PBS: As grantees become more aware of the resources that health care navigation staff provides, more grantees are referring their clients to them for assistance. Lead MCH staff have been instrumental in linking local grantees to health care navigators located across Kansas.

State Performance Measure 6: *The percent of high school students who had at least one drink of alcohol during the past 30 days.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			37	37	30
Annual Indicator		38.7	32.6	32.6	32.6
Numerator					
Denominator					
Data Source		YRBS, 2009	YRBS, 2011	YRBS, 2011	YRBS, 2011
Is the Data Provisional or Final?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	30	28	28	26	26

Notes - 2013
The 2012 and 2013 columns are populated with 2011 data. 2013 data will be available Fall 2014.

Notes - 2012
The 2012 and 2013 columns are populated with 2011 data. 2013 data will be available Fall 2014.

Notes - 2011
DATA SOURCE:
CDC. Youth Risk Behavior Surveillance System (YRBSS), Youth Online. 2011.
http://apps.nccd.cdc.gov/youthonline/App/Results.aspx?LID=KS.

a. Last Year's Accomplishments
The 2011 Kansas Youth Risk Behavior Survey (YRBS) showed that compared to 2009, fewer students reported having at least one drink of alcohol (32.6% vs. 38.7%) on at least 1 day during the 30 days before the survey. During 2005-2012, a statistically significant decreasing trend was observed (Annual Percent Change = -4.58).

DS: Law enforcement officials and community alcohol prevention centers provided enforcement of alcohol-related laws and cessation services for those who become addicted to its use.

ES:
Information and resources on alcohol use and preventive services available in Kansas are provided to school nurses, teachers, and MCH grantees through newsletter articles and routine communications.

Students Against Destructive Decisions (SADD) events are promoted among stakeholders interested in preventing underage drinking.

Safe Streets coalitions in communities across Kansas serve to educate and inform parents and teenagers of the dangers of alcohol use and of the laws that exist to protect families from the inappropriate handling and use of alcohol.

The Kansas Leadership to Keep Children Alcohol Free Coalition produces an annual report to inform various stakeholders on the risks, costs and consequences of underage drinking called, "State of the State on Underage Drinking by the Numbers." This coalition also provides a website of various resources for legislators, parents, state agencies, health care and social service providers and others interested in underage drinking.

PBS: SADD students and their sponsors received leadership training including information on

capacity building, refusal skills, peer mentoring, using media to promote positive youth development and Kansas laws.

IB:
MCH staff participated in the Kansas Family Partnership's (KFP) committee, Kansas Leadership to Keep Children Alcohol Free, which includes members from Kansas Highway Patrol, Kansas State Department of Education (KSDE), Kansas Department of Transportation, Kansas Sheriff's Association, Kansas SADD Chapter, Kansas State Nurses Association, Kansas Legislature, American Indian Tribal Council, American Automobile Association (AAA) of Kansas, Kansas Funeral Home Directors, Addiction and Prevention Services, local school districts and drug and alcohol treatment centers.

MCH staff actively serves on the state-level Fetal Alcohol Spectrum Disorders (FASD) speakers' bureau providing education and resources to statewide stakeholders. MCH staff received training through the Midwest Regional Fetal Alcohol Syndrome Training Center (MRFASTC) in Kansas.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Increase stakeholder knowledge of adolescent health issues.			X	X
2. Participate in activities of the Kansas Leadership to Keep Children Alcohol Free to leverage funds from several groups in an effort to decrease underage alcohol use.			X	X
3. Continue development of peer educator role program model with SADD chapter leaders that educate teens and parents.			X	X
4. Educate public and private partners and families on issues associated with underage consumption of alcohol and available prevention and treatment resources.		X	X	X
5. Make available information on training school/community members on how to establish SADD chapters in schools.			X	X
6. Assess Kansas Leadership to Keep Children Alcohol Free committee's membership to help ensure a broad representation of statewide stakeholders.				X
7. MCH staff serves as State Coordinator for NAFSC and is member of state's FASD prevention speaker's bureau.				X
8. Kansas laws prohibit the sale, possession and consumption of alcohol by anyone under age 21 years and social hosting laws.				X
9. Law enforcement and community prevention centers provide enforcement and cessation services to teens and parents.		X		
10. Develop state capacity to better address FASD prevention.				X

b. Current Activities
DS: Law enforcement officials and community alcohol prevention centers provide enforcement of alcohol-related laws and cessation services for addicted teens.

ES: Resources on alcohol use and prevention are provided to MCH grantees and shared among interested stakeholders through newsletter articles, the Web and routine communications. SADD events are promoted among stakeholders interested in preventing underage drinking in schools.

PBS: MCH staff provided FASD training to SADD groups and providers that work with adolescent teen parents on FASD prevention. MCH staff provided FASD prevention training to local school district nursing staff which included resources and tools to use with the families and youth they serve.

IBS:
KDHE staff participated in the KFP's Kansas Leadership to Keep Children Alcohol Free committee that addressed underage alcohol use issues, alcohol-related legislation and assessed impacts from member activities. A new annual document addressing underage drinking was produced and distributed widely.

MCH staff serves as the Kansas coordinator for FASD with the National Association of Fetal Alcohol Spectrum Disorders State Coordinators (NAFSC) in collaboration with the FASD Center for Excellence under the Substance Abuse and Mental Health Services Administration (SAMHSA). The Kansas Chapter of the American Academy of Pediatrics maintained its position as a NOFAS affiliate.

c. Plan for the Coming Year
DS: Law enforcement officials and community alcohol prevention centers will continue enforcement of alcohol-related laws and cessation services for those who become addicted to its use.

ES:
SADD chapters will engage students and parents in promoting positive activities for youth and providing them with education on the impact of underage alcohol consumption.

MCH staff will provide current research and resources related to the prevention of underage alcohol consumption and alcohol-exposed pregnancies using a variety of electronic and print materials by pooling its resources with those of partnering organizations.

MCH staff will provide FASD prevention trainings to any interested stakeholder groups.

PBS: KSDE and MCH staff will continue to collaborate on trainings focused on adolescent risky behaviors and alcohol use by minors at annual HIV/AIDS/STD conference.

IBS:
MCH staff will address the prevention of alcohol-exposed pregnancies to stakeholders currently involved with a variety of topics that have an impact on perinatal health: Kansas Perinatal Quality Collaborative, Kansas Maternal and Child Health (advisory) Council, local perinatal disparities collaboratives and FIMR groups.

MCH staff will serve as the Kansas Coordinator with NAFSC to work toward developing state capacity to fully address FASD prevention (FASD Task Force) and evidence-based training on screening, brief intervention, referral and treatment (SBIRT) for health care providers caring for women of reproductive age at risk for alcohol-exposed pregnancies.

State Performance Measure 7: *The Percent of children who are obese.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			13.1	12.6	12.4

Annual Indicator	13.2	13.0	12.8	12.8	12.8
Numerator	4878	4919	4803	4803	4803
Denominator	36956	37838	37523	37523	37523
Data Source	Kansas PeNSS, 2009	Kansas PeNSS, 2010	Kansas PeNSS, 2011	Kansas PeNSS, 2011	Kansas PeNSS, 2011
Is the Data Provisional or Final?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	12.2	12	12	11.8	11.8

Notes - 2013
The 2012 and 2013 column are populated with 2011 data. 2012 and 2013 data will be available Fall 2014.

Notes - 2012
The 2012 and 2013 column are populated with 2011 data. 2012 and 2013 data will be available Fall 2014.

Notes - 2011
Data Source: Pediatric Nutriton Surveillance System (PedNSS), 2012(Kansas WIC database).

a. Last Year's Accomplishments
According to the 2011 Pediatric Nutrition Surveillance System (PedNSS), which assesses nutritional status of children from low-income families (below 185% of poverty level) participating in WIC, 28.4% of low-income children ages 24-59 months in Kansas were overweight (at or above 85%) or obese (above 95%). Kansas prevalence was significantly lower than the prevalence nationally (30.4%). Over the 10-year period (2002-2011), there was a significant increasing trend during 2002-2004, since 2004 the trend has decreased significantly. For both periods, the annual percent changes (APCs) were significant (8.15, -1.17, respectively).

Infrastructure Building:

Trainings, websites and other resources that promote good nutrition and physical activity were published the Zero to age 21: Information for Promoting for Public Health Professionals working with Kansas Kids (ZIPS) newsletter and WIC Information Memos throughout the year.

Assisted LHDs in identifying funding mechanisms and partnerships to support initiatives at the community level.

Surveyed school nurses to assess if children are being weighed, measured and referred, as appropriate.

Four state staff attended the 2013 Annual Meeting of the Association of State and Territorial Public Health Nutrition Directors (ASTPHND).

University of California Davis Human Lactation Center Baby Behavior train-the-trainer attended by 48 state and local WIC staff and other Kansas health professionals. This program discourages overfeeding and future overweight. This program discourages overfeeding and future overweight.

Kansas Baby Behavior Campaign training planned and developed.

Population Based Services:

Participated in the development of a targeted media campaign aimed at reducing sugary drinks in

the diet of tweens in Shawnee County.

Approximately 270 local and state health department staff attended the Sixth annual Governor's Public Health Conference in April 2012. The conference featured a keynote presentation on "Healthy People 2020."

Enabling Services:

Participated on the Kansas Governor's Council on Fitness.

Participated in planning and promotion of the 2012 Statewide Obesity Summit.

Worked with the Bureau of Health Promotion (BHP) to promote the Kansas Kids Fitness Day, a statewide event focused on increasing physical activity among 3rd grade students in Kansas. This event was held on May 4, 2012.

Promoted the use of existing online staff educational programs that promote good nutrition and physical activity.

Enhanced and expanded existing partnerships with federally funded nutrition programs for coordination to meet the overall maternal and child health nutrition goals by participating in the Nutrition and Physical Activity Collaborative (NuPAC).

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Assure access to a food supply and healthy food choices.			X	
2. Assure access to safe, affordable opportunities to be physical active.			X	
3. Identify funding resources and partners.		X	X	
4. Utilize and improve data systems.		X	X	X
5. Use and communicate results of program and policy interventions that contribute to evidence-based strategies.		X		X
6. Increase the number of well-trained MCH personnel who support healthy eating and physical activity.				
7. Promote consistent messages with best evidence available.		X	X	
8.				
9.				
10.				

b. Current Activities
Infrastructure Building:

Provide child care providers education on health and physical activity for young children and their families.

Work with KU School of Medicine and KDHE epidemiologists to study feeding behaviors and weight.

Work with KDHE epidemiologists to produce reports comparable to former PNSS and PedNSS reports.

Provide Kansas Baby Behavior Campaign trainings to all local KS WIC clinic staff (450+) and

other interested health professionals at 15 sites around Kansas.

Collaborate with federally funded nutrition programs to identify opportunities for coordination to meet overall maternal and child health nutrition goals by participating in NuPAC.

Survey school nurses to assess if children are being weighed, measured and referred, as appropriate.

Population Based Services:

Work with BHP to develop food procurement standards.

Support continuing education opportunities on nutrition and physical activity from credentialing organizations, member associations, academic institutions and other groups.

Enabling Services:

Participate on Kansas Governor's Council on Fitness

Work with the BHP to promote the Kansas Kids Fitness Day, a statewide event focused on increasing physical activity among 3rd grade students in Kansas. This event was scheduled for May 3, 2013.

Promote use of existing online staff educational programs that promote good nutrition and physical activity.

c. Plan for the Coming Year

Infrastructure Building:

Advocate for policies and environmental changes that support daily physical activity opportunities in all settings.

Provide child care providers education on health and physical activity for young children and their families.

Utilize and improve data systems to measure the development and impact of community-based policy and program interventions at the individual, organizational and community level.

Strengthen partnerships related to healthy eating, nutrition and physical activity.

Coordinate with federally funded nutrition programs to identify opportunities for collaboration to meet the overall maternal and child health nutrition goals.

Survey school nurses to assess if school-aged children are being weighed, measured and referred, as appropriate. Importance of assessing these parameters and referring to the health care provider will be covered in newsletters and trainings.

Provide follow up to Kansas Baby Behavior Campaign trainings at the Kansas WIC Conference.

Population Based Services:

Work with the BHP and other stakeholders to design and promote consistent and culturally appropriate nutrition and physical activity messages.

Support continuing education opportunities on nutrition and physical activity from credentialing organizations, member associations, academic institutions and other groups.

Enabling Services:

Participate on the Kansas Governor's Council on Fitness.

Model health education and physical activity for 3rd grade students in Kansas, by working with the BHP to promote the Kansas Kids Fitness Day, a statewide event focused on increasing physical activity among 3rd grade students in Kansas. Nearly half of all third graders in the state of Kansas participate each year.

Promote the use of existing online staff educational programs that promote good nutrition and physical activity.

State Performance Measure 9: *The percent of youth with special health care needs (YSHCN) whose doctors usually or always encourage development of age appropriate self management skills.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			84	84	85
Annual Indicator		84	83.5	83.5	83.5
Numerator					
Denominator					
Data Source		National Survey of CSHCN, 2005/2006	National CSHCN 2009/2010. KS Estimate.	National CSHCN 2009/2010. KS Estimate.	National CSHCN 2009/2010. KS Estimate.
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	85	86	86	87	87

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for SPM 9, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the SPM 9 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for SPM 9, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the SPM 9 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for SPM 9, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the SPM 9 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments
The 2009-2010 National Survey of Children with Special Health Care Needs (NS-CSHCN) showed that overall 52.7% of Kansas youth with special health care needs (YSHCN), 12-17 years, received the services necessary to make appropriate transitions to adult health care, work and independence and 83.5% reported that their doctors or other health care providers usually or always encouraged them to take responsibility for their health care needs, such as taking medication, understanding their diagnosis, or following medical advice.

Of the 52.7% of Kansas YSHCN that received the services necessary to make appropriate transitions, 57.7% reported that they received anticipatory guidance for transition to adult health care. Among the 57.7% of Kansas YSHCN that received the anticipatory guidance, 59.8% reported that their health providers discussed the shift to adult health care providers, and 72.6% reported that their health providers discussed their changing health needs as they become an adult. About 66.5% reported that their health providers discussed health insurance as they become as adult.

Staff with the KS Family-to-Family Health Information Center (F2F) assists families with the development and use of a personal healthcare notebook, the CARing Notebooks. The Family Advisory Council developed of a series of transition checklists for parents of children 0-6, pre-teens and teenagers age 7-13, and youth and young adults ages 14-19. These booklets cover a variety of topics, including health, education, employment, community living, and more. The appropriate booklet in the series is included in each CARing notebook provided to the families.

Through a partnership with Families Together, transition-related issues were embedded into

regional and statewide conferences for parents/families, educators, community and health providers, and other interested parties. A strong focus on engaging youth early and providing resources to parents prior to the formal transition period was evident. Partnerships with others assisted with the development of the Building a Life website, www.buildingalife.ku.edu. This website is dedicated to families to navigating transition. The website includes resources, tools and stories to aid families in supporting youth transition related to the following six transition-related topics: Life in the Community; Your Home; Work; School; Health; and Circle of Support. The website is housed at the University of Kansas Medical Center, Center for Child Health and Development for ongoing technical support and sustainability.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaborate with the KS F2F program to disseminate information about transition through the CARing Medical Notebooks.		X	X	
2. Work with FAC members to develop and disseminate transition resources and information to families and providers.		X	X	X
3. Develop and disseminate tools and resources that can support youth transition and engaging children and youth early in their transition planning.		X		
4. Dissemination of the Kansas Health Care Transition Model to providers and other stakeholders.			X	X
5. Continue collaborations with the Center for Child Health and Development to maintain up-to-date and valuable information about transition resources on the Building a Life Kansas Transition website.				X
6. Partner with the Kansas Youth Empowerment Academy to develop a Youth Leadership program.		X	X	X
7.				
8.				
9.				
10.				

b. Current Activities
Previous year activities were continued.

Throughout the KS-SHCN strategic planning process, a focus has primarily been on care coordination, which incorporates some of the components of transition. As described earlier, a previous transition activity included the development of a website that has experienced a number of setbacks and barriers to dissemination. The primary focus this year has been on restoring administrative access to we can share the curriculum with youth to promote independence and provide opportunities for skill-building, self-determination and support in becoming an empowered patient. Through this curriculum, youth will learn how to communicate with peers, parents and health care providers. The program consists of the following six modules: About Me, Taking Charge, Staying Healthy, Empowered Patient, Taking Care of Myself and After High School. Each module consists of an overview of that section, the youth's personal learning goal, a status check to see if the youth met their goal and a "Very Important Points" section. The modules are progressive and each one builds on skills and information learned previously. The interactive system will save their responses and place this in their "Plan" for the youth to look back on and use in future transition planning.

c. Plan for the Coming Year
Integration of the Health Care Transition model into the KS-SHCN Care Coordination Program will provide opportunities to work with youth to support them to build partnerships with doctors. We will assist the youth in developing their skills to learn necessary self-management skills to successfully transition to adult care. Another part of the care coordination model will include working with medical providers of the YSHCN on our program to provide tools and resources that support transition.

As mentioned previously, the new D-70 grant proposal includes piloting a self-assessment tool for youth transition. We will also integrate this into a medical/health home learning collaborative for providers to learn about transition and how to incorporate that into their practices.

State Performance Measure 11: *The percent of infants with Permanent Congenital Hearing Loss (PCHL) enrolled in early intervention services before 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective					66
Annual Indicator		46.6	65.1	55.3	43.0
Numerator		41	41	52	34
Denominator		88	63	94	79
Data Source		SoundBeginning, 2010	SoundBeginning, 2011	SoundBeginning, 2012	SoundBeginning, 2013
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	66	68	68	70	70

Notes - 2012
Data Source: SoundBeginnings Program data, 2012
Numerator = Number of infants with PCHL enrolled in early intervention by 6 months of age
Denominator = Number of infants identified with PCHL

Notes - 2011
Data Source: SoundBeginnings Program data, 2011
Numerator = Number of infants with PCHL enrolled in early intervention by 6 months of age
Denominator = Number of infants identified with PCHL

a. Last Year's Accomplishments
Hearing loss is the most common congenital anomaly found in newborns and 2-3 in 1,000 births will be diagnosed with some degree of hearing loss each year. 90-95 % of babies with hearing loss are born to parents who have normal hearing. Any degree of hearing loss can be

educationally handicapping for children. In 2011, 66 babies were identified through the newborn hearing screening program as having some degree of hearing loss. All children residing in Kansas, birth to three years of age, identified with any type or degree of hearing loss are eligible for Early Intervention services. Three infants were not eligible for services because they did not reside in Kansas. Forty of the 63 (63%) babies that were identified with hearing loss were enrolled in early intervention services before the recommended Joint Committee on Infant Hearing (JCIH) guidelines of 6 months of age. About 76% of the 63 babies identified, with age not factored, were enrolled in early intervention services receiving the appropriate services for the normal development of speech and language. Enrollment in Early Intervention before 6 months of age increased at a rate of 13% than that in 2010 and is 13% higher than the national average for 2011. The first three years of life is the most critical period in the development of speech and language. Research indicates if early identification before 3 months and intervention before 6 months of age, children with hearing loss have language development that is comparable to their age peers when they are three to eight years old. Great measures have been implemented throughout the past several years that have proven to be indicators in reducing the LFU/LTD.

SoundBeginnings (SB) continues to provide Infant-Toddler programs with ongoing technical assistance in the use of the equipment, reporting, referrals, and providing any information to the program that will assist in increasing their rates of children identified with hearing loss enrolled before 6 months of age. It is felt that this collaboration was a large asset to the decrease in the percentage of those infants lost to follow-up and documentation.

ES: Collaboration and direct referrals to local tiny-k early intervention networks when a child is identified with hearing loss. Family Support Consultant calls from parents of previously identified children to newly identified parents for support and assistance with resources and to emphasize the importance of early intervention on the child's speech and language development. Continual work to develop the parent-driven Kansas Hands & Voices Chapter family support organization. Other collaborators include: Pediatric Audiologists, Kansas Infant- Kansas School for the Deaf, Hartley Family Center, Parents As Teachers, Early Head Start and family support organizations.

Early Intervention referral services were implemented at the local level by birthing facilities, SoundBeginnings, and Medical Home providers for any child birth to three years of age with a diagnosed hearing loss. Early Intervention programs were provided educational OAE Hearing Screening trainings, technical assistance and presentations.

Support through grants for reducing loss to follow-up and loss to documentation and tracking, surveillance and integration. SoundBeginnings Advisory Committee met quarterly to incorporate, collaborate and disseminate education materials to professionals and parents. SoundBeginnings staff continues to focus on maintaining the national JCIH goals for Early Intervention and improve the understanding of the benefits of early intervention to all professionals touching the lives of our children and to improve the health and quality of life for children with hearing loss and their families in Kansas. The staff attends the annual Early Hearing Detection and Intervention Conference each year to be a part of an amazing collaboration of health care and early intervention service providers, families, and state and national representatives who join forces to exchange best practices, discuss program improvement and raise awareness of successful strategies for improving the early hearing detection and intervention process at state and local levels.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue data submission through the web-based birth certificate (VRV) reporting system.				X
2. Continue quarterly meetings of the SoundBeginnings Advisory				X

Committee				
3. Continue the education training to professionals on early intervention				X
4. Collaborate to assist Kansas Hands and Voices chapter enabling parental input and parent to parent support				X
5. Continue dissemination of Newborn Hearing Screening brochures for families to hospitals, etc			X	
6. Support to hospitals to enhance screening equipment				X
7. Family and Audiologist Consultants to assist reduce loss to follow-up				X
8. Formalization of a regional program to assist newly identified families at first contact.				X
9. Collaborate with entities to provide technical assistance and education about underserved populations.				X
10. Continued attendance at EHDI, parent support and deaf education focused meetings				X

b. Current Activities
Activities will continue to provide assistance for family support activities and assist parent consultants. Through partnerships, SoundBeginnings provides resources to parents upon child being newly identified with hearing loss regarding resources state and nationwide and distributes letters to parents if their child has not been enrolled in services before 6 months of age to seek explanation as to why the child is not receiving early intervention services or if the child is receiving services through a private sector.

The program provides Pediatric Audiologists with packets of early intervention services to give the parents upon diagnosis. A Family Support Network is in the process of being designed to help connect families by sharing resources, stories, and strategies when raising children who are Deaf/Hard of Hearing.

SoundBeginnings Newborn Hearing Screening Program Advisory Committee will continue to meet quarterly. The committee has established goals for the Advisory year which begins in January including parent communication and family concerns; focus on education to all members involved in early intervention and including the focus of the family perspective. Staff, parents, and Pediatric Audiologists will continue to attend conferences focusing on Early Hearing Detection and Intervention (EHDI) issues, family support and Deaf Education.

c. Plan for the Coming Year
ES: Continue assistance with the Kansas Hands and Voices Chapter family support organization groups specifically for families of children who are deaf or hard of hearing to promote Parent-to-Parent program services to families, assists with family support activities and assist parent consultants. Continue collaboration with Pediatric Audiologists, Kansas Infant-Toddler Services (Local tiny-k programs), the Kansas School for the Deaf, Hartley Family Center, Parents As Teachers, Early Head Start and family support organizations. Provides resources to parents upon child being newly identified with hearing loss regarding resources state and nationwide. Distribute letters to parents if their child has not been enrolled in services before 6 months of age to seek explanation as to why the child is not receiving early intervention services or if the child is receiving services through a private sector. Provide Pediatric Audiologists with packets of early intervention services to give the parents upon diagnosis. Connect families by sharing resources, stories, and strategies when raising children who are Deaf/Hard of Hearing.

PBS: Maintain and continue to make improvements to ensuring that children identified with hearing loss receive early intervention services before 6 months of age through the statewide

data management tracking and surveillance system.

IBS: Continue referrals to Infant-Toddler Services and accept the required Healthy People 2020 data fields including race, ethnicity, language spoken in the home, and birth defects.

Collaborate with the Kansas School for the Deaf, Infant Toddler Services, tiny-k networks, WIC, Healthy Start Home Visit programs, Hartley Family Center, and Sound Start to provide assistance and training for personnel at tiny-k networks working with families of children identified with hearing loss and develop a regional program to assist in first contacts with families.

SoundBeginnings Newborn Hearing Screening Program Advisory Committee will continue to meet quarterly. The committee has established goals for the Advisory year which begins in January including parent communication and family concerns; focus on education to all members involved in early intervention and including the focus of the family perspective. Staff, parents, and Pediatric Audiologists will continue to attend conferences focusing on Early Hearing Detection and Intervention (EHDI) issues, family support and Deaf Education.

State Performance Measure 12: *The percent of Non-Medically Indicated (NMI) singleton live births of 37 and 38 weeks gestation.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective					
Annual Indicator			35.8	33.0	33.0
Numerator			2689	2368	2368
Denominator			7503	7169	7169
Data Source			Kansas birth certificate, 2011.	Kansas birth certificate, 2012.	Kansas birth certificate, 2012.
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	31	31	29	29	27

Notes - 2013
The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

Notes - 2012
Data Source: Birth certificate (in state resident) data, 2012, Bureau of Epidemiology and Public Health Informatics, KDHE

Notes - 2011
Data Source: Birth certificate (in state resident) data, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE

a. Last Year's Accomplishments
Gestational age is defined using the clinical estimate of completed weeks from the birth certificate. Clinical estimate of gestational age was found to be more accurate than gestational age using last menstrual period based on a medical chart review of late preterm cesarean delivery (unpublished). Non-Medically Indicated (NMI) inductions are induced labor without any

indication for delivery. NMI cesareans are cesarean deliveries without any indication for delivery and no attempt of labor.

In Kansas, in 2012, the percent of NMI singleton live births of 37 and 38 weeks gestation was 33.0%, a decrease from 2011 (35.8%). Women with NMI singleton live births were more likely to be married, non-Hispanic white, live in rural areas, and have private insurance. During the eight year period (2005-2012), there was a statistically significant increasing trend over the interval 2005-2008 (Annual Percent Change (APC)=4.06), followed by a statistically significant decreasing trend from 2008-2012 (APC=-5.64).

DS, ES, PBS, IBS: New performance measure -- no report.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Delivering physicians/practitioners (OB-GYNs, Family Practice physicians, Certified Nurse Midwives, etc.) will follow practice guidelines and policies by performing only medically indicated Cesarean Sections or inductions.	X			
2. MCH staff and other KDHE staff will partner with the Kansas Health Care Collaborative to: share data where feasible; educate local grantees, hospital staff and the general public on the risks of non-medically indicated Cesarean Section deliveries and		X		
3. Links to March of Dimes and CDC web resources will be shared among stakeholders/partners providing education on the reduction of non-medically indicated Cesarean Section deliveries and inductions.		X		
4. MCH staff will educate grantees to counsel their clients and communities on the benefits of delivering babies at full term (at least 39 gestational weeks) and the risks associated with delivering babies without medical indication before 39 weeks of g			X	
5. MCH staff will work with KanCare (Kansas Medicaid and SCHIP) staff on sharing information and integrating/aligning strategies to decrease the number of non-medically indicated Cesarean deliveries and inductions in a typically high-risk population.				X
6. Ensure that the network of communities with birth disparities collaboratives include information in their prenatal education curriculum on risks associated with non-medically indicated Cesarean deliveries and inductions and the benefits of delivering				X
7. MCH staff will work with the Kansas Maternal Child Health Council, the Kansas Perinatal Quality Collaborative, the Kansas Blue Ribbon Panel on Infant Mortality and others to align strategies across program and practice disciplines, develop consistent				X
8. MCH and other KDHE staff will continue to monitor data related to non-medically indicated Cesarean deliveries and inductions.				X
9.				
10.				

b. Current Activities

DS, ES, PBS: New performance measure -- no report

IBS:
Before becoming a new measure for FFY 2015, ongoing monitoring of data related to this measure was conducted by MCH and other KDHE staff.

Kansas Health Care Collaborative works within Hospital Engagement Network that includes some Kansas hospitals.

c. Plan for the Coming Year
DS: Delivering physicians/practitioners (OB-GYNs, Family Practice physicians, Certified Nurse Midwives, etc.) will follow practice guidelines and policies by performing only medically indicated Cesarean Sections or inductions.

ES:
MCH staff and other KDHE staff will continue in partnership with the Kansas Health Care Collaborative to: share data where feasible; educate local grantees, hospital staff and the general public on the risks of non-medically indicated Cesarean Section deliveries and inductions and the health benefits to mother and child of delivering at term; and assist in disseminating results of the early elective delivery quality improvement project to health care providers and other interested stakeholders.

Links to March of Dimes and CDC web resources will be shared among stakeholders/partners providing education on the reduction of non-medically indicated Cesarean Section deliveries and inductions.

PBS:
MCH staff will educate grantees to counsel their clients and communities on the benefits of delivering babies at full term (at least 39 gestational weeks) and the risks associated with delivering babies without medical indication before 39 weeks of gestation.

IBS:
MCH staff will work with KanCare (Kansas Medicaid and SCHIP) staff on sharing information and integrating/aligning strategies to decrease the number of non-medically indicated Cesarean deliveries and inductions in a typically high-risk population.

Ensure that the network of communities with birth disparities collaboratives include information in their prenatal education curriculum on risks associated with non-medically indicated Cesarean deliveries and inductions and the benefits of delivering a baby at full term (at least 39 weeks of gestation).

MCH staff will work with the Kansas Maternal Child Health Council, the Kansas Perinatal Quality Collaborative, the Kansas Blue Ribbon Panel on Infant Mortality and others to align strategies across program and practice disciplines, develop consistent messaging, and encourage policy development in delivering hospitals and birth centers that will serve to decrease the number of non-medically indicated Cesarean deliveries and inductions.

MCH and other KDHE staff will continue to monitor data related to non-medically indicated Cesarean deliveries and inductions.

State Performance Measure 13: *The percentage of newborns who have been screened for critical congenital heart defects (CCHD) before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective					
Annual Indicator			66.7	66.7	66.7
Numerator			25895	25895	25895
Denominator			38801	38801	38801
Data Source			KDHE. Kansas Newborn Screening Data, 2013.	KDHE. Kansas Newborn Screening Data, 2013.	KDHE. Kansas Newborn Screening Data, 2013.
Is the Data Provisional or Final?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	70	75	80	85	95

Notes - 2013
Data Source: Kansas newborn screening data based on the 2013 survey.

Notes - 2012
Data Source: Kansas newborn screening data based on the 2013 survey.

Notes - 2011
Data Source: Kansas newborn screening data based on the 2013 survey.

a. Last Year's Accomplishments
DS: The SHCN program has assisted with the cost of diagnostic testing to rule out cardiac conditions as a part of
their program prior to implementation of any formal CCHD screening. The one time diagnostic evaluations are
covered with a Pediatric Cardiologist when conditions are suspected including heart murmurs. Ongoing services are
available for patients diagnosed with an eligible condition who meet financial criteria for SHCN and this has included
surgical procedures for CCHD.

ES: Newborn Screening (NBS) staff participate in the Heartland Genetics and Newborn Screening Collaborative on
both the advisory and standing committees. Heartland has provided sharing and education on CCHD at NBS
meetings and conference calls. Heartland funded collaboration with Children's National Hospital and surveys were
completed in each of the Heartland states to assess the status of CCHD implementation. This survey occurred in the
spring of 2012. It was reported that approximately 78% of infants born in Kansas were screened for CCHD prior to
discharge.

A monthly CCHD teleconference has been provided through HRSA and later the NewSteps program which allows
states to learn about strategies and barriers with implementation of CCHD.

PBS: The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children recommended the
addition of CCHD screening to the core panel of disorders on September 17, 2010. Secretary Sebelius adopted the
recommendation in September 2011. CCHD screening is recommended on infants after 24 hours of age. Hospital
personnel conduct a pulse oximetry (PO) reading on the infant's right hand and one lower extremity.

In 2012 the American Heart Association began working with KDHE and the NBS advisory council in an effort to get
CCHD screening mandated for all Kansas births. The advisory council discussed implementation but due to funding
limits no recommendations were made.

IBS: KDHE screened for 29 of the recommended conditions by the American College of Medical Genetics (ACMG).
SCID and CCHD have been added to the recommendations but have not been implemented in Kansas due to the
costs for the additional testing and staffing concerns.

The Vital Statistics information system captures screening information for another Point of Care test, Newborn
Hearing Screening (NBHS) and exports this data into the AURIS NBHS database. The NBS program had discussed
creating a module on the existing AURIS database for the metabolic NBS results.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide and /or develop educational materials for parents, midwives and birthing facilities. Materials will include pamphlets, handouts, videos and website materials.		X		
2. Assure that specialty providers are available for consultation and/or treatment of identified CCHD patients.	X			X
3. Assess need to purchase equipment if this is a barrier for midwives. Assist in locating various funding sources.		X		
4. Conduct training of midwives and birthing facilities regarding CCHD screening.		X		
5. Manage/develop data collection and reporting systems for CCHD follow-up.				X
6. Provide information to policy makers on CCDH as necessary.				X
7. Participate in the newborn screening advisory committee and CCHD subcommittee to include QA activities.				X
8.				
9.				
10.				

b. Current Activities

All activities listed previously were continued. Kansas began a Quality Initiative (QI) to address screening for CCHD
versus mandating hospitals to screen for CCHD. This activated the CCHD subcommittee which had been developed
under the NBS advisory committee. Committee members include: March of Dimes, Specialty providers, Kansas
Hospital Association, American Heart Association, Pediatricians, hospital representatives and parent advocates.
Consultants who provide services in the state were asked to join the CCHD workgroup.

As part of the QI effort, a website to share information and materials was developed. A survey was sent to birthing
facilities and midwifes to assess current CCHD screening practices and capacity for pediatric echocardiograms and
referral patterns. NBS staff developed training materials for Kansas hospitals including an algorithm and testing
result chart which will assist in the interpretation of PO readings. The materials will be provided to facilities as
training takes place. Site visits are scheduled which include facility assessment, pre and post tests, hands on
training and ongoing assistance with policy development etc.

A CCHD newsletter has been developed that will provide updates to the Quality Initiative. Children's Mercy has
developed a Toolkit for facilities in both Kansas and Missouri. NBS staff will distribute the toolkit with trainings. The
CCHD subcommittee feels that the distribution should be in person versus a mass mailing.

c. Plan for the Coming Year

NBS staff will continue to work with specialty providers who will work with CCHD patients. New providers may be
identified and notified of NBS and SHCN program.

Activities will continue as described previously. The NBS advisory committee continues to be supportive of the QI
project and staff feels that one-on-one training will assist the state in ensuring all infants are screened. A
legislative mandate will not ensure that screening is being done accurately or may not require reporting to KDHE.
The QI has developed a reporting system through RedCAP that will be used by facilities. The data elements have
been formulated to match what is expected to be used in the Vital System database in the future.

The first phase of the project includes site visits to four initial sites (both large and small who screen and do not
screen). The second phase of the QI project will include identification of additional pilot sites. NBS staff will meet at
least monthly to identify training needs and assist with implementation barriers. If equipment needs are identified
as a barrier, funding will be discussed to assist with this. When facilities are reporting results, NBS staff will monitor
for inconsistencies and provide training as necessary.

Approval has been obtained for NBS to have a module on the Auris NBHS database. An

interface is planned with
NewSteps, who currently receives data on diagnosed cases identified through NBS. Conversations have taken place
with Vital Statistics to discuss adding the CCHD reporting to the electronic birth record. NBS staff will continue to
work on implementation of the addition of a CCHD module on the electronic birth record. When the NBS system is
merged with Auris we will be able to monitor babies who have not completed the screening and identify facilities
that need education/training.

E. Health Status Indicators

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01A - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	7.3	7.1	7.2	7.2	7.2
Numerator	3021	2867	2867	2888	2888
Denominator	41378	40429	39628	40301	40301
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

Notes - 2012
Data Source: Birth certificate (resident) data, 2012, Bureau of Epidemiology and Public Health Informatics, KDHE; Births for which birthweights are not reported are excluded from the computation of percentages.

Notes - 2011
Data Source: Birth certificate (resident) data, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE; Births for which birthweights are not reported are excluded from the computation of percentages.

Narrative:
Reducing births with low birthweight (LBW) is a Kansas MCH priority in the MCH 2015, the 5-year state MCH needs assessment (2011-2015).

Three strategies are being implemented:
Strategy 3.1: Partner to educate the public and health providers on issues related to contributing factors leading to preterm birth, low-birth weight, and infant mortality.
Strategy 3.2: Educate reproductive health providers and the public health workforce on best practice for prenatal risk assessment of all women of reproductive age.

Strategy 3.3: Direct targeted funding to provide comprehensive outreach and support services to pregnant women of racial and ethnic minorities.

In 2012, LBW infants accounted for 2,888 or 7.2% of births to Kansas residents mothers. Kansas surpasses the Healthy People 2020 targets for LBW babies. The target for LBW babies is 7.8%. The Kansas rate is 7.7% lower than the target (HP2020 objective MICH-8.1). Recent trends in LBW are influenced by the multiple birth rate. Twins and higher order multiples are much more likely to be born LBW than singletons. In 2012, 53.6% of all plural births in Kansas were LBW. Non-Hispanic black women (13.2%) are more likely than non-Hispanic white (6.5%) or Hispanic (6.9%) women to give birth to a LBW. About 78.4% of infants who died were born to non-Hispanic black mothers and were LBW, compared to 60.8% of infants of non-Hispanic white mothers.

In Kansas, regardless of maternal race and ethnicity, LBW is associated with a small percentage of live births, but a disproportionately larger percentage of infant deaths. During 2010-2012, among the infant deaths where birthweight was known, 64.8% of infants who died were LBW in comparison to 7.2% for all live births at LBW. Similarly, 49.0% of infant deaths occurred among the 1.4% of infants born at VLBW.

The infant mortality rate (56.8/1,000 live births) for LBW infants with linked death and birth files (2008-2012 combined) was 22 times that for infants weighing 2,500 grams or more (2.6/1,000 live births). Similarly, the infant mortality rate for VLBW infants (227.5/1,000 live births) was 88 times higher than the rate for infants born weighing 2,500 grams or more.

In 2012, the risk of LBW was greater for smokers than for nonsmokers (11.5% vs. 6.4%), creating an excessive LBW risk of 5.1% associated with smoking. Other risk factors for LBW live births include low socioeconomic status, inadequate weight gain during the pregnancy, history of infertility problems, close inter-pregnancy spacing and age of mother (younger and older maternal age).

F. Other Program Activities

State MCH program activities have considerable breadth. Many fall outside the parameters of priority needs and National and State performance measures. Some make significant contributions to the health and well-being of mothers and infants, children, and CYSHCN.

/2015/ Kansas Perinatal Quality Collaborative (KPQC): KPQC was formed as the result of a coordinated effort by the Greater Kansas Chapter of the March of Dimes and various Kansas perinatal health care stakeholders. The KPQC's goal is to improve service quality and access to care for women and babies in Kansas. This is to be achieved by assuring quality perinatal care using data-driven, evidenced-based practices and quality improvement processes. The KPQC identified their first priority project is to increase the number of infants exclusively fed breast milk.

Kansas Blue Ribbon Panel on Infant Mortality (Panel): The Panel consists of 22 representatives from state, local, and private organizations who have a broad range of expertise in maternal child health. It was originally formed in 2009 in response to Kansas' ranking of 40 out of the 50 states in infant mortality and its ranking of 50 out of the 50 states in black infant mortality. The Panel continued to make strides in its quest to decrease the rate of infant mortality in Kansas in 2012 as evidenced by the Healthy Babies are Worth the Wait awareness campaign, the formation of the KPQC and the establishment and continued work of various community collaboratives focused on the reduction of infant mortality.

High 5 for Mom&Baby Project was initiated through efforts of KDHE and the Kansas Breastfeeding Coalition, Inc. and is funded by the private foundation United Methodist Health Ministry Fund. The project is designed to help Kansas hospitals develop and implement policies and procedures that help mothers successfully initiate and continue to breastfeed after leaving the facility. Hospital staff receives training on five evidence based practices that improve breastfeeding success. Staff can also receive scholarships to become International Board Certified Lactation Consultants. Thirty-four hospitals are in the process of being trained and developing policies and procedures to implement High 5. Three hospitals have received the designation.

The Kansas Breastfeeding Coalition, Inc. (KBC) works to improve the health of children and mothers by increasing breastfeeding rates in Kansas. MCH collaborates with the KBC on a variety of projects. Projects include the Business Case for Breastfeeding -- workshops around Kansas train interested persons to assist employers in setting up lactation support for their employees who are breastfeeding. The KBC promotes, enhances and supports this project through free workshops, promotion of the project, employer grants, and employer recognition. The KBC encourages businesses throughout Kansas to support breastfeeding customers through the Breastfeeding Welcome Here Campaign. Stickers on store windows or doors let customers know that the business welcomes them. Additional projects help develop and support local (city/regional) breastfeeding coalitions through coalition building trainings and seed projects; provide education to child care providers about breastfeeding support through Child Care Provider train-the-trainer and on-line education, a joint project with KDHE Child Care Licensing, Child Care Aware and the Kansas Childcare Training Organization; and support of the largest delivering hospital in Kansas which is working toward Baby Friendly status with a Continuity of Care prenatal education and breastfeeding support project.

Kansas Nutrition Council is a statewide non-profit organization of nutrition professionals that supports improved nutrition for Kansans. The Kansas WIC program collaborates with the Kansas Nutrition Council (KNC) by providing financial support to bring recognized experts in the field of maternal and child health to speak at KNC's annual conference. The 2013 joint conference focused on sustainable agriculture and nutrition projects in Kansas. Kansas WIC staff spoke about WIC nutrition and breastfeeding projects. All of the state WIC nutritionists are KNC members and past or current Board members. KNC also provides mini-grant support for member nutrition projects, based on a grant application process. Many funded projects have centered on maternal and child health.

Kansas law, K.S.A. 38-2282, called "Newborn Infant Protection Act", was amended to expand the list of locations where an infant can be surrendered to include police stations, sheriff's offices, and law enforcement centers. Additionally, the bill protects disclosure of the name or other identifiable information of a parent or custodian who voluntarily surrenders physical custody of an infant under the Act, unless there is reasonable suspicion the infant has been abused, and protects the person or facility receiving the infant from civil and criminal liability for any action taken under the Act. This will go into effect on July 1, 2014. A MCH staff member participates in a Kansas-Missouri Safe Haven coalition and public education activities. "Safe Haven for Newborns" signs were placed at area hospitals, fire departments, and county health departments.

KDHE contracted with the Kansas Infant Death and SIDS (KIDS) Network with Children's Initiative Fund dollars from the state's tobacco settlement to conduct safe sleep education and bereavement services statewide. Activities include one-on-one and group safe sleep education, training for professionals, Cribs for Kids and community baby shower programs. Local health departments and Healthy Start Home Visitors regularly receive training and materials. The KIDS Network director participates in the Kansas Maternal and Child Health Council, Blue Ribbon Panel on Infant Mortality, FIMR, and other state and local perinatal and infant mortality projects.

MCH staff continued to serve as a state school nurse consultant. In addition to serving as a resource for school nurses, administrators and others on school nurse and school health issues, an annual state school nurse conference was presented along with training for new school nurses, and an annual school nurse survey was conducted. During this past year, KDHE staff and partners such as the Kansas School Nurse Organization have been discussing roles, priorities, and effective strategies to address school health in alignment with the Title V performance measures and MCH state priorities.

The Kansas Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program continued with both annual formula fund and competitive development grant funds administered by KDHE BFH. In the targeted at-risk communities - Wyandotte County (urban Kansas City, Kansas) and Montgomery, Labette, and Cherokee counties (rural southeast Kansas) - Early Head Start, Healthy Families America, and Parents as Teachers evidence-based home visiting programs and, in Wyandotte County specifically, a promising approach, the Team for Infants Endangered by Substance Abuse (TIES) Program, continued to scale up. Over 500 families have been served since Kansas MIECHV enrollment initiated in late 2011. Training and consultation and other innovative evidence-based practices have been provided for staff to enhance effectiveness with identifying, engaging, serving and referring families with mental health and substance abuse concerns. Coordinated, centralized outreach and referral systems have been enhanced. A comprehensive, cross-program data collection and reporting system has been implemented using common indicators and measures for required benchmarks and continuous quality improvement. A state level Home Visiting Workgroup composed a state strategic plan.

In August 2013, KDHE BFH was awarded a new three-year Early Childhood Comprehensive Systems: Building Health Through Integration (ECCS) grant. Kansas selected strategy two to expand and effectively coordinate, improve, and track developmental screenings and referrals for infant and toddlers across early childhood support systems including home visiting and early education settings, pediatricians and medical homes, intervention services, and child care programs and families. The project has been named the Kansas Initiative of Developmental Ongoing Screening (KIDOS). Using the Collective Impact Framework, a state Work Group to guide and monitor the project was convened led by a pediatrician. An implementation plan and a community tool kit are under construction. Training and data collection plans are underway to expand effective use of a common screening instrument, the Ages and Stages Questionnaire (ASQ-3 and ASQ-SE).

The Title V Director and MCH Epidemiologist worked closely with the March of Dimes, University of Kansas Center for Public Partnerships and Research, Geary County Health Department, and Geary County federally qualified health center to submit a grant application in March 2014 for HRSA's Healthy Start Initiative: Eliminating Disparities in Perinatal Health. If the application is selected for funding, the project will target the general population of pregnant women, new mothers, infants, and families in Geary County, Kansas, where the infant mortality rate from 2007-2009 was 10.9, more than 1.5 times the national rate. During that same time period, there were 27 infant deaths, exceeding the requirements indicated in the Healthy Start eligibility criteria. Total funds requested: $3,562,000. The project was named "Delivering Change", a comprehensive approach to eliminating disparities in perinatal health in Geary County. //2015//

G. Technical Assistance

Infant Mortality Reduction

In 2009, Kansas requested and received technical assistance on infant mortality reduction with an

emphasis on black infant mortality. Rosemary Fournier, from Michigan FIMR, presented to the Kansas Blue Ribbon Panel on Infant Mortality, a subcommittee of the Governor's Child Health Advisory Committee. She provided an overview of how data from PRAMS and FIMR have guided Michigan with good examples from Detroit. Then she facilitated a discussion with panelists about next steps. The panel adopted a number of recommendations which are posted on this website -- http://www.datacounts.net/infant_mortality/

During the 2010 session, they focused on changing the Vital statutes that have prohibited use of birth certificates for "follow-back" that is, for PRAMS and FIMR. The result is this law http://www.kslegislature.org/bills/2010/2454.pdf Hooray for our Panel members (especially Kansas Action for Children and March of Dimes). They worked hard to get this bill through the legislature. And there were many ups and downs. We are very grateful to them and for the technical assistance that helped moved this process along.

Birth Defects Information System

For the coming year, Kansas is requesting technical assistance from CDC. Senate Bill 418 passed in the 2004 Kansas legislative session. It creates, pending the availability of funding, a birth defects surveillance system. The statutory language is similar to that of model statutes for the State of Ohio. BCYF submitted an application to the CDC for funding of a birth defects surveillance system. The application was approved but not funded. Resources are not available to establish a surveillance system at this time. Some very limited components of a system such as a database are maintained using MCH federal funds. BFH needs CDC technical assistance to review current efforts and to make recommendations about next steps. /2012/ Two consultants from CDC visited Kansas. They reviewed existing systems with staff and senior management. They have provided Kansas with a document that outlines the steps needed to achieve a quality system for Kansas. Within funding constraints, Kansas MCH is implementing recommended steps. //2012//

/2012/ MCH/Medicaid Intragency Coordination/Collaboration

As indicated earlier in this document, ERO 38 introduced in the 2011 Legislative Session, mandates the merger of the KDHE (Title V MCH State Agency) and the Kansas Health Policy Authority (The State Medicaid Agency). Consultation with a national expert is needed to take advantage of the opportunities and to meet new challenges to MCH posed by this merger. No specific consultant has been suggested. //2012//

/2013/ Technical Assistance is requested from CDC to evaluate our current birth defects information system and to make recommendations: Vital Statistics was reengineered and we are analyzing our birth defects database and staffing needs for data collection and reporting.

Technical Assistance is requested from CDC to evaluate our current MCH/NBS information system and to make recommendations: Database and staffing needs for data collection and reporting. //2013//

/2014/ Technical assistance is requested from peer states and a national expert (no specific consultant) to develop and apply an Aid To Local (ATL) funding formula for annual grants awarded to local health departments for MCH service delivery. [Current program information and contractor requirements are online at:
http://www.kdheks.gov/doc_lib/MaternalAndChildHealthServices.html. The allocations by county were set years ago (no formula/criteria), and awards have not changed based on population, MCH services, needs assessments, etc.]
Objective 1: Develop applicable and organized process(es) to evaluate and update ATL funding formula.
Objective 2: Apply strategic process(es) to evaluate and update ATL funding formula.

Objective 3: Finalize implementation plan for updating current ATL funding formula.
Objective 4: Discuss implications in updating current ATL funding formula (change in awards, impact, etc).
Objective 5: Provide examples of other states similar to Kansas undergoing an ATL funding formula revision. //2014//

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2013		FY 2014		FY 2015	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	4670131	2445517	4670131		4682822	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	3972344	3527860	3722188		3524276	
4. Local MCH Funds *(Line4, Form 2)*	4190160	4403168	4740394		4401548	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	0	0	0		0	
7. Subtotal	12832635	10376545	13132713		12608646	
8. Other Federal Funds *(Line10, Form 2)*	70032836	78292923	80287199		76395057	
9. Total *(Line11, Form 2)*	82865471	88669468	93419912		89003703	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2013		FY 2014		FY 2015	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	2550360	2269900	2743042		2527877	
b. Infants < 1 year old	2550360	2269901	2743042		2527877	
c. Children 1 to 22 years old	5076243	4649154	5339541		5297578	
d. Children with	2320672	1187590	2057088		2055314	

Special Healthcare Needs						
e. Others	0	0	0		0	
f. Administration	335000	0	250000		200000	
g. SUBTOTAL	12832635	10376545	13132713		12608646	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	97260		0		91045	
c. CISS	135813		0		0	
d. Abstinence Education	359879		359879		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	60000000		67338600		64509746	
h. AIDS	0		0		0	
i. CDC	100000		0		0	
j. Education	4030759		4010088		4217833	
k. Home Visiting	0		0		0	
k. Other						
Breastfeed Peer Ed					455200	
ECCS					140000	
Family Planning	2300000		2471250		2545387	
Medicaid Teen Preg					338846	
MIECHV			4172802		3847000	
Newborn Hearing					250000	
Medicaid TPTCM			338846			
NB Hearing Screening			207000			
Other-ICC,SC,SB,KRG			138000			
Project LAUNCH			850000			
WIC BF Peer Ed			400734			
Other	3009125					

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2013		**FY 2014**		**FY 2015**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	1179092	546067	1271992		1116052	
II. Enabling Services	6929242	5672015	6780384		6285329	
III. Population-Based Services	3629085	3453162	3963147		3655305	
IV. Infrastructure Building Services	1095216	705301	1117190		1551960	
V. Federal-State Title V Block Grant Partnership Total	12832635	10376545	13132713		12608646	

A. Expenditures

/2012/ Form 3 - SFY 10 Block Grant partnership expenditures were as follows: $4,164,028 federal; $3,880,903 state; and $4,598,337 local. In comparison, for FFY 09, Block Grant partnership expenditures were: $4,718,608 federal; $4,512,530 state; and $4,782,085 local match. So, from SFY 09 to SFY 10 there were decreases in all three expenditures categories.

In SFY 10, Kansas spent federal dollars within the amount available and also compatible with the priority needs identified in the State Needs Assessment.

In SFY 10, federal MCH funding to support MCH/CYSHCN initiatives was expended within the department as follows: Office of Health Assessment $23,085; Office of Local and Rural Health $39,999; Child Care Licensing and Registration $146,775. Within the Bureau of Family Health (the MCH unit within KDHE) $475,784 in federal MCH funds was spent for staff and operating costs working in programs for Pregnant Women & Infants, and for Children & Adolescents. Staff, operating costs, and CYSHCN contracts and supplies were $1,001,064. Nutrition consultation through the WIC program was $1,800. Aid to Local agencies and contracts with providers for MCH services totaled $1,806,306.

Newborn screening follow-up expenditures (2 salaries) were $90,868. Salary and operating for one epidemiologist, the director and assistant were $203,366 while indirect costs totaled $334,907.

Federal MCH dollars have declined over the past 17 years from $5,004,067 in FFY 94 to $4,710,420 in FY 10. While this decline appears small, taking into account inflation, the Kansas federal MCH grant has lost almost half of its spending value. What cost $5 million in FFY 94, would cost $7.4 million today. To a great extent increased costs for MCH/CYSHCN have shifted to state and local governments. MCH dollars have been directed towards priority work with accountability for work performed.

For FY 10, no State dollars were expended for Pregnancy Maintenance Initiative. This funding accounts for much of the variability from year to year in state expenditures. It is routinely cut by executive branch and then some or all is restored by the legislature or vice versa. This is also the case for Teen Pregnancy Prevention.

Local agency expenditures data is obtained from the quarterly expenditure affidavits submitted by local agencies. All MCH local agencies meet contractual matching requirements. However, most provide a dollar for dollar match or greater. A very few local health departments have had difficulties meeting minimal local matching requirements. We continue to monitor this situation as local budgets tighten.

Form 4 - Two other items relating to expenditures should be noted here: 1) When considering federal MCH funds only, the state meets its federal obligation of 30-30 that is, equity in funding for each of the three population groups. When considering all Block Grant partnership expenditures, the Children and Adolescent (C&A) services funding is three times the funding for CYSHCN, and 2.5 times that for Pregnant Women & Infants (P&I). The reason for this is twofold. First, CYSHCN contracts require no local matching dollars. Second, MCH grants to local communities do not require services for CYSHCN. Various solutions to address this have been proposed such as requiring CYSHCN contractors to provide a match, or require that local MCH agencies serve children with special health care needs, and/or a combination of these. Such changes are not likely to take place in the near future.

Another item worth noting is that the funding paradigm has shifted in the MCH grants to local agencies. Previously, services were weighted towards pregnant women and infants through such programs as M&I and Healthy Start Home Visitor. After consolidation of these two grants with the Child Health grants to make one MCH grant, the instruction to local agencies was to allocate

resources 50% to pregnant women and infants, and 50% to children and adolescents. Since there were already other aid to local grants focusing on youth services (e.g., teen pregnancy, disparity, school health) the effect of this change was a slight over-allocation of resources to the C&A population group.

Form 5 - Direct health care expenditures are approximately 8% of the total MCH budget. Enabling services are 50% of the overall budget with population-based at 31% and core public health at 10% each. Over the past five years of this program, there has been a shift away from expenditures for direct services towards other levels of the pyramid.

With State expenditures of $3,880,903 in FY 10, the State of Kansas is well within its required maintenance of effort requirement of $2,352,511.

Kansas meets its 75% matching requirement through use of State funds. The increase in state and local fiscal responsibility for the program has continued over the past several years.

Detailed information about the Federal-State Title V Block Grant Partnership is provided on the attached Excel spreadsheet. //2012//

/2013/ Form 3. SFY 11 Block Grant partnership expenditures were: $3,637,101 federal; $3,408,049 state, and $3,854,940 local. There were decreases in all 3 expenditure areas from SFY 10 to SFY 11.

In SFY 11, federal spending to support MCH/CYSHCN initiatives expended within the department were: $22, 595 Office of Health Assessment, $28,534 Office of Local and Rural Health, $156,112 Office of Child Care Licensing and Registration. Within the Bureau of Family Health (MCH Section) $392,790 in federal MCH funds was spent for staff and operating costs. CYSHCN staff, operating costs, contracts and supplies were $975,801. Aid to Local agencies and contracts with providers for MCH services totaled $1,675,505.

Newborn screening follow-up expenditures (2 salaries) were $77,395. Salary and operating for one epidemiologist, director and assistant were $86,309. Indirect costs totaled $203,009.

Federal MCH dollars have declined over the past 18 years. To an increasing extent, costs for MCH/CYSHCN have shifted to state and local governments. This shift is increasingly more difficult to sustain.

Local agency expenditures data is obtained from the quarterly expenditure affidavits submitted by local agencies. All MCH local agencies meet contractual matching requirements. We continue to monitor this as local budgets tighten.

Form 4. The state meets its federal obligation of 30-30, equity in funding for each of the three population groups. Including all Block Grant partnership expenditures, the Children & Adolescent services funding is 3 times the funding for CYSHCN and 2.5 times the funding for Pregnant Women & Infants. CYSHCN contracts require no local matching dollars.

Form 5. Direct health care expenditures are approximately 8% of the total MCH budget. Enabling services are 51% of the overall budget. Population based services are 31%, and core public health at 10%. The shift of expenditures from direct services toward other pyramid levels continues.

The State Kansas is well within its required maintenance of effort of $2,352,311 with expenditures of $3,408,049 in SFY 11.

Kansas meets its matching requirement of $3 state/$4 federal through the use of State funds. Detailed information about the Federal-State Title V Block Grant Partnership is provided on the

attached spreadsheet. //2013//

/2014/

2011 Expenditures Updated:

Form 3. SFY11 Block Grant partnership expenditures were updated as part of this application: $4,670,131 federal; $3,695,620 state; and $5,093,392 local. Total MCH expenditures are $13,459,143. During SFY11, federal spending to support MCH/CYSHCN initiatives within the department included: $31,977 Office of Health Assessment/Vital Statistics, $33,905 Local and Rural Health/Public Health Program, $197,127 Child Care Licensing Program. Within the Bureau of Family Health (MCH Section) $455,452 in federal MCH funds was spent for staff and operating costs. CYSHCN staff, operating costs, contracts and supplies were $1,102,982, and WIC Nutrition consultation costs totaled $5,371. Aid to Local agencies and contracts with providers for MCH services totaled $2,266,882. Newborn screening follow-up expenditures (2 salaries) were $99,766. Salary and operating for two epidemiologists, director, assistant, and fiscal were $156,898. Indirect costs totaled $319,770.

Form 4. The state meets its federal obligation of 30-30, equity in funding for each of the three population groups. Including all Block Grant partnership expenditures: Pregnant Women & Infants 40%, Children & Adolescent services 45%, CYSHCN 15%. The CYSHCN contracts require no local matching dollars.

Form 5. Direct health care expenditures are approximately 8% of the total MCH budget. Enabling services are 52% of the overall budget. Population based services are 31%, and core public health is approximately 9%.

2012 Expenditures:

Form 3. According to fiscal reports at the time of submission, SFY12 Block Grant partnership expenditures were: $3,951,063 federal; $3,564,172 state; and $4,712,166 local. Total MCH expenditures are $12,227,401. During SFY12, federal spending to support MCH/CYSHCN initiatives within the department included: $22,459 Office of Health Assessment/Vital Statistics; $56,659 Local and Rural Health/Public Health Program; $106,489 Child Care Licensing Program; and $5,000 Center for Health Equity (partnership to support preconception peer educator community events). Within the Bureau of Family Health (MCH Section) $322,919 in federal MCH funds was spent for staff and operating costs. CYSHCN staff, operating costs, contracts and supplies were $1,271,964. Aid to Local agencies and contracts with providers for MCH services totaled $1,955,079. Newborn screening follow-up expenditures (2 salaries) were $89,871. Salary and operating for two epidemiologists, director, assistant and fiscal were $115,622. Indirect costs totaled $5,000 at the time of this application.

Form 4. The state meets its federal obligation of 30-30, equity in funding for each of the three population groups. Local match bolsters total expenditures for pregnant women/infants and children/adolescents due to the local match. More than $5,000,000 was reported in expenditures by local MCH grantees. CYSHCN contracts require no local matching dollars.

Form 5. Direct health care expenditures are approximately 7% of the total MCH budget. Enabling services are 54% of the overall budget. Population based services are 32%, and core public health is approximately 7%. The shift of expenditures from direct services toward other pyramid levels continues.

The State Kansas is well within its required maintenance of effort of $2,352,311 with expenditures of $3,564,172 in SFY12. Kansas meets its matching requirement of $3 state/$4 federal through the use of State funds. //2014//

/2015/ The State maintains budget documentation for all Block Grant funding/expenditures for reporting. Expenditure detail for SFY12 and SFY13 reflected on Forms 3, 4, and 5 follows.

2012 Expenditures Updated: The SFY2012 expenditures were updated to reflect actuals at the time of submission. The reasons for the changes in expenditures from last year relate to the State's two-year spending authority and time remaining in the grant/funding cycle at time of submission last year.

Form 3. SFY12 Block Grant partnership expenditures were updated as part of this application which reflects the following: $4,626,932 federal; $3,562,624 state; and $4,775,509 local for total MCH expenditures of $12,965,065. During SFY12, federal spending to support MCH/CYSHCN initiatives within the state health department included: $30,114 Office of Health Assessment/Vital Statistics; $61,213 Community Health Systems/Local Public Health; $154,679 Child Care Licensing. Within the Bureau of Family Health (MCH Section) $423,265 in federal MCH funds was spent for staff and operating costs related to overseeing the MCH grantee/aid to local program, conducting site monitoring visits, supporting local and state initiatives, etc. CYSHCN staff, operating costs, contracts and supplies were $1,214,277. Aid to Local agencies and contracts with providers for MCH services totaled $2,266,882. Newborn screening follow-up expenditures were $277,060. Salary and operating for two epidemiologists, director, assistant, and fiscal were $160,371. Indirect costs totaled $261,643.

Form 4. Including all Block Grant partnership expenditures, totals for each population group are as follows: Pregnant Women & Infants $5,251,416; Children & Adolescents $5,521,182; CYSHCN $1,930,822. The CYSHCN contracts required no local matching dollars for SFY12.

Form 5. There were no significant changes in expenditures reported for SFY12 by the four tiers of MCH services and levels of funding. Expenditures include: 9% for direct health care services (gap filling), 51% for enabling services, 31% for population-based services, and 9% for infrastructure building.

2013 Expenditures Reported:

Form 3. According to State fiscal reports at the time of submission, SFY13 Block Grant partnership expenditures reflect the following: $2,445,517 federal; $3,527,860 state; and $4,403,168 local for total MCH expenditures of $10,376,545. At the time of submission (months prior to end of state and federal fiscal years), federal spending to support MCH/CYSHCN initiatives within the state health department included: $11,910 Office of Health Assessment/Vital Statistics; $21,396 Community Health Systems/Local Public Health; $98,474 Child Care Licensing. Within the Bureau of Family Health (MCH Section) $301,228 in federal MCH funds had been expended for staff and operating costs related to overseeing the MCH grantee/aid to local program, conducting site monitoring visits, supporting local and state initiatives, etc. CYSHCN staff, operating costs, contracts and supplies totaled $587,099. Federal funding expended to date for Aid to Local agencies and contracts with providers for MCH services totals $1,003,352. Newborn screening follow-up expenditures are $69,549. Salary and operating for two epidemiologists, director, assistant, and fiscal were $151,630.

Form 4. Including all Block Grant partnership expenditures, according to State fiscal reports at the time of submission, totals by population group are as follows: Pregnant Women & Infants $4,539,800; Children & Adolescents $4,649,154; CYSHCN $1,187,590. The CYSHCN contracts required no local matching dollars for SFY13.

Form 5. According to State fiscal reports at the time of submission, SFY13 expenditures

by the four tiers of MCH services and levels of funding include: 5.3% for direct health care services (gap filling), 54.7% for enabling services, 33.3% for population-based services, and 6.8% for infrastructure building. The shift of expenditures from direct services toward other pyramid levels continues and more work, specifically around CYSHCN is being done to look at supporting care coordination and medical homes vs. direct care.

The State Kansas is well within its required maintenance of effort of $2,352,311 with expenditures of $3,562,624 in SFY12 and $3,527,860 in SFY13. Kansas meets its match requirement through the use of State funds. //2015//

B. Budget

/2012/

Form 2 - The Kansas budget for MCH federal dollars is $4,710,420. This is the full amount of the anticipated federal Title V award. There is an additional $70 million other federal dollars budgeted and $6.3 million other state dollars.

For FFY 12, the Block Grant partnership budget is: $4,710,420 federal; $3,880,903 state match; and $4,598,337 local. Overall Kansas Maternal and Child Health Services' funding is about one-third federal, one-third state, and one-third local. Kansas meets the 75% match for the federal dollars. Local agencies who receive MCH funds report all local funds used for MCH services.

Comparing the budgeted amounts of MCH dollars for FFY 11 and FFY 12 there is a small reduction in funds for Child Care Licensing ($8,188) that corresponds to the estimated amount of the federal reduction at the time of the submission. Child Care Licensing has gone to a fee-funded operation due to passage of Lexie's Law.

Form 2 - Amounts of funding allocated to children and adolescents and CYSHCN meet the 30-30 allocation requirement with $1,539,884 (33%) of the federal grant allocated to children and adolescents and $1,491,017 (32%) allocated to children with special health care needs.

Form 3 - Kansas' budget for FFY 12 meets its maintenance of effort requirement of $2,352,511. The Title V matching requirement of 75% is achieved through projected State matching funds of $3,972,344. Kansas also anticipates local reporting of expenditures of $4,710,220.

Form 4 - Of its overall MCH budget (fed, state and local), Kansas allocates about $2.7 million to services for pregnant women and $2.7 for infants. Another $5.4 million is allocated to children and adolescents and $2.3 million for CYSHCN.

Form 5 - Considering the overall MCH budget, about $1.2 million (9%) is allocated to direct services, $7.3 million (54%) to enabling services such as case management and transportation. $3.8 million and $1.2 million are allocated respectively to population-based services and to core public health infrastructure services.

The indirect cost rate for KDHE is 21%. For Kansas, administrative costs are defined as indirect costs charged to the MCH Title V grant. As such they are within the 10% limit set forth in federal Title V law.

At this time, Kansas is in compliance with all requirements of the law.

Detailed information about the FFY 12 budget is provided in the attached Excel spreadsheets.

The State of Kansas assures that the MCH and CYSHCN Directors provide input into the

allocation and budgeting process for the MCH Block Grant, into the state budget, and into the process of prioritizing programs for MCH resources based on the State MCH needs assessment.

The Children & Families Section administers MCH grant funding for local agencies relating to: perinatal and reproductive health services, and child and adolescent health services. The contracts for this section include: MCH-- 85 contracts with local health departments and other local agencies for coverage of all 105 counties; Family Planning -- 58 contracts with local health departments and other local agencies for coverage of all counties. In addition there are contracts with providers of teen pregnancy case management services, pregnancy maintenance initiative services, SIDS outreach and education.

Following is the list of MCH contracts with local agencies for SFY 12 -- totaling $4,095,403
Barber Co Health Dept $4,413
Barton Co Health Dept (multi county) $57,116
Butler Co Health Dept $51,244
Chase Co Health Dept $3,039
Chautauqua Co Health Dept $8,160
Cherokee Co Health Dept $30,176
Cheyenne Co Health Dept $3,083
Clay Co Health Dept $38,422
Cloud Co Health Dept $9,145
Coffey Co Health Dept $5,887
Cowley Co Health Dept $43,509
Crawford Co Health Dept $43,614
Dickinson Co Health Dept $37,333
Doniphan Co Health Dept $9,989
Douglas Co Health Dept $76,997
Edwards Co Health Dept $6,173
Ellsworth Co Health Dept $3,194
Finney Co Health Dept $130,208
Ford Co Health Dept $66,442
Franklin Co Health Dept $23,576
Geary Co Health Dept $98,173
Gove Co Health Dept B $3,115
Grant Co Health Dept $8,606
Gray Co Health Dept $5,016
Greeley Co Health Dept - $5,595
Greenwood Co Health Dept $7,656
Hamilton Co Health Dept $6,565
Harper Co Health Dept $5,782
Harvey Co Health Dept $44,798
Haskell Co Health Dept $7,306
Hodgeman Co Health Dept $3,363
Jefferson Co Health Dept $17,610
Johnson Co Health Dept $215,615
Kearny Co Health Dept $5,640
Kingman Co Health Dept $7,286
Kiowa Co Health Dept $5,303
Labette Co Health Dept $31,759
Lane Co Health Dept $4,990
Leavenworth Co Health Dept $70,992
Lincoln Co Health Dept $4,403
Linn Co Health Dept $13,004
Lyon Co Health Dept $73,899
Marion Co Health Dept $9,240
Marshall Co Health Dept $12,809

McPherson Co Health Dept $26,037
Meade Co Health Dept $4,409
Miami Co Health Dept $20,857
Mitchell Co Health Dept $13,521
Montgomery Co Health Dept $42,954
Morris Co Health Dept $5,100
Morton Co Health Dept $3,590
NEK (multi county) $92,645
Nemaha Co Health Dept $12,056
Neosho Co Health Dept $18,925
Osage Co Health Dept $14,864
Ottawa Co Health Dept $8,874
Pawnee Co Health Dept $10,036
Phillips Co Health Dept $9,341
Pottawatomie Co Health Dept $29,906
Pratt Co Health Dept $8,629
Rawlins Co Health Dept $2,565
Reno Co Health Dept $105,226
Republic Co Health Dept $6,763
Rice Co Health Dept $9,900
Riley Co Health Dept $115,225
Rooks Co Health Dept $48,751
Saline Co Health Dept $74,626
Scott Co Health Dept $3,221
Sedgwick Co Health Dept $581,317
SEK (multi county) $40,225
Seward Co Health Dept $88,831
Shawnee Co Health Dept $454,592
Sheridan Co Health Dept $2,802
Stafford Co Health Dept $6,275
Stanton Co Health Dept $3,903
Stevens Co Health Dept $6,389
Sumner Co Health Dept $24,896
Thomas Co Health Dept $15,895
Wabaunsee Co Health Dept $6,940
Washington Co Health Dept $9,015
Wilson Co Health Dept $11,167
Wyandotte Co Health Dept $698,918
CHC of SE Kansas $54,571
Hays Area Children's Center $18,156
Mercy Hospital $63,245

Teen Pregnancy Case Management Contracts for SFY 12 -- $338,846 (plus Medicaid match)

School-Public Health Nurse Collaboratives -- not funded in SFY 12

Pregnancy Maintenance Initiative for SFY 12 -- funding restored to $338,846

SIDS Network of Kansas contract for SFY 12 -- reduction from $75,000 in SFY 11 to $71,374 in SFY 12

Women's Right to Know budget for SFY 12 --no budget

//2012//

/2013/

Form 2. The Kansas federal budget for MCH dollars is $4,670,131. There is an additional $70 million other federal dollars budgeted and $6.3 million other state dollars.

The SFY 13 Block Grant parntership is: $4,670,131 federal; $3,972,344 state match; and $4,190,150 local. Overall, Kansas' MCH Services funding is approximately 36% federal, 31% state, and 33% local.

The amounts of funding allocated to Children and Adolescents (C&A) and CYSHCN meet the 30-30 allocation requirement. Children and Adolescents (C&A) with $1,527,101 (33%) and CYSHCN with $1,482,002 (32%).

Form 3. The Kansas budget for SFY 13 meets its maintenance of effort requirement of $2,352,511. The Title V matching requirement of $3 state/$4 federal is achieved through projected State matching funds of $3,972,344. Kansas anticipates local match of $4,190,160.

Form 4. Kansas allocates approximately $2.5 million to services for pregnant women and $2.5 million for infants. An additional approximate $5.1 mlllion is allocated to C&A and $2.3 million for CYSHCN.

Form 5. Approximately $1.1 million (9%) is allocated to Direct Health services. Approximately $6.8 million (53%) is allocated to Enabling services. Approximately $3.5 million (28%) is allocated to Population Based services. Approximately $1.1 million (9%) is allocated to Core Public Health/Infrastructure services.

The indirect cost rate for KDHE is 21.4%. Administrative costs are indirect costs charged to the MCH Title V Grant. They are within the 10% limit set forth in federal Title V law.

Kansas is in compliance with all requirements of the law.

Kansas MCH and CYSHCN Directors provide input into the allocation and budgeting process for the MCH Block Grant, state budget, and process of prioritizing programs for MCH resources based upon the State MCH Needs Assessment.

Following is the list of MCH contracts with local agencies for SFY 13 -- totaling $4,095,403.00

Barber Co Health Dept $4,413
Barton Co Health Dept $57,116
Butler Co Health Dept $51,244
Chase Co Health Dept $3,039
Chautauqua Co Health Dept $8,160
Cherokee Co Health Dept $30,176
Cheyenne Co Health Dept $3,083
Clay Co Health Dept $38,422
Cloud Co Health Dept $9,145
Coffey Co Health Dept $5,887
Cowley Co Health Dept $43,509
Crawford Co Health Dept $43,614
Dickinson Co Health Dept $37,333
Doniphan Co Health Dept $9,989
Douglas Co Health Dept $77,000
Edwards Co Health Dept $6,173
Ellsworth Co Health Dept $3,194
Finney Co Health Dept $130,208
Ford Co Health Dept $66,442

Franklin Co Health Dept $23,576
Geary Co Health Dept $98,173
Gove Co Health Dept $3,115
Grant Co Health Dept $8,549
Gray Co Health Dept $5,016
Greeley Co Health Dept $5,595
Greenwood Co Health Dept $7,656
Hamilton Co Health Dept $6,565
Harper Co Health Dept $5,782
Harvey Co Health Dept $44,798
Haskell Co Health Dept $7,306
Hodgeman Co Health Dept $3,363
Jefferson Co Health Dept $17,610
Johnson Co Health Dept $215,615
Kearny Co Health Dept $5,640
Kingman Co Health Dept $7,286
Kiowa Co Health Dept $5,300
Labette Co Health Dept $31,759
Lane Co Health Dept $4,990
Leavenworth Co Health Dept $70,992
Lincoln Co Health Dept $4,403
Linn Co Health Dept $13,004
Lyon Co Health Dept $73,899
Marion Co Health Dept $9,240
Marshall Co Health Dept $12,809
McPherson Co Health Dept $26,037
Meade Co Health Dept $4,409
Miami Co Health Dept $20,857
Mitchell Co Health Dept $13,521
Montgomery Co Health Dept $42,954
Morris Co Health Dept $5,100
Morton Co Health Dept $3,590
NEK Multi- Co Health Dept $92,645
Neosho Co Health Dept $18,925
Nemaha Co Health Services $12,056
Neosho Co Health Dept $18,925
Osage Co Health Dept $14,864
Ottawa Co Health Dept $8,874
Pawnee Co Health Dept $10,036
Phillips Co Health Dept $9,341
Pottawatomie Co Health Dept $29,906
Pratt Co Health Dept $8,629
Rawlins Co Health Dept $2,565
Reno Co Health Dept $105,226
Republic Co Health Dept $6,763
Rice Co Health Dept $9,900
Riley Co Health Dept $115,225
Rooks Co Health Dept $48,751
Saline Co Health Dept $74,626
Scott Co Health Dept $3,221
Sedgwick Co Health Dept $581,317
SEK Multi-Co Health Dept $40,225
Seward Co Health Dept $88,831
Shawnee Co Health Agency $454,592
Sheridan Co Health Dept $2,802
Stafford Co Health Dept $6,275

Stanton Co Health Dept $3,903
Stevens Co Health Dept $6,389
Sumner Co Health Dept $24,896
Thomas Co Health Dept $15,895
Wabaunsee Co Health Dept $6,940
Washington Co Health Dept $9,015
Wilson Co Health Dept $11,167
Wyandotte Co Health Dept $698,918
Community Health Center $54,571
Hays Area Children's Center $18,156
Mercy Health System of KS $63,245

//2013//

/2014/ Kansas MCH and CYSHCN Directors provide input into the allocation and budgeting process for the MCH Block Grant, state budget, and process of prioritizing programs for MCH resources based upon the State MCH Needs Assessment.

Form 2. The Kansas total MCH budget is $93,419,912. The federal budget for MCH dollars is $4,670,131, the final authorized amount for FFY13. State match is budgeted at $3,722,188 and local match totals $4,740,394 (estimated based on total SFY13 match reported by local grantees). Overall, Kansas' MCH federal-state partnership total funding is $13,132,713. There is an additional $80 million other federal dollars budgeted, including $3 million for the MIECHV development grant, and $6.4 million other state dollars.

The amounts of Title V funding allocated to Children and Adolescents (C&A) and CYSHCN meet the 30-30 allocation requirement: Children and Adolescents (C&A) $1,550,312 (33%); CYSHCN $1,444,782 (31%).

Form 3. The Kansas budget for SFY14 meets its maintenance of effort requirement of $2,352,511. The Title V matching requirement of $3 state for every $4 federal is achieved through projected State matching funds of $3,722,188. Kansas anticipates local match of $4,740,394, which is approximate and based on the SFY13 match reported by local grantees and calculated at the time of this application.

Form 4. Kansas allocates approximately $2.8 million to services for pregnant women and $2.8 million for infants. An additional approximate $5.5 million is allocated to C&A and $2.1 million for CYSHCN.

Form 5. Approximately $1.3 million (10%) is allocated to Direct Health services. Approximately $6.9 million (52%) is allocated to Enabling services. Approximately $4.1 million (30%) is allocated to Population Based services. Approximately $1.1 million (8%) is allocated to Core Public Health/Infrastructure.

The current indirect cost rate for KDHE is 17.9%. Administrative costs charged to the block grant are indirect costs within the 10% limited set forth in federal Title V law. For this budget period, $250,000 is budgeted (5.35%).

Following is the list of MCH contracts with local agencies for SFY14 totaling $4,088,872. The Title V portion allocted for the contracts this budget period is $1,935,940.

Barber Co Health Dept $4,413
Barton Co Health Dept $57,116
Butler Co Health Dept $51,244
Chase Co Health Dept $3,039
Chautauqua Co Health Dept $8,160

Cherokee Co Health Dept $30,176
Cheyenne Co Health Dept $3,083
Clay Co Health Dept $38,422
Cloud Co Health Dept $9,099
Coffey Co Health Dept $5,887
Cowley Co Health Dept $43,509
Crawford Co Health Dept $43,614
Dickinson Co Health Dept $37,333
Doniphan Co Health Dept $9,989
Douglas Co Health Dept $77,000
Edwards Co Health Dept $6,173
Ellsworth Co Health Dept $3,194
Finney Co Health Dept $130,068
Ford Co Health Dept $66,442
Franklin Co Health Dept $22,356
Geary Co Health Dept $98,173
Gove Co Health Dept $3,115
Grant Co Health Dept $8,606
Gray Co Health Dept $5,016
Greeley Co Health Dept $5,595
Greenwood Co Health Dept $7,656
Hamilton Co Health Dept $6,565
Harper Co Health Dept $5,782
Harvey Co Health Dept $44,798
Haskell Co Health Dept $7,306
Hodgeman Co Health Dept $3,363
Jefferson Co Health Dept $17,610
Johnson Co Health Dept $215,615
Kearny Co Health Dept $5,640
Kingman Co Health Dept $7,286
Kiowa Co Health Dept $5,300
Labette Co Health Dept $31,759
Lane Co Health Dept $4,990
Leavenworth Co Health Dept $70,992
Lincoln Co Health Dept $4,403
Linn Co Health Dept $13,004
Lyon Co Health Dept $73,899
Marion Co Health Dept $9,240
Marshall Co Health Dept $12,809
McPherson Co Health Dept $26,037
Meade Co Health Dept $4,409
Miami Co Health Dept $20,857
Mitchell Co Health Dept $13,521
Montgomery Co Health Dept $42,954
Morris Co Health Dept $5,100
Morton Co Health Dept $3,590
NEK Multi- Co Health Dept $92,645
Neosho Co Health Dept $18,925
Nemaha Co Health Services $12,056
Neosho Co Health Dept $18,925
Osage Co Health Dept $14,864
Ottawa Co Health Dept $8,874
Pawnee Co Health Dept $10,036
Phillips Co Health Dept $9,341
Pottawatomie Co Health Dept $29,906
Pratt Co Health Dept $8,603

Rawlins Co Health Dept $2,565
Reno Co Health Dept $105,226
Republic Co Health Dept $6,763
Rice Co Health Dept $9,900
Riley Co Health Dept $115,225
Rooks Co Health Dept $48,751
Saline Co Health Dept $74,626
Scott Co Health Dept $3,221
Sedgwick Co Health Dept $581,317
SEK Multi-Co Health Dept $40,225
Seward Co Health Dept $88,831
Shawnee Co Health Agency $454,592
Sheridan Co Health Dept $2,802
Stafford Co Health Dept $6,275
Stanton Co Health Dept $3,903
Stevens Co Health Dept $6,389
Sumner Co Health Dept $24,896
Thomas Co Health Dept $15,895
Wabaunsee Co Health Dept $6,940
Washington Co Health Dept $9,015
Wilson Co Health Dept $11,167
Wyandotte Co Health Dept $698,918
Community Health Center $54,571
Hays Area Children's Center $18,156
Mercy Health System of KS $63,245

//2014//

/2015/

Form 2. The total State budget submitted is $89,003,703. The federal budget for MCH dollars is $4,682,822, based on the allocated amounts in the State budget and a projected award amount based on FFY13 and FFY14 authorized amounts. There is an additional $76 million in other federal dollars budgeted, including $3.8 million for the MIECHV development grant. Other state dollars budgeted for SFY15 total $5.9 million for Infant Toddler Services/Part C, Family Planning, and other state level funding sources which support CYSHCN programming.

The amounts of Title V funding allocated to Children and Adolescents (C&A) and CYSHCN meet the 30-30 allocation requirement: Children and Adolescents (C&A) $1,598,811 (34%); CYSHCN $1,477,508 (32%).

Form 3. The Kansas budget for FY15 meets its maintenance of effort requirement of $2,352,511. The Title V match requirement is achieved through projected State matching funds budgeted at $3,524,276 which include universal home visiting services delivered by MCH grantees/local health departments, KIDS Network of Kansas (safe sleep initiatives), Pregnancy Maintenance Initiative, PKU and Seating. Local match is projected to total $4,401,548 (estimated based on total SFY13 match reported by local grantees). Overall, Kansas' MCH federal-state partnership funding totals $12,608,646. There is not a significant difference from the FY14 budget, only estimated to be due to a slight decrease in local match based on FY13 actuals. However, all requirements under the law are met.

Form 4. The total partnership budget for Kansas (including federal, state, and local funds totaling $12,608,646) allocates approximately $2.5 million to services for pregnant women and $2.5 million for infants. An additional $5.3 million is allocated to C&A and $2 million for CYSHCN.

Form 5. Approximately $1.1 million (9%) is allocated to Direct Health services. Approximately $6.2 million (50%) is allocated to Enabling services. Approximately $3.6 million (29%) is allocated to Population Based services. Approximately $1.5 million (12%) is allocated to Core Public Health/Infrastructure.

The current indirect cost rate for KDHE is 17.59%. Administrative costs charged to the block grant are indirect costs within the 10% limit set forth in federal Title V law. For this budget period, $200,000 is budgeted (4.3% of total federal funds).

There are 82 local agencies/health departments that will receive funds totaling $4,095,402 to provide MCH services to communities. The Title V portion allocated for the contracts this budget period is $1,935,940. //2015//

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.

Title V Block Grant Application Forms (2-21)
State: KS
Application Year: 2015

- Form 2 - MCH Budget Details
- Form 3 - State MCH Funding Profile
- Form 4 - Budget Details By Types of Individuals Served and Sources of Federal Funds
- Form 5 - State Title V Program Budget and Expenditures by Types of Services
- Form 6 - Number and Percentage of Newborn and Others Screened, Case Confirmed, and Treated
- Form 7 - Number of Individuals Served (Unduplicated) Under Title V
- Form 8 - Deliveries and Infants Served by Title V and Entitled to Benefits under Title XIX
- Form 9 - State MCH Toll-Free Telephone Line Data
- Form 10 - Title V Maternal and Child Health Services Block Grant State Profile for FY 2013
- Form 11 - National and State Performance Measures
- Form 12 - National and State Outcome Measures
- Form 13 - Characteristics Documenting Family Participation in Children with Special Health Care Needs
- Form 14 - List of MCH Priority Needs
- Form 15 - Technical Assistance (TA) Request and tracking
- Form 16 - State Performance/Outcome Measure Detail Sheets
- Form 17 - Health System Capacity Indicators (01 through 04,07,08) - Multi-year Data
- Form 18
  - Medicaid and Non-Medicaid comparison
  - Medicaid Eligibility Level (HSCI 06)
  - SCHIP Eligibility Level (HSCI 06)
- Form 19
  - General MCH Data Capacity (HSCI 09A)
  - Adolescent Tobacco Use Data Capacity (HSCI 09B)
- Form 20 - Health Status Indicators 01-05 - Multi-year Data
- Form 21
  - Population Demographics Data (HSI 06)
  - Live Birth Demographics Data (HSI 07)
  - Infant and Children Mortality Data (HSI 08)
  - Miscellaneous Demographics Data (HSI 09)
  - Geographic Living Area Demographic Data (HSI 10)
  - Poverty Level Demographic Data (HSI 11)
  - Poverty Level for Children Demographics Data (HSI 12)

Form 2

MCH Budget Details for FY 2015

[Secs. 504 (d) and 505(a)(3)(4)]

State: KS

1. Federal Allocation $ 4,682,822
(Item 15a of the Application Face Sheet [SF 424])
Of the Federal Allocation (1 above), the amount earmarked for:

A.Preventive and primary care for children:

$ 1,598,811 (34.14 %)

B.Children with special health care needs:

$ 1,477,508 (31.55 %)

(If either A or B is less than 30%, a waiver request must accompany the application)[Sec. 505(a)(3)]

C.Title V admininstrative costs:

$ 200,000 (4.27 %)

(The above figure cannot be more than 10%)[Sec. 504(d)]

2. Unobligated Balance (Item 15b of SF 424) $ 0

3. State MCH Funds (Item 15c of the SF 424) $ 3,524,276

4. Local MCH Funds (Item 15d of SF 424) $ 4,401,548

5. Other Funds (Item 15e of SF 424) $ 0

6. Program Income (Item 15f of SF 424) $ 0

7. Total State Match (Lines 3 through 6) $ 7,925,824
(Below is your State's FY 1989 Maintainence of Effort Amount)
$ 2,352,511

8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP (SUBTOTAL) $ 12,608,646
(Total lines 1 through 6. Same as line 15g of SF 424)

9. Other Federal Funds
(Funds under the control of the person responsible for the administration of the Title V program)

a. SPRANS:	$ 0
b. SSDI:	$ 91,045
c. CISS:	$ 0
d. Abstinence Education:	$ 0
e. Healthy Start:	$ 0
f. EMSC:	$ 0
g. WIC:	$ 64,509,746
h. AIDS:	$ 0
i. CDC:	$ 0
j. Education:	$ 4,217,833
k. Home Visiting:	$ 0
l. Other:	
Breastfeed Peer Ed	$ 455,200
EOCS	$ 140,000
Family Planning	$ 2,545,387
Medicaid Teen Preg	$ 338,846
MIECHV	$ 3,847,000
New born Hearing	$ 250,000

10. Other Federal Funds (SUBTOTAL of all Funds under item 9) $ 76,395,057

11. STATE MCH BUDGET TOTAL $ 89,003,703
(Partnership subtotal + Other Federal MCH Funds subtotal)

Form Notes for Form 2

None

Field Level Notes

None

Form 3
State MCH Funding Profile
[Secs. 505(a) and 506((a)(I-3)]
State: KS

	FY 2010		FY 2011		FY 2012	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation *(Line1, Form 2)*	$ 4,719,246	$ 4,164,028	$ 4,718,608	$ 4,670,131	$ 4,710,420	$ 4,626,932
2. Unobligated Balance *(Line2, Form 2)*	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
3. State Funds *(Line3, Form 2)*	$ 4,079,395	$ 3,880,903	$ 4,462,639	$ 3,695,620	$ 3,972,344	$ 3,562,624
4. Local MCH Funds *(Line4, Form 2)*	$ 5,475,000	$ 4,598,337	$ 4,374,000	$ 5,093,392	$ 4,710,220	$ 4,775,509
5. Other Funds *(Line5, Form 2)*	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
6. Program Income *(Line6, Form 2)*	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
7. Subtotal	$ 14,273,641	$ 12,643,268	$ 13,555,247	$ 13,459,143	$ 13,392,984	$ 12,965,065
	(THE FEDERAL-STATE TITLE BLOCK GRANT PARTNERSHIP)					
8. Other Federal Funds *(Line10, Form 2)*	$ 70,812,887	$ 70,812,887	$ 72,444,016	$ 70,032,836	$ 70,032,836	$ 72,095,778
9. Total *(Line11, Form 2)*	$ 85,086,528	$ 83,456,155	$ 85,999,263	$ 83,491,979	$ 83,425,820	$ 85,060,843
	(STATE MCH BUDGET TOTAL)					

Form 3
State MCH Funding Profile
[Secs. 505(a) and 506((a)(I-3)]
State: KS

	FY 2013		FY 2014		FY 2015	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation *(Line1, Form 2)*	$ 4,670,131	$ 2,445,517	$ 4,670,131	$	$ 4,682,822	$
2. Unobligated Balance *(Line2, Form 2)*	$ 0	$ 0	$ 0	$	$ 0	$
3. State Funds *(Line3, Form 2)*	$ 3,972,344	$ 3,527,860	$ 3,722,188	$	$ 3,524,276	$
4. Local MCH Funds *(Line4, Form 2)*	$ 4,190,160	$ 4,403,168	$ 4,740,394	$	$ 4,401,548	$
5. Other Funds *(Line5, Form 2)*	$ 0	$ 0	$ 0	$	$ 0	$
6. Program Income *(Line6, Form 2)*	$ 0	$ 0	$ 0	$	$ 0	$
7. Subtotal	$ 12,832,635	$ 10,376,545	$ 13,132,713	$ 0	$ 12,608,646	$ 0
	(THE FEDERAL-STATE TITLE BLOCK GRANT PARTNERSHIP)					
8. Other Federal Funds *(Line10, Form 2)*	$ 70,032,836	$ 78,292,923	$ 80,287,199	$	$ 76,395,057	$
9. Total *(Line11, Form 2)*	$ 82,865,471	$ 88,669,468	$ 93,419,912	$ 0	$ 89,003,703	$ 0
	(STATE MCH BUDGET TOTAL)					

Form Notes for Form 3

None

Field Level Notes

1. **Section Number:** Form3_Main
   Field Name: FedAllocExpended
   Row Name: Federal Allocation
   Column Name: Expended
   Year: 2013
   Field Note:
   Difference greater than 10% of budgeted is due to early reporting for MCH Block Grant application, time remaining to expend funds due to two year spending authority and liquidation period. Actual expenditures will be updated on next year's application/report.
2. **Section Number:** Form3_Main
   Field Name: FedAllocExpended
   Row Name: Federal Allocation
   Column Name: Expended
   Year: 2012
   Field Note:
   Positions not filled have resulted in unspent funds. Projects under review to be funded with Title V dollars before year end include perinatal quality collaborative initiatives.
3. **Section Number:** Form3_Main
   Field Name: StateMCHFundsExpended
   Row Name: State Funds
   Column Name: Expended
   Year: 2013
   Field Note:
   Difference greater than 10% of budgeted is due to early reporting for MCH Block Grant application, time remaining to expend funds due to two year spending authority and liquidation period. Actual expenditures will be updated on next year's application/report. The state funds does meet MOE/match requirement, however.
4. **Section Number:** Form3_Main
   Field Name: StateMCHFundsExpended
   Row Name: State Funds
   Column Name: Expended
   Year: 2012
   Field Note:
   Overestimated state match figured for FFY12 budget; required amount of state match still met.
5. **Section Number:** Form3_Main
   Field Name: LocalMCHFundsExpended
   Row Name: Local MCH Funds
   Column Name: Expended
   Year: 2012
   Field Note:
   Change in reported expenses due to local agency affidavits for FY12 were submitted after the totals were reported as part of the MCH Block Grant application/report. The total has been updated to reflect the actual local contributions.
6. **Section Number:** Form3_Main
   Field Name: OtherFedFundsExpended
   Row Name: Other Federal Funds
   Column Name: Expended
   Year: 2013
   Field Note:
   Difference greater than 10% of budgeted is due to increase in other federal funds reported as expended and/or funds received/expended but not included in original amount budgeted: abstinence education, family planning (increase), SSDI.
7. **Section Number:** Form3_Main
   Field Name: OtherFedFundsExpended
   Row Name: Other Federal Funds
   Column Name: Expended
   Year: 2012
   Field Note:
   Change in reported expenses due to additional FY12 funds spent after the previous amount was reported and submitted as part of the MCH Block Grant application/report. The bulk of the increase is due to the LAUNCH funding/carryover. The total has been updated to reflect the actual expenditures.

Form 4

Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds (II)

[Secs 506(2)(2)(iv)]

State: KS

	FY 2010		FY 2011		FY 2012	
I. Federal-State MCH Block Grant Partnership	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
a. Pregnant Women	$ 2,800,492	$ 2,431,175	$ 2,774,634	$ 2,608,527	$ 2,674,119	$ 2,625,709
b. Infants < 1 year old	$ 2,800,492	$ 2,431,176	$ 2,774,635	$ 2,608,527	$ 2,674,120	$ 2,625,709
c. Children 1 to 22 years old	$ 5,868,371	$ 5,569,489	$ 5,456,728	$ 5,954,256	$ 5,375,059	$ 5,521,182
d. Children with Special Healthcare Needs	$ 2,415,786	$ 1,876,521	$ 2,179,250	$ 1,968,063	$ 2,329,686	$ 1,930,822
e. Others	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
f. Administration	$ 388,500	$ 334,907	$ 370,000	$ 319,770	$ 340,000	$ 261,643
g. SUBTOTAL	$ 14,273,641	$ 12,643,268	$ 13,555,247	$ 13,459,143	$ 13,392,984	$ 12,965,065
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	$ 0		$ 0		$ 0	
b. SSDI	$ 94,644		$ 94,644		$ 97,260	
c. CISS	$ 140,000		$ 132,000		$ 135,813	
d. Abstinence Education	$ 0		$ 0		$ 359,879	
e. Healthy Start	$ 0		$ 0		$ 0	
f. EMSC	$ 0		$ 0		$ 0	
g. WIC	$ 61,543,000		$ 62,000,000		$ 60,000,000	
h. AIDS	$ 0		$ 0		$ 0	
i. CDC	$ 100,000		$ 100,000		$ 100,000	
j. Education	$ 5,851,667		$ 4,030,759		$ 4,030,759	
k. Home Visiting	$ 0		$ 0		$ 0	
l. Other						
Family Planning	$ 2,482,320		$ 2,300,000		$ 2,300,000	
Other	$		$ 3,786,613		$ 3,009,125	
NBHS, BF, XIX, SRS	$ 601,256		$		$	
III. TOTAL	$ 70,812,887		$ 72,444,016		$ 70,032,836	

Form 4

Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds (II)

[Secs 506(2)(2)(iv)]

State: KS

	FY 2013		FY 2014		FY 2015	
I. Federal-State MCH Block Grant Partnership	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
a. Pregnant Women	$ 2,550,360	$ 2,269,900	$ 2,743,042	$	$ 2,527,877	$
b. Infants < 1 year old	$ 2,550,360	$ 2,269,901	$ 2,743,042	$	$ 2,527,877	$
c. Children 1 to 22 years old	$ 5,076,243	$ 4,649,154	$ 5,339,541	$	$ 5,297,578	$
d. Children with Special Healthcare Needs	$ 2,320,672	$ 1,187,590	$ 2,057,088	$	$ 2,055,314	$
e. Others	$ 0	$ 0	$ 0	$	$ 0	$
f. Administration	$ 335,000	$ 0	$ 250,000	$	$ 200,000	$
g. SUBTOTAL	$ 12,832,635	$ 10,376,545	$ 13,132,713	$ 0	$ 12,608,646	$ 0
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	$ 0		$ 0		$ 0	
b. SSDI	$ 97,260		$ 0		$ 91,045	
c. CISS	$ 135,813		$ 0		$ 0	
d. Abstinence Education	$ 359,879		$ 359,879		$ 0	
e. Healthy Start	$ 0		$ 0		$ 0	
f. EMSC	$ 0		$ 0		$ 0	
g. WIC	$ 60,000,000		$ 67,338,600		$ 64,509,746	
h. AIDS	$ 0		$ 0		$ 0	
i. CDC	$ 100,000		$ 0		$ 0	
j. Education	$ 4,030,759		$ 4,010,088		$ 4,217,833	
k. Home Visiting	$ 0		$ 0		$ 0	
l. Other						
Breastfeed Peer Ed	$		$		$ 455,200	
ECCS	$		$		$ 140,000	
Family Planning	$ 2,300,000		$ 2,471,250		$ 2,545,387	
Medicaid Teen Preg	$		$		$ 338,846	
MIECHV	$		$ 4,172,802		$ 3,847,000	
Newborn Hearing	$		$		$ 250,000	
Medicaid TPTCM	$		$ 338,846		$	
NB Hearing Screening	$		$ 207,000		$	
Other-ICC,SC,SB,KRG	$		$ 138,000		$	
Project LAUNCH	$		$ 850,000		$	
WIC BF Peer Ed	$		$ 400,734		$	
Other	$ 3,009,125		$		$	
III. TOTAL	$ 70,032,836		$ 80,287,199		$ 76,395,057	

Form Notes for Form 4

None

Field Level Notes

1. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: PregWomenExpended
   Row Name: Pregnant Women
   Column Name: Expended
   Year: 2013
   Field Note:
   Difference greater than 10% of budgeted is due to early reporting for MCH Block Grant application, time remaining to expend funds due to two year spending authority and liquidation period. Actual expenditures will be updated on next year's application/report.
2. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: PregWomenExpended
   Row Name: Pregnant Women
   Column Name: Expended
   Year: 2012
   Field Note:
   Change due to additional local agency and state reporting after submission of the block grant application/report. These totals represent actuals expended for each category.
3. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: Children_0_1Expended
   Row Name: Infants <1 year old
   Column Name: Expended
   Year: 2013
   Field Note:
   Difference greater than 10% of budgeted is due to early reporting for MCH Block Grant application, time remaining to expend funds due to two year spending authority and liquidation period. Actual expenditures will be updated on next year's application/report.
4. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: Children_0_1Expended
   Row Name: Infants <1 year old
   Column Name: Expended
   Year: 2012
   Field Note:
   Change due to additional local agency and state reporting after submission of the block grant application/report. These totals represent actuals expended for each category.
5. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: Children_1_22Expended
   Row Name: Children 1 to 22 years old
   Column Name: Expended
   Year: 2012
   Field Note:
   Change due to additional local agency and state reporting after submission of the block grant application/report. These totals represent actuals expended for each category.
6. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: CSHCNExpended
   Row Name: CSHCN
   Column Name: Expended
   Year: 2013
   Field Note:
   Difference greater than 10% of budgeted is due to early reporting for MCH Block Grant application, time remaining to expend funds due to two year spending authority and liquidation period. Actual expenditures will be updated on next year's application/report.
7. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: CSHCNExpended
   Row Name: CSHCN
   Column Name: Expended
   Year: 2012
   Field Note:
   funds obligated for SFY13 CYSHCN contracts not fully expended at the time of the expense reports provided from Fiscal/SMART system
8. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: AdminExpended
   Row Name: Administration
   Column Name: Expended
   Year: 2013
   Field Note:
   Difference greater than 10% of budgeted is due to early reporting for MCH Block Grant application, time remaining to expend funds due to two year spending authority and liquidation period. Actual expenditures will be updated on next year's application/report.
9. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: AdminExpended
   Row Name: Administration
   Column Name: Expended
   Year: 2012
   Field Note:
   administration costs expended at the time of submission

Form 5

State Title V Program Budget and Expenditures by Types of Services

[Secs. 505(a)(2)(A-B) and 506(a)(1)(A-D)]

State: KS

Type of Service	FY 2010		FY 2011		FY 2012	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services (Basic Health Services and Health Services for CSHCN.)	$ 4,877,888	$ 1,042,866	$ 1,086,334	$ 1,103,996	$ 1,180,342	$ 1,108,500
II. Enabling Services (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC, and Education.)	$ 7,570,830	$ 6,360,872	$ 6,901,877	$ 7,003,638	$ 7,258,507	$ 6,675,353
III. Population-Based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.)	$ 566,913	$ 3,975,450	$ 4,254,786	$ 4,111,664	$ 3,827,857	$ 4,077,014
IV. Infrastructure Building Services (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems.)	$ 1,258,010	$ 1,264,080	$ 1,312,250	$ 1,239,845	$ 1,126,278	$ 1,104,198
V. Federal-State Title V Block Grant Partnership Total (Federal-State Partnership only. Item 15g of SF 42r. For the "Budget" columns this is the same figure that appears in Line 8, Form 2, and in the "Budgeted" columns of Line 7 Form 3. For the "Expended" columns this is the same figure that appears in the "Expended" columns of Line 7, Form 3.)	$ 14,273,641	$ 12,643,268	$ 13,555,247	$ 13,459,143	$ 13,392,984	$ 12,965,065

Form 5

State Title V Program Budget and Expenditures by Types of Services

[Secs. 505(a)(2)(A-B) and 506(a)(1)(A-D)]

State: KS

Type of Service	FY 2013		FY 2014		FY 2015	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services (Basic Health Services and Health Services for CSHCN.)	$ 1,179,092	$ 546,067	$ 1,271,992	$	$ 1,116,052	$
II. Enabling Services (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC, and Education.)	$ 6,929,242	$ 5,672,015	$ 6,780,384	$	$ 6,285,329	$
III. Population-Based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.)	$ 3,629,085	$ 3,453,162	$ 3,963,147	$	$ 3,655,305	$
IV. Infrastructure Building Services (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems.)	$ 1,095,216	$ 705,301	$ 1,117,190	$	$ 1,551,960	$
V. Federal-State Title V Block Grant Partnership Total (Federal-State Partnership only. Item 15g of SF 42r. For the "Budget" columns this is the same figure that appears in Line 8, Form 2, and in the "Budgeted" columns of Line 7 Form 3. For the "Expended" columns this is the same figure that appears in the "Expended" columns of Line 7, Form 3.)	$ 12,832,635	$ 10,376,545	$ 13,132,713	$ 0	$ 12,608,646	$ 0

Form Notes for Form 5

None

Field Level Notes

1. **Section Number:** Form5_Main
   Field Name: DirectHCExpended
   Row Name: Direct Health Care Services
   Column Name: Expended
   Year: 2013
   Field Note:
   Difference greater than 10% of budgeted is due to early reporting for MCH Block Grant application, time remaining to expend funds due to two year spending authority and liquidation period. Actual expenditures will be updated on next year's application/report.
2. **Section Number:** Form5_Main
   Field Name: DirectHCExpended
   Row Name: Direct Health Care Services
   Column Name: Expended
   Year: 2012
   Field Note:
   funds yet to be expended for SFY13 and SFY14 contracts for CYSHCN
3. **Section Number:** Form5_Main
   Field Name: EnablingExpended
   Row Name: Enabling Services
   Column Name: Expended
   Year: 2013
   Field Note:
   Difference greater than 10% of budgeted is due to early reporting for MCH Block Grant application, time remaining to expend funds due to two year spending authority and liquidation period. Actual expenditures will be updated on next year's application/report.
4. **Section Number:** Form5_Main
   Field Name: EnablingExpended
   Row Name: Enabling Services
   Column Name: Expended
   Year: 2012
   Field Note:
   Change due to local agency and state reporting of expenditures to reflect actuals calculated since submission on the block grant application/report last year.
5. **Section Number:** Form5_Main
   Field Name: PopBasedExpended
   Row Name: Population-Based Services
   Column Name: Expended
   Year: 2012
   Field Note:
   Change due to local agency and state reporting of expenditures to reflect actuals calculated since submission on the block grant application/report last year.
6. **Section Number:** Form5_Main
   Field Name: InfrastrBuildExpended
   Row Name: Infrastructure Building Services
   Column Name: Expended
   Year: 2013
   Field Note:
   Difference greater than 10% of budgeted is due to early reporting for MCH Block Grant application, time remaining to expend funds due to two year spending authority and liquidation period. Actual expenditures will be updated on next year's application/report.
7. **Section Number:** Form5_Main
   Field Name: InfrastrBuildExpended
   Row Name: Infrastructure Building Services
   Column Name: Expended
   Year: 2012
   Field Note:
   vacant positions have allowed remaining funds

Form 6

Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

Sect. 506(a)(2)(B)(iii)

State: KS

Total Births by Occurrence: 41,163 | Reporting Year: 2012

Type of Screening Tests	(A) Receiving at least one Screen (1)		(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment (3)	
	No.	%			No.	%
Phenylketonuria	41,163	100	30	5	5	100
Congenital Hypothyroidism	41,163	100	36	30	30	100
Galactosemia	41,163	100	5	2	2	100
Sickle Cell Disease	41,163	100	10	10	10	100
Other Screening (Specify)						
Biotinidase Deficiency	41,163	100	2	1	1	100
Cystic Fibrosis	41,163	100	46	9	9	100
Homocystinuria	41,163	100	130	0	0	
Maple Syrup Urine Disease	41,163	100	24	0	0	
Tyrosinemia Type I	41,163	100	14	0	0	
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	41,163	100	4	3	3	100
Citrullinemia	41,163	100	2	0	0	
Isovaleric Acidemia	41,163	100	13	0	0	
Carnitine Uptake Defect	41,163	100	11	1	1	100
3-Methylcrotonyl-CoA Carboxylase Deficiency	41,163	100	12	2	2	100
Methylmalonic acidemia (Cbl A,B)	41,163	100	17	0	0	
Glutaric Acidemia Type I	41,163	100	7	2	2	100
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	41,163	100	9	1	1	100
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	41,163	100	21	5	5	100
Screening Programs for Older Children & Women (Specify Tests by name)						

(1) Use occurrent births as denominator.
(2) Report only those from resident births.
(3) Use number of confirmed cases as denominator.

Form Notes for Form 6

None

Field Level Notes

1. **Section Number:** Form6_Main
   Field Name: SickleCellDisease_Confirmed
   Row Name: SickleCellDisease
   Column Name: Confirmed Cases
   Year: 2015
   Field Note:
   In Kansas, in 2012, the number of confirmed cases for Sickle Cell Disease is equal to the number of presumptive positive screens for Sickle Cell Disease.

FORM 7

Number of Individuals Served (Unduplicated) under Title V
(By Class of Individuals and Percent of Health Coverage)

[Sec. 506(a)(2)(A)(i-ii)]

State: KS

Number of Individuals Served - Historical Data by Annual Report Year

Types of Individuals Served	2008	2009	2010	2011	2012
Pregnant Women	7,158	9,912	9,675	9,011	8,958
Infants < 1 year old	41,951	42,566	42,511	41,580	40,467
Children 1 to 22 years old	50,523	60,110	81,070	64,935	66,258
Children with Special Healthcare Needs	4,005	4,716	3,210	3,847	2,688
Others	9,043	7,290	5,140	4,353	4,147
Total	112,680	124,594	141,606	123,726	122,518

Reporting Year: 2012

	TITLE V	PRIMARY SOURCES OF COVERAGE				
Types of Individuals Served	(A) Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private/Other %	(E) None %	(F) Unknown %
Pregnant Women	7,993	19.0	12.0	15.6	48.5	4.9
Infants < 1 year old	41,163	32.6	0.0	59.5	7.4	0.4
Children 1 to 22 years old	61,310	21.4	24.1	25.3	23.7	5.5
Children with Special Healthcare Needs	1,797	42.1	3.0	31.1	21.4	2.4
Others	3,553	24.2	18.6	31.6	21.8	3.8
TOTAL	115,816					

Form Notes for Form 7

None

Field Level Notes

1. **Section Number:** Form7_Main
   Field Name: CSHCN_TS
   Row Name: Children with Special Health Care Needs
   Column Name: Title V Total Served
   Year: 2015
   Field Note:
   The total number served includes those who receive specialty medical care services through the CYSHCN program as well as through outreach in the CYSHCN multi-disciplinary clinics. Due to reporting inconsistencies and insufficiencies, the insurance source breakdown is based upon data from the CYSHCN data management system for those who receive specialty medical care services through the CYSHCN program only. Modifications to clinic reporting requirements will be made beginning July 1 for data submitted to ensure this information is captured.

FORM 8

DELIVERIES AND INFANTS SERVED BY TITLE V AND ENTITLED TO BENEFITS UNDER TITLE XIX

(BY RACE AND ETHNICITY)

[SEC. 506(A)(2)(C-D)]

STATE: KS

Reporting Year: 2012

I. UNDUPLICATED COUNT BY RACE

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than one race reported	(H) Other and Unknown
DELIVERIES								
Total Deliveries in State	41,356	34,142	2,967	230	1,187	72	812	1,946
Title V Served	7,994	7,061	443	62	109	11	218	90
Eligible for Title XIX	14,823	11,598	1,905	293	300	31		696
INFANTS								
Total Infants in State	41,164	33,991	2,947	228	1,181	72	811	1,934
Title V Served	41,164	33,991	2,947	228	1,181	72	811	1,934
Eligible for Title XIX	18,166	13,973	2,472	376	401	36		908

II. UNDUPLICATED COUNT BY ETHNICITY

				HISPANIC OR LATINO (Sub-categories by country or area of origin)				
	(A) Total NOT Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(B.1) Mexican	(B.2) Cuban	(B.3) Puerto Rican	(B.4) Central and South American	(B.5) Other and Unknown
DELIVERIES								
Total Deliveries in State	34,954	6,351	51	4,731	31	158	479	952
Title V Served	5,905	2,087	0	1,622	12	19	106	328
Eligible for Title XIX	11,147	3,676	1	0	0	0	0	0
INFANTS								
Total Infants in State	34,811	6,306	47	4,699	29	157	474	947
Title V Served	34,811	6,306	47	4,699	29	157	474	947
Eligible for Title XIX	13,468	4,698	0	0	0	0	0	0

Form Notes for Form 8

None

Field Level Notes

1. **Section Number:** Form8_I. Unduplicated Count By Race
   Field Name: DeliveriesTitleXIX_More
   Row Name: Eligible for Title XIX
   Column Name: More Than One Race Reported
   Year: 2015
   Field Note:
   NA
2. **Section Number:** Form8_I. Unduplicated Count By Race
   Field Name: InfantsTitleXIX_More
   Row Name: Eligible for Title XIX
   Column Name: More Than One Race Reported
   Year: 2015
   Field Note:
   NA
3. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
   Field Name: DeliveriesTitleXIX_TotalHispanic
   Row Name: Eligible for Title XIX
   Column Name: Total Hispanic or Latino
   Year: 2015
   Field Note:
   Hispanic sub-categories were not collected in CY2012.
4. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
   Field Name: DeliveriesTitleXIX_Mexican
   Row Name: Eligible for Title XIX
   Column Name: Mexican
   Year: 2015
   Field Note:
   Hispanic sub-categories were not collected in CY2012.
5. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
   Field Name: DeliveriesTitleXIX_Cuban
   Row Name: Eligible for Title XIX
   Column Name: Cuban
   Year: 2015
   Field Note:
   Hispanic sub-categories were not collected in CY2012.
6. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
   Field Name: DeliveriesTitleXIX_PuertoRican
   Row Name: Eligible for Title XIX
   Column Name: Puerto Rican
   Year: 2015
   Field Note:
   Hispanic sub-categories were not collected in CY2012.
7. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
   Field Name: DeliveriesTitleXIX_CentralAmerican
   Row Name: Eligible for Title XIX
   Column Name: Central and South American
   Year: 2015
   Field Note:
   Hispanic sub-categories were not collected in CY2012.
8. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
   Field Name: DeliveriesTitleXIX_EthnicityOther
   Row Name: Eligible for Title XIX
   Column Name: Other and Unknown
   Year: 2015
   Field Note:
   Hispanic sub-categories were not collected in CY2012.
9. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
   Field Name: InfantsTitleXIX_TotalHispanic
   Row Name: Eligible for Title XIX
   Column Name: Total Hispanic or Latino
   Year: 2015
   Field Note:
   Hispanic sub-categories were not collected in CY2012.
10. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
    Field Name: InfantsTitleXIX_Mexican
    Row Name: Eligible for Title XIX
    Column Name: Mexican
    Year: 2015
    Field Note:
    Hispanic sub-categories were not collected in CY2012.
11. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
    Field Name: InfantsTitleXIX_Cuban
    Row Name: Eligible for Title XIX
    Column Name: Cuban
    Year: 2015
    Field Note:
    Hispanic sub-categories were not collected in CY2012.

12. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
Field Name: InfantsTitleXIX_PuertoRican
Row Name: Eligible for Title XIX
Column Name: Puerto Rican
Year: 2015
Field Note:
Hispanic sub-categories were not collected in CY2012.

13. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
Field Name: InfantsTitleXIX_CentralAmerican
Row Name: Eligible for Title XIX
Column Name: Central and South American
Year: 2015
Field Note:
Hispanic sub-categories were not collected in CY2012.

14. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
Field Name: InfantsTitleXIX_EthnicityOther
Row Name: Eligible for Title XIX
Column Name: Other and Unknown
Year: 2015
Field Note:
Hispanic sub-categories were not collected in CY2012.

Form 9
State MCH Toll-Free Telephone Line Data Form (Optional)
[Secs. 505(a)(E) and 509(a)(8)]
State: KS

	FY 2015	FY 2014	FY 2013	FY 2012	FY 2011
1. State MCH Toll-Free "Hotline" Telephone Number		1-888-744-4825			(888) 744-4825
2. State MCH Toll-Free "Hotline" Name		Women's Right To Know			Effective Fiscal Year 2008 WRTK calls are included in MADIN call
3. Name of Contact Person for State MCH "Hotline"		Genoveva Fernandez			Daniel Gibbons
4. Contact Person's Telephone Number		785-296-1317			785-296-1317
5. Contact Person's Email		gfernandez@kdheks.gov			dgibbons@kdheks.gov
6. Number of calls received on the State MCH "Hotline" this reporting period	0	0	0	32	0

Form 9
State MCH Toll-Free Telephone Line Data Form
[Secs. 505(a)(E) and 509(a)(8)]
State: KS

	FY 2015	FY 2014	FY 2013	FY 2012	FY 2011
1. State MCH Toll-Free "Hotline" Telephone Number	800-332-6262	800-332-6262	800-332-6262	800-332-6262	(800)-332-6262
2. State MCH Toll-Free "Hotline" Name	Kansas Resource Guide	Kansas Resource Guide	Kansas Resource Guide	Kansas Resource Guide	Make a Difference Information Network (MADIN)
3. Name of Contact Person for State MCH "Hotline"	Geno Fernandez	Genoveva (Geno) Fernandez	Daniel Gibbons	Daniel Gibbons	Daniel Gibbons
4. Contact Person's Telephone Number	785-296-1313	785-296-1317	785-296-1317	785-296-1317	785-296-1317
5. Contact Person's Email	gfernandez@kdheks.gov	gfernandez@kdheks.gov	dgibbons@kdheks.gov	dgibbons@kdheks.gov	dgibbons@kdheks.gov
6. Number of calls received on the State MCH "Hotline" this reporting period	0	0	1804	1732	1932

Form Notes for Form 9

None

Field Level Notes

None

Form 10
Title V Maternal & Child Health Services Block Grant
State Profile for FY 2015
[Sec. 506(a)(1)]
State: KS

1. State MCH Administration:
(max 2500 characters)

The Bureau of Family Health in the Kansas Department of Health and Environment administers the Maternal and Child Health 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. Core functions include assessment, policy development, and assurance. The bureau engages in the ten essential public health services to promote the health of all Kansas mothers and children: assess and monitor MCH health status; diagnose and investigate health problems; inform and educate the public and families about MCH issues; mobilize community partnershps; engage in priority setting, planning and policy development; enforce legal requirements to protect the health and safety of mothers and children; link mothers and children to services; assure a competent workforce; evaluate services and conduct research to improve MCH.

Block Grant Funds	
2. Federal Allocation (Line 1, Form 2)	$ 4,682,822
3. Unobligated balance (Line 2, Form 2)	$ 0
4. State Funds (Line 3, Form 2)	$ 3,524,276
5. Local MCH Funds (Line 4, Form 2)	$ 4,401,548
6. Other Funds (Line 5, Form 2)	$ 0
7. Program Income (Line 6, Form 2)	$ 0
8. Total Federal-State Partnership (Line 8, Form 2)	$ 12,608,646

9. Most significant providers receiving MCH funds:

- Local County Public Health Departments
- Medical Specialty Service Providers
- Community Based Organizations
- Early Childhood Service Providers

10. Individuals served by the Title V Program (Col. A, Form 7)

a. Pregnant Women	7,993
b. Infants < 1 year old	41,163
c. Children 1 to 22 years old	61,310
d. CSHCN	1,797
e. Others	3,553

11. Statewide Initiatives and Partnerships:

a. Direct Medical Care and Enabling Services:
(max 2500 characters)

CSHCN provides case management services to families to assure access to appropriate services. Financial aqssistance may be provided when health care for the children's conditions pose a financial hardship for the family and there is no other source of assistance. MCH staff in local health departments provide care coordination to pregnant women and link them with local providers and community services.

b. Population-Based Services:
(max 2500 characters)

Kansas newborns receive screening for all but one (SCID) of the conditions recommended by a national panel. This includes screening for metabolic conditions and hearing loss. Out-of-range-findings are reported to a nurse or audiologist who notifies the provider and/or family of the need for further testing. Families are linked with appropriate services and in some cases may receive financial assistance.

c. Infrastructure Building Services:
(max 2500 characters)

Kansas MCH/CSHCN staff assume leadership roles in a number of state initiatives to represent the needs of mothers and children and to provide data as appropriate. Initiatives include: Blue Ribbon Panel on Infant Mortality; School Readiness Task Force; KS Perinatal Quality Collaborative; State Developmental Disabilities Council; KS MCH Council, and others.

	12. The primary Title V Program contact person:	13. The children with special health care needs (CSHCN) contact person:	14. State Family or Youth Leader Contact person:
Name	Rachel Sisson (Berroth)	Heather Smith	Donna Yadrich
Title	Bureau of Family Health Director	Special Health Services Section Director	Owner, AudreySpirit LLC
Address	1000 SW Jackson Street, Ste 220	1000 SW Jackson Street, Ste 220	13605 Polfer Road
City	Topeka	Topeka	Kansas City
State	KS	KS	KS
Zip	66612	66612	66109
Phone	785-296-1310	785-296-1316	913-980-6282
Fax	785-296-8616	785-296-8616	
Email	rsisson@kdheks.gov	hsmith@kdheks.gov	donna@audreyspirit.com

Web	www.kdheks.gov/bfh	Web	www.kdheks.gov/bfh	Web	

Form Notes for Form 10

None

Field Level Notes

None

Form 11
Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]
State: KS

Form Level Notes for Form 11

None

Performance Measure # 01

The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	57	59	71	72	82
Denominator	57	59	71	72	82
Data Source	Kansas Newborn Screening data, 2009	Kansas Newborn Screening data, 2010	Kansas Newborn Screening data, 2011	Kansas Newborn Screening data, 2012	Kansas Newborn Screening data, 2013
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	100	100	100	100	100
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

None

PERFORMANCE MEASURE # 02

The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	70	67	66	73	73
Annual Indicator	65.6	65.6	72.6	72.6	72.6
Numerator					
Denominator					
Data Source	National CSHCN 2005-2006. KS Estimate.	National CSHCN 2005-2006. KS Estimate.	National CSHCN 2009/2010. KS Estimate.	National CSHCN 2009/2010. KS Estimate.	National CSHCN 2009/2010. KS Estimate.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	74	74	75	75	75
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #2
   Field Name: PM02
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

   All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Section Number:** Form11_Performance Measure #2
   Field Name: PM02
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

   All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Section Number:** Form11_Performance Measure #2
   Field Name: PM02
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

   All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Performance Measure # 03

The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	60	60	60	50	51
Annual Indicator	55.3	55.3	49.4	53.8	53.8
Numerator					
Denominator					
Data Source	National CSHCN 2005-2006. KS Estimate.	National CSHCN 2005-2006. KS Estimate.	National CSHCN 2009/2010. KS Estimate.	NSCH 2011/2012. KS Estimate.	NSCH 2011/2012. KS Estimate.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	54	56	58	60	62
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #3
   Field Name: PM03
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   For 2012 and 2013, indicator data come from the National Survey of Children's Health (NSCH), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2011-2012. The same questions were used to generate the NPM3 indicator for both the 2009/10 NS-CSHCN and 2011/12 NSCH, therefore these two surveys are comparable.

   All estimates from NS-CSHCN and NSCH are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Section Number:** Form11_Performance Measure #3
   Field Name: PM03
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   For 2012 and 2013, indicator data come from the National Survey of Children's Health (NSCH), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2011-2012. The same questions were used to generate the NPM3 indicator for both the 2009/10 NS-CSHCN and 2011/12 NSCH, therefore these two surveys are comparable.

   All estimates from NS-CSHCN and NSCH are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Section Number:** Form11_Performance Measure #3
   Field Name: PM03
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   For 2011, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM3. However, the same questions were used to generate the NPM3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

   All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

PERFORMANCE MEASURE # 04

The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	64	64	65	61	61
Annual Indicator	62.9	62.9	60	75.2	75.2
Numerator					
Denominator					
Data Source	National CSCHN 2005-2006. KS Estimate.	National CSCHN 2005-2006. KS Estimate.	National CSHCN 2009/2010. KS Estimate.	NSCH 2011/2012. KS Estimate.	NSCH 2011/2012. KS Estimate.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	76	78	78	80	80
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #4
   Field Name: PM04
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   For 2012 and 2013, indicator data come from the National Survey of Children's Health (NSCH), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2011-2012. The same questions were used to generate the NPM4 indicator for both the 2009/10 NS-CSHCN and 2011/12 NSCH, therefore these two surveys are comparable.

   All estimates from NS-CSHCN and NSCH are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Section Number:** Form11_Performance Measure #4
   Field Name: PM04
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   For 2012 and 2013, indicator data come from the National Survey of Children's Health (NSCH), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2011-2012. The same questions were used to generate the NPM4 indicator for both the 2009/10 NS-CSHCN and 2011/12 NSCH, therefore these two surveys are comparable.

   All estimates from NS-CSHCN and NSCH are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Section Number:** Form11_Performance Measure #4
   Field Name: PM04
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   For 2011, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

   All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Performance Measure # 05

Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	95	99	93	67	68
Annual Indicator	92.5	92.5	66.8	66.8	66.8
Numerator					
Denominator					
Data Source	National CSHCN 2005-2006. Estimate KS	National CSHCN 2005-2006. Estimate KS	National CSHCN 2009/2010. Estimate KS.	National CSHCN 2009/2010. Estimate KS.	National CSHCN 2009/2010. Estimate KS.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	68	69	69	69	69
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #5
   Field Name: PM05
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

   All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Section Number:** Form11_Performance Measure #5
   Field Name: PM05
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

   All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Section Number:** Form11_Performance Measure #5
   Field Name: PM05
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

   All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Performance Measure # 06

The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	53	55	53	53	54
Annual Indicator	50.3	50.3	52.7	52.7	52.7
Numerator					
Denominator					
Data Source	National CSHCN 2005-2006. KS Estimate.	National CSHCN 2005-2006. KS Estimate.	National CSHCN 2009/2010. KS Estimate.	National CSHCN 2009/2010. KS Estimate.	National CSHCN 2009/2010. KS Estimate.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	54	55	55	55	55
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #6
   Field Name: PM06
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
   All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Section Number:** Form11_Performance Measure #6
   Field Name: PM06
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

   All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Section Number:** Form11_Performance Measure #6
   Field Name: PM06
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

   All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Performance Measure # 07

Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	90	79	79	83	85
Annual Indicator	77.5	80.1	77.7	68	68
Numerator					
Denominator					
Data Source	CDC National Immunization Survey 2009, KS	CDC National Immunization Survey 2010	CDC National Immunization Survey 2011	CDC National Immunization Survey 2012	CDC National Immunization Survey 2012
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	70	70	72	72	72
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #7
   Field Name: PM07
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

2. **Section Number:** Form11_Performance Measure #7
   Field Name: PM07
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   DATA SOURCE: Centers for Disease Control and Prevention. Vaccination coverage for the 4:3:1:3:3 vaccine series among children 19 to 35 months U.S., National Immunization Survey, 2012. http://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/tables/12/tab03_antigen_state_2012.pdf

   The 2012 coverage estimate is based on the new definition, 4:3:1 plus full series of Hib vaccine (3 or 4 doses depending on the brand) and 3 or more dosese of HepB vaccine. The 2011 and 2012 data not comparable to previous years.

   In Kansas, Haemophilus Influenza type B (HiB) is not required for school entry but is required for public preschools or school operated child care for children under five years of age.

3. **Section Number:** Form11_Performance Measure #7
   Field Name: PM07
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   DATA SOURCE: Centers for Disease Control and Prevention. Vaccination coverage for the 4:3:1:3:3 vaccine series among children 19 to 35 months U.S., National Immunization Survey, 2011. Adhoc report.

   The 2011 coverage estimate is based on the new definition, 4:3:1 plus full series of Hib vaccine (3 or 4 doses depending on the brand) and 3 or more dosese of HepB vaccine. The 2011 data not comparable to previous years.

   In Kansas, Haemophilus Influenza type B (HiB) is not required for school entry but is required for public preschools or school operated child care for children under five years of age.

PERFORMANCE MEASURE # 08

The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	20	20	20	18	15
Annual Indicator	20.6	19.1	15.5	14.5	14.5
Numerator	1,162	1,106	896	833	833
Denominator	56,277	57,952	57,687	57,341	57,341
Data Source	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2012	Kansas Vital Statistics, 2012
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	14	14	13	13	12
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #8
   Field Name: PM08
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

2. **Section Number:** Form11_Performance Measure #8
   Field Name: PM08
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source:
   Numerator = Birth certificate (resident) data, 2012, Bureau of Epidemiology and Public Health Informatics, KDHE
   Denominator = U.S. Bureau of the Census

3. **Section Number:** Form11_Performance Measure #8
   Field Name: PM08
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source:
   Numerator = Birth certificate (resident) data, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE
   Denominator = U.S. Bureau of the Census

Performance Measure # 09

Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	40	40	40	41	38
Annual Indicator	38.2	38.2	35.7	35.7	35.7
Numerator	13,176	13,176			
Denominator	34,506	34,506			
Data Source	KDHE. Smiles Across Kansas: 2007	KDHE. Smiles Across Kansas: 2007	KDHE. Smiles Across Kansas: 2012	KDHE. Smiles Across Kansas: 2012	KDHE. Smiles Across Kansas: 2012
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	38	40	40	42	42
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #9
   Field Name: PM09
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Data Source: KDHE. Bureau of Oral Health. Smiles Across Kansas: 2012.

2. **Section Number:** Form11_Performance Measure #9
   Field Name: PM09
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: KDHE. Bureau of Oral Health. Smiles Across Kansas: 2012.

3. **Section Number:** Form11_Performance Measure #9
   Field Name: PM09
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: KDHE. Bureau of Oral Health. Smiles Across Kansas: 2012.

Performance Measure # 10

The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	3.6	3.6	2.5	3.6	2.6
Annual Indicator	2.7	4.0	2.8	3.3	3.3
Numerator	16	24	17	20	20
Denominator	588,523	606,823	605,120	606,608	606,608
Data Source	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2012	Kansas Vital Statistics, 2012
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	2.6	2.4	2.4	2.2	2.2
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #10
   Field Name: PM10
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

2. **Section Number:** Form11_Performance Measure #10
   Field Name: PM10
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source:
   Numerator = Death certificate (resident) data, 2012, Bureau of Epidemiology and Public Health Informatics, KDHE
   Denominator = U.S. Bureau of the Census; 2012 estimates.

3. **Section Number:** Form11_Performance Measure #10
   Field Name: PM10
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source:
   Numerator = Death certificate (resident) data, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE
   Denominator = U.S. Bureau of the Census; 2011 estimates.

Performance Measure # 11

The percent of mothers who breastfeed their infants at 6 months of age.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	45	45	50	42	47
Annual Indicator	47.4	41	45.1	41.8	41.8
Numerator					
Denominator					
Data Source	National Immunization Survey, 2007 birth cohort	National Immunization Survey, 2008 births	National Immunization Survey, 2009 births	National Immunization Survey, 2010 births	National Immunization Survey, 2010 births
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	44	44	46	46	48
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #11
   Field Name: PM11
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The 2013 column is populated with 2012 data (provisional data, 2010 births). Data will be available in 2015.

2. **Section Number:** Form11_Performance Measure #11
   Field Name: PM11
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services.

   Breastfeeding Report Card - United States, 2013
   http://www.cdc.gov/breastfeeding/pdf/2013breastfeedingreportcard.pdf

3. **Section Number:** Form11_Performance Measure #11
   Field Name: PM11
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services.

   Breastfeeding Report Card - United States, 2012
   http://www.cdc.gov/breastfeeding/pdf/2011BreastfeedingReportCard.pdf

PERFORMANCE MEASURE # 12

Percentage of newborns who have been screened for hearing before hospital discharge.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	98	98.2	98.2	99	99
Annual Indicator	98.0	98.5	98.7	98.7	98.6
Numerator	41,645	40,962	39,908	40,636	39,207
Denominator	42,515	41,593	40,452	41,177	39,771
Data Source	KDHE. Kansas Newborn Screening program, 2009	KDHE. Kansas Newborn Screening program, 2010	KDHE. Kansas Newborn Screening program, 2011	KDHE. Kansas Newborn Screening program, 2012	KDHE. Kansas Newborn Screening program, 2013
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	99	99	99	99	99
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #12
   Field Name: PM12
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   DATA SOURCE:
   Numerator= KDHE. Bureau of Family Health. Kansas Newborn Screening program for Calendar Year 2013.
   Denominator= KDHE. Bureau of Epidemiology and Public Health Informatics. Kansas Live Birth by Occurrences.

2. **Section Number:** Form11_Performance Measure #12
   Field Name: PM12
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   DATA SOURCE:
   Numerator= KDHE. Bureau of Family Health. Kansas Newborn Screening program for Calendar Year 2012.
   Denominator= KDHE. Bureau of Epidemiology and Public Health Informatics. Kansas Live Birth by Occurrences.

3. **Section Number:** Form11_Performance Measure #12
   Field Name: PM12
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   DATA SOURCE:
   Numerator= KDHE. Bureau of Family Health. Kansas Newborn Screening program for Calendar Year 2011.
   Denominator= KDHE. Office of Health Assessment. Kansas Live Birth by Occurrences.

PERFORMANCE MEASURE # 13

Percent of children without health insurance.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	7	10.5	8	7.5	9.2
Annual Indicator	7.3	7.5	9.4	6.1	6.1
Numerator					
Denominator					
Data Source	US Census. ASEC supplement. Table HI05	US Census. ASEC supplement. Table HIB-5	US Census. ASEC supplement. Table HIB-5	US Census. ASEC supplement. Table HIB-5	US Census. ASEC supplement. Table HIB-5
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	5.9	5.9	5.7	5.7	5.5
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #13
   Field Name: PM13
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Data for 2013 is not available. 2012 data was used to pre-populate this performance measure. Data for 2013 will be available in Fall 2014

2. **Section Number:** Form11_Performance Measure #13
   Field Name: PM13
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: U.S. Census Bureau and Bureau of Labor Statistics. Current Population Survey. Annual Social and Economic (ASEC) supplement. Table HIB-5. Table HIB-5. Health Insurance Coverage Status and Type of Coverage by State--Children Under 18: 1999 to 2012.
   http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html

3. **Section Number:** Form11_Performance Measure #13
   Field Name: PM13
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   DATA SOURCE: U.S. Census Bureau and Bureau of Labor Statistics. Current Population Survey. Annual Social and Economic (ASEC) supplement. Table HIB-5. Table HIB-5. Health Insurance Coverage Status and Type of Coverage by State--Children Under 18: 1999 to 2011.
   http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html

Performance Measure # 14

Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	29	28	28	28	27
Annual Indicator	29.8	28.7	28.4	28.4	28.4
Numerator	11,013	10,860	10,657	10,657	10,657
Denominator	36,956	37,838	37,524	37,524	37,524
Data Source	Kansas PedNSS, 2009	Kansas PedNSS, 2010	Kansas PedNSS, 2011	Kansas PedNSS, 2011	Kansas PedNSS, 2011
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	27	27	26	26	25
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #14
   Field Name: PM14
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The 2012 and 2013 columns are populated with 2011 data. CDC discontinued operation of the PedNSS and PNSS in the Fall of 2012 after production of the 2011 reports.

2. **Section Number:** Form11_Performance Measure #14
   Field Name: PM14
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 and 2013 columns are populated with 2011 data. CDC discontinued operation of the PedNSS and PNSS in the Fall of 2012 after production of the 2011 reports.

3. **Section Number:** Form11_Performance Measure #14
   Field Name: PM14
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Pediatric Nutriton Surveillance System (PedNSS), 2011(Kansas WIC database).

Performance Measure # 15

Percentage of women who smoke in the last three months of pregnancy.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	13	13	12.5	12.5	12
Annual Indicator	12.7	12.7	12.2	11.5	11.5
Numerator	5,246	5,005	4,795	4,624	4,624
Denominator	41,210	39,409	39,441	40,212	40,212
Data Source	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2012	Kansas Vital Statistics, 2012
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	12	11.8	11.8	11.6	11.4
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #15
   Field Name: PM15
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

2. **Section Number:** Form11_Performance Measure #15
   Field Name: PM15
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Birth certificate (resident) data, 2012, Bureau of Epidemiology and Public Health Informatics, KDHE

   Denominator: Live birth records with unknown/missing values for smoking status were excluded from analysis.

3. **Section Number:** Form11_Performance Measure #15
   Field Name: PM15
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Birth certificate (resident) data, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE

   Denominator: Live birth records with unknown/missing values for smoking status were excluded from analysis.

Performance Measure # 16

The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	9.3	11	9	10	10
Annual Indicator	9.1	10.1	10.5	13.8	13.8
Numerator	55	61	64	84	84
Denominator	602,256	604,262	608,906	609,260	609,260
Data Source	Kansas Vital Statistics, 2007-2009	Kansas Vital Statistics, 2008-2010	Kansas Vital Statistics, 2009-2011	Kansas Vital Statistics, 2010-2012	Kansas Vital Statistics, 2010-2012
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	12	12	10	10	8
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #16
   Field Name: PM16
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

2. **Section Number:** Form11_Performance Measure #16
   Field Name: PM16
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source:
   Numerator = Death certificate (resident) data, 2010-2012, Bureau of Epidemiology and Public Health Informatics, KDHE

   Reporting years were combined to calculate 3 year rolling averages due to small sample size. ICD-10 coding: U03, X60-X84, Y87.0.

   Denominator =U.S. Bureau of the Census
   2010-2012 data are U.S. Census estimates (Bridged-Race Vintage data set); 2010 data are actual Census counts, not estimates.

3. **Section Number:** Form11_Performance Measure #16
   Field Name: PM16
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source:
   Numerator = Death certificate (resident) data, 2009-2011, Bureau of Epidemiology and Public Health Informatics, KDHE

   Reporting years were combined to calculate 3 year rolling averages due to small sample size. ICD-10 coding: U03, X60-X84, Y87.0.

   Denominator =U.S. Bureau of the Census
   2009-2011 data are U.S. Census estimates (Bridged-Race Vintage data set); 2010 data are actual Census counts, not estimates.

Performance Measure # 17

Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	86	86	87	87	88
Annual Indicator	80.8	82.3	86.6	87.1	87.1
Numerator	437	377	425	438	438
Denominator	541	458	491	503	503
Data Source	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2012	Kansas Vital Statistics, 2012
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	88	89	89	90	90
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #17
   Field Name: PM17
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

2. **Section Number:** Form11_Performance Measure #17
   Field Name: PM17
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Birth certificate (resident instate births) data, 2012, Bureau of Epidemiology and Public Health Informatics, KDHE

   Hospitals with level III nurseries are Irwin Army Community Hospital, Menorah Medical Center, Olathe Medical Center, Overland Park Regional Medical Center (Overland Park), Shawnee Mission Medical Center (Kansas City), St Luke's South (Overland Park), Stormont-Vail Regional Health Center (Topeka), University of Kansas Medical Center (Kansas City), and Via Christi-St Joseph and Wesley Medical Center (Wichita).

3. **Section Number:** Form11_Performance Measure #17
   Field Name: PM17
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Birth certificate (resident instate births) data, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE

   Hospitals with level III nurseries are Irwin Army Community Hospital, Menorah Medical Center, Olathe Medical Center, Overland Park Regional Medical Center (Overland Park), Shawnee Mission Medical Center (Kansas City), St Luke's South (Overland Park), Stormont-Vail Regional Health Center (Topeka), University of Kansas Hospital (Kansas City), and Via Christi-St Joseph and Wesley Medical Center (Wichita).

Performance Measure # 18

Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	79	79	80	80	80
Annual Indicator	74.1	75.1	77.3	78.9	78.9
Numerator	29,244	29,552	29,618	31,457	31,457
Denominator	39,481	39,362	38,296	39,871	39,871
Data Source	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2012	Kansas Vital Statistics, 2012
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	80	80	82	82	84
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #18
   Field Name: PM18
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

2. **Section Number:** Form11_Performance Measure #18
   Field Name: PM18
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Birth certificate (resident) data, 2012, Bureau of Epidemiology and Public Health Informatics, KDHE

3. **Section Number:** Form11_Performance Measure #18
   Field Name: PM18
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Birth certificate (resident) data, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE

Form 11
Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]
State: KS

Form Level Notes for Form 11

None

State Performance Measure # 2 - Reporting Year

The percent of women in their reproductive years (18-44 years) who report consuming four or more alcoholic drinks on an occasion in the past 30 days.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective			14.4	13.5	13
Annual Indicator	14.5	14	17.7	15.7	15.7
Numerator					
Denominator					
Data Source	Kansas BRFSS, 2009	Kansas BRFSS, 2010	Kansas BRFSS, 2011	Kansas BRFSS, 2012	Kansas BRFSS, 2012
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	12.5	12	11.5	11	10.5
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #2
   Field Name: SM2
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

2. **Section Number:** Form11_State Performance Measure #2
   Field Name: SM2
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Kansas BRFSS 2012
   Note: The 2011 and 2012 BRFSS dataset included modifications of weighting methods and modes of data collection. Raking weighting was used, and cellular telephone surveys were incorporated into the data. These changes affect state-level estimates of health risk behaviors and chronic disease. Trend analyses might show artifactual differences between 2011 data and data from previous years. Changes caused by changes in methods from real changes cannot be distinguished. Estimates before 2011 and after 2011 are not comparable and should not be compared.

3. **Section Number:** Form11_State Performance Measure #2
   Field Name: SM2
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Kansas BRFSS 2011
   Note: The 2011 BRFSS dataset included modifications of weighting methods and modes of data collection. Raking weighting was used, and cellular telephone surveys were incorporated into the data. These changes affect state-level estimates of health risk behaviors and chronic disease. Trend analyses might show artifactual differences between 2011 data and data from previous years. Changes caused by changes in methods from real changes cannot be distinguished. Estimates before 2011 and after 2011 are not comparable and should not be compared.

State Performance Measure # 3 - Reporting Year

The percent of live births that are born preterm less than 37 weeks of gestation.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective			9.1	8.6	8.6
Annual Indicator	9.2	8.8	9.1	9.0	9.0
Numerator	3,804	3,534	3,598	3,629	3,629
Denominator	41,313	40,381	39,593	40,282	40,282
Data Source	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2012	Kansas Vital Statistics, 2012
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	8.4	8.4	8.2	8.2	8
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #3
   Field Name: SM3
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

2. **Section Number:** Form11_State Performance Measure #3
   Field Name: SM3
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Birth certificate (resident) data, 2012, Bureau of Epidemiology and Public Health Informatics, KDHE; Births for which gestational ages (i.e., obstetric estimate of gestation, completed weeks) are not reported are excluded from the computation of percentages.

3. **Section Number:** Form11_State Performance Measure #3
   Field Name: SM3
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Birth certificate (resident) data, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE; Births for which gestational ages (i.e., obstetric estimate of gestation, completed weeks) are not reported are excluded from the computation of percentages.

State Performance Measure # 5 - Reporting Year

The percent of children age 0 to 17 who received coordinated, ongoing, comprehensive care within a medical home.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective			63	63	62
Annual Indicator	61.3	61.3	59.1	59.1	59.1
Numerator					
Denominator					
Data Source	National Survey Of Children's Health, 2007	National Survey Of Children's Health, 2007	NSCH, 2011/2012. Kansas Estimate.	NSCH, 2011/2012. Kansas Estimate.	NSCH, 2011/2012. Kansas Estimate.
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	62	64	64	66	66
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #5
   Field Name: SM5
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   For 2011-2013, indicator data come from the National Survey of Children's Health (NSCH), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2011-2012.

   All estimates from NSCH are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Section Number:** Form11_State Performance Measure #5
   Field Name: SM5
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   For 2011-2013, indicator data come from the National Survey of Children's Health (NSCH), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2011-2012.

   All estimates from NSCH are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Section Number:** Form11_State Performance Measure #5
   Field Name: SM5
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   For 2011-2013, indicator data come from the National Survey of Children's Health (NSCH), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2011-2012.

   All estimates from NSCH are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

State Performance Measure # 6 - Reporting Year

The percent of high school students who had at least one drink of alcohol during the past 30 days.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective			37	37	30
Annual Indicator		38.7	32.6	32.6	32.6
Numerator					
Denominator					
Data Source		YRBS, 2009	YRBS, 2011	YRBS, 2011	YRBS, 2011
Is the Data Provisional or Final?				Provisional	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	30	28	28	26	26
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #6
   Field Name: SM6
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The 2012 and 2013 columns are populated with 2011 data. 2013 data will be available Fall 2014.

2. **Section Number:** Form11_State Performance Measure #6
   Field Name: SM6
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 and 2013 columns are populated with 2011 data. 2013 data will be available Fall 2014.

3. **Section Number:** Form11_State Performance Measure #6
   Field Name: SM6
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   DATA SOURCE:
   CDC. Youth Risk Behavior Surveillance System (YRBSS), Youth Online. 2011. http://apps.nccd.cdc.gov/youthonline/App/Results.aspx?LID=KS.

State Performance Measure # 7 - Reporting Year

The Percent of children who are obese.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective			13.1	12.6	12.4
Annual Indicator	13.2	13.0	12.8	12.8	12.8
Numerator	4,878	4,919	4,803	4,803	4,803
Denominator	36,956	37,838	37,523	37,523	37,523
Data Source	Kansas PeNSS, 2009	Kansas PeNSS, 2010	Kansas PeNSS, 2011	Kansas PeNSS, 2011	Kansas PeNSS, 2011
Is the Data Provisional or Final?				Provisional	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	12.2	12	12	11.8	11.8
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #7
   Field Name: SM7
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The 2012 and 2013 column are populated with 2011 data. 2012 and 2013 data will be available Fall 2014.

2. **Section Number:** Form11_State Performance Measure #7
   Field Name: SM7
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 and 2013 column are populated with 2011 data. 2012 and 2013 data will be available Fall 2014.

3. **Section Number:** Form11_State Performance Measure #7
   Field Name: SM7
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Pediatric Nutriton Surveillance System (PedNSS), 2012(Kansas WIC database).

State Performance Measure # 9 - Reporting Year

The percent of youth with special health care needs (YSHCN) whose doctors usually or always encourage development of age appropriate self management skills.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective			84	84	85
Annual Indicator		84	83.5	83.5	83.5
Numerator					
Denominator					
Data Source		National Survey of CSHCN, 2005/2006	National CSHCN 2009/2010. KS Estimate.	National CSHCN 2009/2010. KS Estimate.	National CSHCN 2009/2010. KS Estimate.
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	85	86	86	87	87
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #9
   Field Name: SM9
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for SPM9, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the SPM9 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
   All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Section Number:** Form11_State Performance Measure #9
   Field Name: SM9
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for SPM9, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the SPM9 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
   All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Section Number:** Form11_State Performance Measure #9
   Field Name: SM9
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for SPM9, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the SPM9 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
   All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

State Performance Measure # 11 - Reporting Year

The percent of infants with Permanent Congenital Hearing Loss (PCHL) enrolled in early intervention services before 6 months of age.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective					66
Annual Indicator		46.6	65.1	55.3	43.0
Numerator		41	41	52	34
Denominator		88	63	94	79
Data Source		SoundBeginning, 2010	SoundBeginning, 2011	SoundBeginning, 2012	SoundBeginning, 2013
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	66	68	68	70	70
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #11
   Field Name: SM11
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: SoundBeginnings Program data, 2012
   Numerator = Number of infants with PCHL enrolled in early intervention by 6 months of age
   Denominator = Number of infants identified with PCHL

2. **Section Number:** Form11_State Performance Measure #11
   Field Name: SM11
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: SoundBeginnings Program data, 2011
   Numerator = Number of infants with PCHL enrolled in early intervention by 6 months of age
   Denominator = Number of infants identified with PCHL

State Performance Measure # 12 - Reporting Year

The percent of Non-Medically Indicated (NMI) singleton live births of 37 and 38 weeks gestation.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective					
Annual Indicator			35.8	33.0	33.0
Numerator			2,689	2,368	2,368
Denominator			7,503	7,169	7,169
Data Source			Kansas birth certificate, 2011.	Kansas birth certificate, 2012.	Kansas birth certificate, 2012.
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	31	31	29	29	27
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #12
   Field Name: SM12
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

2. **Section Number:** Form11_State Performance Measure #12
   Field Name: SM12
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Birth certificate (in state resident) data, 2012, Bureau of Epidemiology and Public Health Informatics, KDHE

3. **Section Number:** Form11_State Performance Measure #12
   Field Name: SM12
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Birth certificate (in state resident) data, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE

State Performance Measure # 13 - Reporting Year

The percentage of newborns who have been screened for critical congenital heart defects (CCHD) before hospital discharge.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective					
Annual Indicator			66.7	66.7	66.7
Numerator			25,895	25,895	25,895
Denominator			38,801	38,801	38,801
Data Source			KDHE. Kansas Newborn Screening Data, 2013.	KDHE. Kansas Newborn Screening Data, 2013.	KDHE. Kansas Newborn Screening Data, 2013.
Is the Data Provisional or Final?				Provisional	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	70	75	80	85	95
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #13
   Field Name: SM13
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Data Source: Kansas newborn screening data based on the 2013 survey.

2. **Section Number:** Form11_State Performance Measure #13
   Field Name: SM13
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Kansas newborn screening data based on the 2013 survey.

3. **Section Number:** Form11_State Performance Measure #13
   Field Name: SM13
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Kansas newborn screening data based on the 2013 survey.

Form 12
Tracking Health Outcome Measures
[Secs 505 (a)(2)(B)(iii) and 506 (a)(2)(A)(iii)]
State: KS

Form Level Notes for Form 12

None

Outcome Measure # 01

The infant mortality rate per 1,000 live births.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	6.1	6.1	6.1	6.1	6.1
Annual Indicator	7.0	6.3	6.2	6.3	6.3
Numerator	290	253	247	254	254
Denominator	41,388	40,439	39,628	40,304	40,304
Data Source	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2012	Kansas Vital Statistics, 2012
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	6.1	6	6	5.9	5.9
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 1
   Field Name: OM01
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

2. **Section Number:** Form12_Outcome Measure 1
   Field Name: OM01
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Kansas Annual Summary of Vital Statistics, 2012, Bureau of Epidemiology and Public Health Informatics, KDHE

   Numerator = Death certificate (resident) data, 2012
   Denominator = Birth certificate (resident) data, 2012

3. **Section Number:** Form12_Outcome Measure 1
   Field Name: OM01
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Kansas Annual Summary of Vital Statistics, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE

   Numerator = Death certificate (resident) data, 2011
   Denominator = Birth certificate (resident) data, 2011

Outcome Measure # 02

The ratio of the black infant mortality rate to the white infant mortality rate.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	1.7	1.6	1.6	1.6	2.2
Annual Indicator	2.6	2.4	2.4	2.8	2.8
Numerator	15.5	11.9	12.9	14.2	14.2
Denominator	6	4.9	5.3	5	5
Data Source	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2012	Kansas Vital Statistics, 2012
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	2.2	2	2	1.8	1.8
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 2
   Field Name: OM02
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

2. **Section Number:** Form12_Outcome Measure 2
   Field Name: OM02
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Kansas Annual Summary of Vital Statistics, 2012, Bureau of Epidemiology and Public Health Informatics, KDHE

   For 2012, race and ethnicity is reported out an white non-Hispanic and black Non-Hispanic to more accuratly reflect population numbers.

3. **Section Number:** Form12_Outcome Measure 2
   Field Name: OM02
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Kansas Annual Summary of Vital Statistics, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE

   For 2011, race and ethnicity is reported out an white non-Hispanic and black Non-Hispanic to more accuratly reflect population numbers.

Outcome Measure # 03

The neonatal mortality rate per 1,000 live births.

	Annual Objective and Performance Data				
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	4.1	4.1	4	4	3.8
Annual Indicator	4.3	4.2	4.0	4.3	4.3
Numerator	176	170	157	173	173
Denominator	41,388	40,439	39,628	40,304	40,304
Data Source	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2012	Kansas Vital Statistics, 2012
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

	Annual Objective and Performance Data				
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	3.8	3.6	3.6	3.4	3.4
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 3
   Field Name: OM03
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

2. **Section Number:** Form12_Outcome Measure 3
   Field Name: OM03
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Kansas Annual Summary of Vital Statistics, 2012, Bureau of Epidemiology and Public Health Informatics, KDHE

   Numerator = Death certificate (resident) data, 2012
   Denominator = Birth certificate (resident) data, 2012

3. **Section Number:** Form12_Outcome Measure 3
   Field Name: OM03
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Kansas Annual Summary of Vital Statistics, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE

   Numerator = Death certificate (resident) data, 2011
   Denominator = Birth certificate (resident) data, 2011

Outcome Measure # 04

The postneonatal mortality rate per 1,000 live births.

	Annual Objective and Performance Data				
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	1.9	1.8	1.8	1.8	2.1
Annual Indicator	2.8	2.3	2.3	2.0	2.0
Numerator	114	93	90	81	81
Denominator	41,388	40,439	39,628	40,304	40,304
Data Source	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2012	Kansas Vital Statistics, 2012
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

	Annual Objective and Performance Data				
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	2.1	1.9	1.9	1.7	1.7
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 4
   Field Name: OM04
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

2. **Section Number:** Form12_Outcome Measure 4
   Field Name: OM04
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Kansas Annual Summary of Vital Statistics, 2012, Bureau of Epidemiology and Public Health Informatics, KDHE

   Numerator = Death certificate (resident) data, 2012
   Denominator = Birth certificate (resident) data, 2012

3. **Section Number:** Form12_Outcome Measure 4
   Field Name: OM04
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Kansas Annual Summary of Vital Statistics, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE

   Numerator = Death certificate (resident) data, 2011
   Denominator = Birth certificate (resident) data, 2011

Outcome Measure # 05

The perinatal mortality rate per 1,000 live births plus fetal deaths.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	5.7	5.6	5.6	5.6	5.6
Annual Indicator	6.6	6.2	5.9	6.9	6.9
Numerator	275	250	234	278	278
Denominator	41,519	40,546	39,741	40,440	40,440
Data Source	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2012	Kansas Vital Statistics, 2012
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	6.7	6.5	6.5	6.3	6.3
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 5
   Field Name: OM05
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

2. **Section Number:** Form12_Outcome Measure 5
   Field Name: OM05
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Kansas Annual Summary of Vital Statistics, 2012, Bureau of Epidemiology and Public Health Informatics, KDHE

   Numerator = Death and stillbirth certificate (resident) data, 2012
   Denominator = Live birth and stillbirth certificate (resident) data, 2012

3. **Section Number:** Form12_Outcome Measure 5
   Field Name: OM05
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Kansas Annual Summary of Vital Statistics, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE

   Numerator = Death and stillbirth certificate (resident) data, 2011
   Denominator = Live birth and stillbirth certificate (resident) data, 2011

Outcome Measure # 06

The child death rate per 100,000 children aged 1 through 14.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	18	18	17	17	17
Annual Indicator	21.4	22.3	19.1	16.8	16.8
Numerator	117	126	108	95	95
Denominator	547,017	566,037	565,128	566,778	566,778
Data Source	Kansas Vital Statistics, 2009	Kansas Vital Statistics, 2010	Kansas Vital Statistics, 2011	Kansas Vital Statistics, 2012	Kansas Vital Statistics, 2012
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	16	16	15	15	14
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 6
   Field Name: OM06
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

2. **Section Number:** Form12_Outcome Measure 6
   Field Name: OM06
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Kansas Annual Summary of Vital Statistics, 2012, Bureau of Epidemiology and Public Health Informatics, KDHE

3. **Section Number:** Form12_Outcome Measure 6
   Field Name: OM06
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Kansas Annual Summary of Vital Statistics, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE

Form 12
Tracking Health Outcome Measures
[Secs 505 (a)(2)(B)(iii) and 506 (a)(2)(A)(iii)]
State: KS

Form Level Notes for Form 12

None

Form 13
Characteristics Documenting Family Participation in CSHCN Programs
State: KS

1. Family members participate on advisory committee or task forces and are offering training, mentoring, and reimbursement, when appropriate.

3

2. Financial support (financial grants, technical assistance, travel, and child care) is offered for parent activities or parent groups.

3

3. Family members are involved in the Children with Special Health Care Needs elements of the MCH Block Grant Application process.

3

4. Family members are involved in service training of CSHCN staff and providers.

2

5. Family members hired as paid staff or consultants to the State CSHCN program (a family member is hired for his or her expertise as a family member).

3

6. Family members of diverse cultures are involved in all of the above activities.

2

Total Score: 16

Rating Key
0 = Not Met
1 = Partially Met
2 = Mostly Met
3 = Completely Met

Form Notes for Form 13

The Kansas Youth Empowerment Academy has been working to develop a new youth leadership program to engage and build youth leaders in the state, while supporting self-determination and building independence. The program development will conclude Summer 2014 and it is anticipated that funding will be allocated to sponsor a portion of this project.

Field Level Notes

1. **Section Number:** Form13_Main
   Field Name: Question1
   Row Name: #1. Family members participate on advisory committee or task forces...
   Column Name:
   Year: 2015
   Field Note:
   NOTES: To date, there 9 parent/family consultants on the KS-SHCN Family Advisory Council (FAC), with partnership with Families Together, Inc. who provides an additional 3 parent/professional staff to support the efforts of the council. Since last year, we were able to recruit 3 new members to the council. However, we have had some turnover within the council: 1 resigned due to work responsibilities; 1 resigned due to family responsibilities; and 1 transitioned from FAC member to parent/professional staff within Families Together and now serves as the FAC Staff Liaison.

   In May 2014, the FAC members voted to approve recommended changes to the bylaws that will increase the membership requirements from a minimum of 9 to a maximum of 15, to a minimum of 15 to a maximum of 17. This expansion is due to the interest in transitioning the council to a family/parent advisory body for all Special Health Services (SHS) programs, further integrating the Special Health Care Needs program with the Newborn Metabolic and Hearing Screening Programs and the Part C, Early Intervention Program. Specific membership requirements will be maintained with representatives from all programs.

   The FAC continues to meet in-person quarterly and via conference call between each in-person meeting. The FAC Executive Committee, established in 2012, continues to support FAC meeting planning and logistics by providing input in developing agendas, recommending changes to the by-laws and council objectives, and addressing concerns of the general member population.

   The past year, the FAC has been instrumental in the KS-SHCN Program Strategic Planning process, providing input, feedback, guidance, and recommending strategies for programmatic changes and enhancements. The FAC assisted in developing the structure for the new SHCN Care Coordination program, to be implemented in Fall 2014. The council also completed a series of white papers, available on www.kdheks.gov/shcn/publications.htm. The white papers were targeted for medical and community providers and policy makers about the impact of raising a child with SHCN. The white paper topics include:
   - "Partner and Communicate with Families of Children with Special Health Care Needs"
   - "Raising Children with Special Health Care Needs and the Impact on Family Health"
   - "Financial Impact of Raising Children with Special Health Care Needs"

   A new KS AMCHP Family Delegate Program was implemented in October, 2013. This included a competitive process to support parent/family leadership development. The Family Delegate was supported to attend the 2014 AMCHP conference in Washington, D.C. and also participated in the post-conference session, the Return on Investment (ROI) Collaborative session, with a team comprised of the State's MCH epidemiologist and KS-SHCN Program Manager. The Family Delegate has also been invited to serve on the Kansas Maternal and Child Health Council, in addition to their role on the FAC.

2. **Section Number:** Form13_Main
   Field Name: Question2
   Row Name: #2. Financial support (...) is offered for parent activities or parent groups.
   Column Name:
   Year: 2015
   Field Note:
   NOTES: Consumer parent consultants on the FAC are provided a stipend for their participation on the council as well as travel and child care costs.

   The Bureau of Family Health (BFH) contracts with Families Together, Inc., the KS Family Voices Affiliate Organization, in a variety of ways. Primarily, the KDHE/Families Together partnership provides services, programs, and training to parents of CYSHCN across Kansas. Specifically, the KS-SHCN program contracts with them to facilitate the FAC; connect families to resources and services (including financial supports and insurance options); conduct conferences for families and youth; and support families and youth in transition and identifying/initiating access to a medical home. Through these contracts, Families Together also provides resources and trainings to service providers on working with and supporting CYSHCN and their families.

3. **Section Number:** Form13_Main
   Field Name: Question3
   Row Name: #3. Family members are involved in the Children with Special Health Care Needs...
   Column Name:
   Year: 2015
   Field Note:
   NOTES: Parent partners have been invited for many years to provide feedback through the development of the needs assessment and MCH Block Grant. The new Title V Block Grant Public Input opportunity the last two years has allowed for more engaged and valuable feedback from parents and families. These changes were presented to the FAC members who expressed excitement and interest in providing feedback through our public input survey. Of the percentage of parents who participated in the public input survey from October 2013 to May 2014, over 15% identified themselves as a parent/guardian of a child with special health care needs. This is a significant increase from previous years. We are hopeful that the new direction of the KS-SHCN program we will gain more awareness of the CYSHCN population and we will continue to see an increase in our families participating in this process.

   Additionally, FAC members have continued to provide invaluable feedback to the KS-SHCN Program throughout the year on needed services and the strategic planning process that launched in July 2013. As changes within the Affordable Care Act, Kansas Managed Care initiatives, and other MCH efforts have begun to seed, it is more evident that a shift in the provision of SHCN services is warranted. Families have been central to this process related to potential changes in services, delivery of services, and appropriate supports for families. To date, two strategic planning sessions have occurred, with another to be held in August 2014. Between large stakeholder sessions, the FAC has remained central to the planning and have provided increased guidance, assisted in developing key definitions and potential measures for new priorities, and recommended detailed strategies for two of the five strategies to date.

4. **Section Number:** Form13_Main
   Field Name: Question4
   Row Name: #4. Family members are involved in service training of CSHCN staff and providers.
   Column Name:
   Year: 2015
   Field Note:
   NOTES: Title V contracts with Families Together to train parents, youth and providers on many different topics including medical home and health care transition. Families Together conducts outreach to a variety of providers, including health and education, to educate about the needs of the CYSHCN population and their families. Additionally, family members are eligible to apply to become a Families Together trainer and conduct trainings for other families. A new partnership agreement with Families Together will enhance these efforts and also provide training and education to KS-SHCN Regional Office staff on care coordination, assessing family needs, community resources, and other topics as identified throughout the year.

   Kansas has submitted an application for the new D-70 grant to support increased access to medical/health homes for the CYSHCN population. Within this grant, multiple opportunities were included for families to develop trainings for providers and their peers, including trainings on culturally-competent care-

management, building partnerships with families and patients, and informational videos for patients to be played in doctor's office waiting rooms on how to best engage their provider and what the medical/health home approach is.

5. **Section Number:** Form13_Main
   Field Name: Question5
   Row Name: #5. Family members hired as paid staff or consultants to the State CSHCN program...
   Column Name:
   Year: 2015
   Field Note:
   NOTES: Stipends and supports for parent consultants are provided through the FAC and contracts provide Families Together partial funding for multiple staff positions within their organization. Additionally, reorganization within the KS-SHCN allowed for the hiring of a Program Manager. A strong desire for this position was to have a parent/professional that understood the unique needs of the CYSHCN population. In December 2013, this position was filled with a strong family leader who had worked with the program as a liaison with Families Together as well as served as co-lead of the FAC, and assisted in efforts to restructuring of the FAC in 2011 to build a stronger council and more integration of the family voice into the program. This addition has been extremely valuable and has strengthened the strategic planning process and development of the new KS-SHCN Care Coordination program.

6. **Section Number:** Form13_Main
   Field Name: Question6
   Row Name: #6. Family members of diverse cultures are involved in all of the above activities
   Column Name:
   Year: 2015
   Field Note:
   NOTES: Through the CYSHCN Family Advisory Council, an active effort is made to ensure families from the various cultural and geographical areas of KS are represented. Approximately 30% of the FAC membership represents rural geographic areas throughout Kansas and there is continued focuses on assuring a variety of cultural backgrounds are represented. FAC member recruitment is ongoing to ensure diversity.

Form 14
List of MCH Priority Needs

[Sec. 505(a)(5)]

State: KS FY: 2015

Your State's 5-year Needs Assessment should identify the need for preventive and primary care services for pregnant women, mothers, and infants; preventive and primary care services for children and services for Children with Special Health Care Needs. With each year's Block Grant application, provide a list (whether or not the priority needs change) of the top maternal and child health needs in your state. Using simple sentence or phrase ,list below your State's needs. Examples of such statements are: "To reduce the barriers to the delivery of care for pregnant women, " and "The infant mortality rate for minorities should be reduced."

MCHB will capture annually every State's top 7 to 10 priority needs in an information system for comparison, tracking, and reporting purposes; you must list at least 7 and no more than 10. Note that the numbers listed below are for computer tracking only and are not meant to indicate priority order. If your State wishes to report more than 10 priority needs, list additional priority needs in a note at the form level.

1. Kansas women need early and comprehensive health care before, during and after pregnancy.
2. The mental health and behavioral health needs of pregnant women and new mothers should be addressed.
3. Kansas preterm births, LBW and infant mortality should be reduced.
4. Kansas women need support to increase initiation, duration, and exclusivity of breastfeeding.
5. All Kansas children and youth should receive health care through medical homes.
6. Child and adolescent risk behaviors relating to alcohol, tobacco and other drugs should be reduced.
7. Kansas children and youth need to achieve and maintain healthy weight
8. All CYSHCN should receive coordinated, comprehensive care within a medical home.
9. Kansas CYSHCN need early transition planning and services necessary to achieve maximum potential in all aspects of adult life, including health care, work and independence.
10. Financing for CYSHCN services should minimize financial hardship for their families

Form Notes for Form 14

None

Field Level Notes

None

Form 15
Technical Assistance (TA) Request

STATE: KS

APPLICATION YEAR: 2015

No.	Category of Technical Assistance Requested	Description of Technical Assistance Requested *(max 250 characters)*	Reason(s) Why Assistance Is Needed *(max 250 characters)*	What State, Organization or Individual Would You suggest Provide the TA (if known) *(max 250 characters)*
1.	**Data-related Issues - Data Systems Development** If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: N/A	Conduct review of systems used by the local health depts/MCH grantees & KDHE to conduct analysis of data collected, methods, ID recommendations for changes; integrate systems if possible to improve program and inform/target efforts/funds.	There are no available resources and/or staff with the expertise necessary to conduct the review and provide information on potential systems used by other states/MCH programs.	Expert; other state systems/vendors utilized
2.	**Other** If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: N/A	Develop and apply a funding formula for grants awarded to local health departments for MCH service delivery.	Allocations by county were set years ago (no formula/criteria); awards haven't changed based on population, services, needs assessments.	Expert/national input; other state formula examples/criteria
3.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
4.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
5.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
6.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
7.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
8.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
9.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
10.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which			

	this issue pertains by entering the measure number here:			
11.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
12.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			

Form Notes for Form 15

None

Field Level Notes

None

Form 16
State Performance and Outcome Measure Detail Sheet
State: KS

SP() # 2

Performance Measure: The percent of women in their reproductive years (18-44 years) who report consuming four or more alcoholic drinks on an occasion in the past 30 days.

Status: Active

Goal Improve mental health and behavioral health of pregnant women and new mothers.

Definition N/A

Numerator:
The estimated number of women in their reproductive years (18-44 years) who report consuming four or more alcoholic drinks on an occasion in the past 30 days.

Denominator:
The estimated number of women in their reproductive years(18-44 years) during the reporting period.

Units: 100 **Text:** Percent

Healthy People 2020 Objective MICH-11: Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women.
MICH-11.1 Alcohol Target: 98.3 percent MICH-11.2 Binge drinking Target: 100 percent

Data Sources and Data Issues Kansas Behavioral Risk Factor Surveillance System (BRFSS)

Significance The use of alcohol, tobacco, and illegal substances during pregnancy is a major risk factor for low birth weight and other poor infant outcomes. Alcohol use is linked to fetal death, LBW, growth abnormalities, mental retardation, and fetal alcohol syndrome (FAS). Overall rates of alcohol use during pregnancy have increased during the 1990s, and the proportion of pregnant women using alcohol at higher and more hazardous levels has increased substantially. (Reference: HP2010)

SP() # 3

Performance Measure:	The percent of live births that are born preterm less than 37 weeks of gestation.
Status:	Active
Goal	Reduce preterm and low birthweight births, and infant mortality.
Definition	Preterm births are defined as live births that occurred before the 37th week of pregnancy. **Numerator:** The Number of resident live births born preterm less than 37 weeks of gestation during the reporting period. **Denominator:** The Number of resident live births during the reporting period. **Units:** 100 **Text:** Percent
Healthy People 2020 Objective	MICH-9: Reduce preterm births MICH-9.1 Total preterm births Target: 11.4 percent MICH-9.2 Late preterm or live births at 34 to 36 weeks of gestation Target: 8.1 percent MICH-9.3 Live births at 32 to 33 weeks of gestation Target: 1.4 percent MICH-9.4 Very preterm or live births at less than 32 weeks of gestation Target: 1.8 percent
Data Sources and Data Issues	Kansas certificate of live birth
Significance	Perterm birth is a major determinant of infant mortality and morbidity and is the leading cause of death among newborns during the first month of life in the U.S. Infants born before 37 weeks gestation are at higher risk than infants born full-term for neurodevelopmental, respiratory, gastrointestinal, immune system, central nervous system, hearing and vision problems. Infants born preterm have longer hospital stys than full-term infants. Nationally, newborns with no complications stay an average of 1.5 days in the hospital, compared with an average of 13 days for preterm infants. Preschool and school-age children who are born preterm can also experience learning difficulties, and more behavioral problems later in life. Infants born very preterm (<32 weeks gestation) are at highest risk for death and life-long disability. (Reference: 2010 Rhode Island Kids Count Factbook.) Kansas baseline for 2002 was 8.7% of live births born preterm less than 37 weeks of gestation.

SP() # 5

Performance Measure:	The percent of children age 0 to 17 who received coordinated, ongoing, comprehensive care within a medical home.
Status:	Active
Goal	All children and youth receive health care through medical homes.
Definition	Medical Home as defined by AAP is derived from 19 questions asked in five core areas. These core areas ask parents whether the child has 1) personal doctor or nurse, 2) usual source for sick and well care, 3) family-centered care, 4) no problems getting needed referrals, and 5) effective care coordination when needed (including translation services). A child was defined to have a medical home if they answered yes to first core key areas and if needed answered yes to core areas 4 and 5. **Numerator:** The estimated number of children who receive care that meets the (AAP) definition of medical home during the reporting period. **Denominator:** The estimated number of children during the reporting period. **Units:** 100 **Text:** Percent
Healthy People 2020 Objective	MICH–30: Increase the proportion of children who have access to a medical home. Target: 63.3 percent. Baseline: 57.5 percent of children under age 18 years had access to a medical home in 2007.
Data Sources and Data Issues	National Survey of Children's Health
Significance	Providing primary care to children and youth in a "medical home" is the standard of practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions.

SP() # 6

Performance Measure:	The percent of high school students who had at least one drink of alcohol during the past 30 days.
Status:	Active
Goal	Reduce child and adolescent risk behaviors relating to alcohol, tobacco and other drugs.
Definition	N/A **Numerator:** The estimated number of students who had at least one drink of alcohol on at least 1 day during the previous 30 days. **Denominator:** The estimated number of students during the reporting period. **Units:** 100 **Text:** Percent
Healthy People 2020 Objective	SA–14.4 Reduce the proportion of adolescents engaging in binge drinking during the past month Target: 8.5 percent. Baseline: 9.4 percent of adolescents aged 12 to 17 years reported that they engaged in binge drinking during the past month in 2008. Target setting method: 10 percent improvement. SA–14.1 Reduce the proportion of high school seniors engaging in binge drinking in the past 2 weeks Target: 22.7 percent. Baseline: 25.2 percent of high school seniors reported that they engaged in binge drinking during the past 2 weeks in 2009. Target: 10 percent improvement.
Data Sources and Data Issues	Youth Risk Behavior Survey (YRBS).
Significance	Adolescent alcohol use remains a continuing problem for Kansas and the U.S. Young people between the ages of 12 and 20 are more likely to use alcohol than use tobacco or illicit drugs and drink considerably more on average per occasion, 5 drinks, than adults. The consequences of underage drinking include higher rates of risk sexual behaviors, injury (including car crashes), crime (including homicide, physical and sexual assaults), suicide, and death from alcohol poisoning. The baseline rate in 2009 for Kansas was 42.4% of youth drank alcohol in the past month since the survey.

SP() # 7

Performance Measure:	The Percent of children who are obese.
Status:	Active
Goal	Help all children and youth achieve and maintain healthy weight.
Definition	Obese is defined as children with BMI-for-age >= 95th percentile. **Numerator:** The number of WIC participant children ages 2-<5 at >= 95 percentile during the reporting period(unduplicated). **Denominator:** The number of WIC participant children ages 2-<5 during the reporting period (unduplicated). **Units:** 100 **Text:** Percent
Healthy People 2020 Objective	NWS-10 Reduce the proportion of children and adolescents who are considered obese NWS–10.1 Children aged 2 to 5 years. Target: 9.6 percent. Baseline: 10.7 percent of children aged 2 to 5 years were considered obese in 2005–08. NWS–10.2 Children aged 6 to 11 years. Target: 15.7 percent. Baseline: 17.4 percent of children aged 6 to 11 years were considered obese in 2005–08. NWS–10.3 Adolescents aged 12 to 19 years. Target: 16.1 percent. Baseline: 17.9 percent of adolescents aged 12 to 19 years were considered obese in 2005–08. NWS–11.4 (Developmental) Prevent inappropriate weight gain in children and adolescents aged 2 to 19
Data Sources and Data Issues	Pediatric Nutrition Surveillance System (PedNSS),CDC, Kansas WIC Program - Table 2C, Summary of Health Indicators Children ages 2-<5. The PedNSS data will be used as a proxy measure.
Significance	Maintenance of healthy weight is a major goal to reduce the burden of illness and its consequent reduction in quality of life and life expectancy. Patterns of healthful eating behavior need to begin in childhood and be maintained throughout adulthood. Overweight and obesity acquired during childhood or adolescence may persist into adulthood and increase the risk for some chronic diseases later in life. Kansas baseline for 2003 was 28.6%.

SP() # 9

Performance Measure:	The percent of youth with special health care needs (YSHCN) whose doctors usually or always encourage development of age appropriate self management skills.
Status:	Active
Goal	YSHCN receive services necessary to make transitions to all aspects of adult life, including health care, work, and independence.
Definition	This SPM was chosen to specifically measure the transition to medical care age 13 to 25. The Kansas CSHCN program serves children through age 21. NPM6 looks at the broad definition of transition (health care, work and independence) for children 0-18. **Numerator:** The estimated number of YSHCN that the doctor or other health care providers usually or always encourage the youth to take responsibility for their health care needs. **Denominator:** The estimated number of YSHCN (ages 12-17). **Units:** 100 **Text:** Percent
Healthy People 2020 Objective	DH–5: Increase the proportion of YSHCN whose health care provider has discussed transition planning Target: 45.3 percent. Baseline: 41.2 percent of youth with special health care needs had health care providers who discussed transition planning from pediatric to adult health care in 2005–06.
Data Sources and Data Issues	National Survey of Children with Special Health Care Needs
Significance	The transition of youth to adulthood remains a priority to fulfill the vision contained in President George W. Bush's "New Freedom Initiative: Delivering on the Promise" (March 2002). Over 90% of CSHCN now live to adulthood, but are less likely than their non-disabled peers to complete high school, attend college or to be employed. Health and health care are cited as two of the major barriers to making successful transitions. The baseline rate for CYSHCN in Kansas with a medical home is 50.7%.

SP() # 11

Performance Measure:	The percent of infants with Permanent Congenital Hearing Loss (PCHL) enrolled in early intervention services before 6 months of age.
Status:	Active
Goal	To increase the proportion of newborns who are enrolled in appropriate intervention services no later than age 6 months.
Definition	N/A **Numerator:** The number of infants with PCHL enrolled in Early Intervention by 6 months of age. **Denominator:** The number of infants identified with PCHL. **Units:** 100 **Text:** Percent
Healthy People 2020 Objective	Related to Hearing and Other Sensory or Communication Disorders Objective 1.3: Enrollment of infants with confirmed hearing loss for intervention services no later than age 6 months.
Data Sources and Data Issues	SoundBeginning Program - State based Early Hearing Detection and Intervention (EHDI) Program
Significance	The advantages of early intervention of hearing impairments are indisputable and include necessary follow-up of free and appropriate enrollment in habilitation and education programs

SP() # 12

Performance Measure: The percent of Non-Medically Indicated (NMI) singleton live births of 37 and 38 weeks gestation.

Status: Active

Goal To reduce the number of non-medically indicated early elective deliveries before 39 weeks gestational age.

Definition Gestational age is defined using the clinical estimate of completed weeks from the birth certificate. Clinical estimate of gestational age was found to be more accurate than gestational age using last menstrual period based on a medical chart review of late preterm cesarean delivery. NMI inductions are induced labor without any indication for delivery. NMI cesareans are cesarean deliveries without any indication for delivery and no attempt of labor.

Numerator:
Number of non-medically indicated singleton live births of 37 and 38 weeks gestation based on clinical estimate.

Denominator:
Number of singleton live births of 37 and 38 weeks gestation based on clinical estimate.

Units: 100 **Text:** Percent

Healthy People 2020 Objective

Related to Maternal, Infant, and Child Health (MICH) Objective 1.3: Reduce the rate of all infant deaths (within 1 year).

Data Sources and Data Issues Kansas birth certificate.

Significance Approximately 10 to 15 percent of all births in the United States are performed early without a medical reason. These births have increased risk of maternal and infant complications. The risk of adverse outcomes is greater for neonates delivered in the early-term period (37/38 weeks of gestation) compared with neonates delivered at 39 weeks of gestation. Because pulmonary development continues well into early childhood, respiratory morbidity is relatively common in neonates delivered in the early-term period.

SP() # 13

Performance Measure:	The percentage of newborns who have been screened for critical congenital heart defects (CCHD) before hospital discharge.
Status:	Active
Goal	To reduce the morbidity and mortality associated with critical congenital heart defects through early detection.
Definition	NA **Numerator:** The number of newborns in Kansas whose CCHD has been screened before hospital discharge by using pulse oximetry. **Denominator:** The number of occurrence births in Kansas in the calendar year. **Units:** 100 **Text:** Percent
Healthy People 2020 Objective	MICH-1.7 Reduce the rate of infant deaths related to birth defects (congenital heart defects) Reduce Baseline: 0.38 infant deaths per 1,000 live births were attributed to congenital heart and vascular defects in 2006 Target: 0.34 infant deaths per 1,000 live births Target-Setting Method: 10 percent improvement Data Source: Linked Birth/Infant Death Data Set, CDC/NCHS
Data Sources and Data Issues	Kansas newborn screening data
Significance	Congenital heart defects (CHDs) account for nearly 30% of infant deaths due to birth defects.1 In the United States, about 7,200 (or 18 per 10,000) babies born every year have critical congenital heart defects (CCHDs, which also are known as critical congenital heart disease). These CCHDs are coarctation of the aorta, double-outlet right ventricle, D-transposition of the great arteries, Ebstein anomaly, hypoplastic left heart syndrome, interrupted aortic arch, pulmonary atresia (intact septum), single ventricle, total anomalous pulmonary venous connection, tetralogy of Fallot, tricuspid atresia, and truncus arteriosus. Babies with CCHDs usually require surgery or catheter intervention in the first year of life. CCHDs can potentially be detected using pulse oximetry screening, which is a test to determine the amount of oxygen in the blood and pulse rate. Pulse oximetry screening is most likely to detect seven of the CCHDs. These seven main screening targets are hypoplastic left heart syndrome, pulmonary atresia (with intact septum), tetralogy of Fallot, total anomalous pulmonary venous return, transposition of the great arteries, tricuspid atresia, and truncus arteriosus. Other heart defects can be just as severe as the main screening targets and also require treatment soon after birth. However, pulse oximetry screening may not detect these heart defects as consistently as the seven disorders listed as the main screening targets.

Form Notes for Form 16

None

Field Level Notes

None

Form 17
Health Systems Capacity Indicators
Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data
State: KS

Form Level Notes for Form 17

None

Health Systems Capacity #01

The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.

	Annual Indicator Data				
	2009	**2010**	**2011**	**2012**	**2013**
Annual Indicator	24.8	23.0	20.3	20.3	20.3
Numerator	509	472	414	414	414
Denominator	205,385	205,492	203,655	203,655	203,655
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #01
   Field Name: HSC01
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The 2012 and 2013 columns are populated with 2011 data. 2012 data will be available Fall 2014 and 2013 data will be available in 2015.

2. **Section Number:** Form17_Health Systems Capacity Indicator #01
   Field Name: HSC01
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 and 2013 columns are populated with 2011 data. 2012 data will be available Fall 2014 and 2013 data will be available in 2015.

3. **Section Number:** Form17_Health Systems Capacity Indicator #01
   Field Name: HSC01
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Kansas Hospital Association. Kansas hospital discharge data, 2011. Accessed through the Bureau of Epidemiology and Public Health Informatics, KDHE.

   Data includes hospital discharges of Kansas residents from non-federal and non-state short-term (average length of stay less than 30 days) general and specialty hospitals whose facilities are open to the general public. Only discharges with asthma as a primary diagnosis were included.

Health Systems Capacity #02

The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	71.5	87.0	82.0	93.6	92.4
Numerator	14,043	17,165	14,808	14,311	13,746
Denominator	19,638	19,732	18,063	15,297	14,882
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #02
   Field Name: HSC02
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   DATA SOURCE: Kansas Medical Assistance Program reporting system, KAN-Be-Healthy annual participation report, report period: 10/1/2012-09/30/2013 (FY 2013).

   Numerator=Total eligibles receiving at least one initial or periodic screen.
   Denominator=Total eligibles who should receive at least one initial or periodic screen.

2. **Section Number:** Form17_Health Systems Capacity Indicator #02
   Field Name: HSC02
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   DATA SOURCE: Kansas Medical Assistance Program reporting system, KAN-Be-Healthy annual participation report, report period: 10/1/2011-09/30/2012 (FY 2012).

   Numerator=Total eligibles receiving at least one initial or periodic screen.
   Denominator=Total eligibles who should receive at least one initial or periodic screen.

3. **Section Number:** Form17_Health Systems Capacity Indicator #02
   Field Name: HSC02
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   DATA SOURCE: Kansas Medical Assistance Program reporting system, KAN-Be-Healthy annual participation report, report period: 10/1/2010-09/30/2011 (FY 2011).

   Numerator=Total eligibles receiving at least one initial or periodic screen.
   Denominator=Total eligibles who should receive at least one initial or periodic screen.

Health Systems Capacity #03

The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	58.8	77.9	65.7	70.9	67.8
Numerator	231	233	326	378	348
Denominator	393	299	496	533	513
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #03
   Field Name: HSC03
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Data Source: Kansas Medical Assistance Program reporting system, Well Child for HW21 report, report period: 10/1/2012-09/30/2013 (FFY 2013).
   Numerator=Total eligibles receiving at least one initial or periodic screen.
   Denominator=Total eligibles who should receive at least one initial or periodic screen.

2. **Section Number:** Form17_Health Systems Capacity Indicator #03
   Field Name: HSC03
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Kansas Medical Assistance Program reporting system, Well Child for HW21 report, report period: 10/1/2011-09/30/2012 (FFY 2012).
   Numerator=Total eligibles receiving at least one initial or periodic screen.
   Denominator=Total eligibles who should receive at least one initial or periodic screen.

3. **Section Number:** Form17_Health Systems Capacity Indicator #03
   Field Name: HSC03
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   DATA SOURCE:
   Kansas Medical Assistance Program reporting system, Well Child for HW21 report, report period: 10/1/2010-09/30/2011 (FFY 2011).
   Numerator=Total eligibles receiving at least one initial or periodic screen.
   Denominator=Total eligibles who should receive at least one initial or periodic screen.

Health Systems Capacity #04

The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	79.0	79.8	81.8	81.9	81.9
Numerator	30,713	30,914	30,852	32,343	32,343
Denominator	38,861	38,730	37,702	39,489	39,489
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #04
   Field Name: HSC04
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

2. **Section Number:** Form17_Health Systems Capacity Indicator #04
   Field Name: HSC04
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Bureau of Epidemiology and Public Health Informatics, KDHE

   Numerator = Number of resident women (15-44) during the reporting calendar year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.
   Denominator = All resident women (15-44) with a live birth during the reporting calendar year for which prenatal visits, date of first prenatal visit and date of last menses were reported on the birth certificate.

3. **Section Number:** Form17_Health Systems Capacity Indicator #04
   Field Name: HSC04
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Bureau of Epidemiology and Public Health Informatics, KDHE

   Numerator = Number of resident women (15-44) during the reporting calendar year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.
   Denominator = All resident women (15-44) with a live birth during the reporting calendar year for which prenatal visits, date of first prenatal visit and date of last menses were reported on the birth certificate.

Health Systems Capacity #07A

Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	85.0	78.4	95.1	97.6	97.6
Numerator	218,523	234,284	304,163	322,152	322,152
Denominator	257,147	298,994	319,926	329,923	329,923
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #07A
   Field Name: HSC07A
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The 2013 columns are populated with 2012 data. 2013 data will be available in Fall 2014.

2. **Section Number:** Form17_Health Systems Capacity Indicator #07A
   Field Name: HSC07A
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The numerator and denominator are entered in reverse. This causes the percentage to exceed 100%.

   Data Source: Medicaid paid claims data file, Division of Health Care Finance, Kansas Department of Health and Environment (calendar year 2012).

   Numerator = # of unduplicated consumers =329,923
   Denominator = # of unduplicated Medicaid beneficiaries = 322,152
   Percent = 102.4%

   Consumer is any person with a paid service during a time period (including capitation payments for managed care plans which may not indicate actual utilization of services), and that Kansas has a 12-month timely filling requirement, so services performed in 2010 can be paid in 2011, and services in 2011 can be paid in 2012. Therefore, consumer counts are higher than beneficiary counts.

3. **Section Number:** Form17_Health Systems Capacity Indicator #07A
   Field Name: HSC07A
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   The numerator and denominator are entered in reverse. This causes the percentage to exceed 100%.

   Data Source: Medicaid paid claims data file, Division of Health Care Finance, Kansas Department of Health and Environment (calendar year 2011).

   Numerator = # of unduplicated consumers =319,926
   Denominator = # of unduplicated Medicaid beneficiaries = 304,163
   Percent = 105.2%

   Consumer is any person with a paid service during a time period (including capitation payments for managed care plans which may not indicate actual utilization of services), and that Kansas has a 12-month timely filling requirement, so services performed in 2009 can be paid in 2010, and services in 2010 can be paid in 2011. Therefore, consumer counts are higher than beneficiary counts.

Health Systems Capacity #07B

The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	58.1	58.6	60.8	54.7	57.3
Numerator	26,380	28,634	31,618	31,189	34,604
Denominator	45,409	48,875	52,007	57,031	60,422
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #07B
   Field Name: HSC07B
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Data Source: Kansas Medical Assistance Program reporting system, KAN-Be-Healthy annual participation report, report period: 10/1/2012-09/30/2013 (FFY 2013)
   Numerator=Number of eligible receiving any dental services.
   Denominator=Number of individuals eligible for Kan Be Healthy.

2. **Section Number:** Form17_Health Systems Capacity Indicator #07B
   Field Name: HSC07B
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Kansas Medical Assistance Program reporting system, KAN-Be-Healthy annual participation report, report period: 10/1/2011-09/30/2012 (FFY 2012)
   Numerator=Number of eligible receiving any dental services.
   Denominator=Number of individuals eligible for Kan Be Healthy.

3. **Section Number:** Form17_Health Systems Capacity Indicator #07B
   Field Name: HSC07B
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   DATA SOURCE:
   Kansas Medical Assistance Program reporting system, KAN-Be-Healthy annual participation report, report period: 10/1/2010-09/30/2011 (FFY 2011)
   Numerator=Number of eligible receiving any dental services.
   Denominator=Number of individuals eligible for Kan Be Healthy.

Health Systems Capacity #08

The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	7,287	7,721	8,034	8,388	8,388
Denominator	7,287	7,721	8,034	8,388	8,388
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #08
   Field Name: HSC08
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The 2013 column is populated with 2012 data. 2013 data will be available in 2014.

2. **Section Number:** Form17_Health Systems Capacity Indicator #08
   Field Name: HSC08
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: http://www.childhealthdata.org/browse/titlev/state-ssi-data

   Numerator=Number of children under age 16 receiving federally administered SSI payments
   Denominator= Number of children under age 16 receiving federally administered SSI payments

   Due to SSA requirements, the CYSHCN program no longer receives monthly printouts or disability determination forms for those clients in Kansas receiving SSI benefits. In Kansas, all children receiving SSI are eligible for Medicaid and therefore have access to needed rehabilitation services through Medicaid coverage.

3. **Section Number:** Form17_Health Systems Capacity Indicator #08
   Field Name: HSC08
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: http://www.childhealthdata.org/browse/titlev/state-ssi-data

   Numerator=Number of children under age 16 receiving federally administered SSI payments
   Denominator= Number of children under age 16 receiving federally administered SSI payments

   Due to SSA requirements, the CYSHCN program no longer receives monthly printouts or disability determination forms for those clients in Kansas receiving SSI benefits. In Kansas, all children receiving SSI are eligible for Medicaid and therefore have access to needed rehabilitation services through Medicaid coverage.

Form 18
Health Systems Capacity Indicator #05
(Medicaid and Non-Medicaid Comparison)
State: KS

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
a) *Percent of low birth weight (< 2,500 grams)*	2012	Payment source from birth certificate	8.9	6.3	7.2
b) *Infant deaths per 1,000 live births*	2012	Matching data files	9.7	4.4	6.3
c) *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*	2012	Payment source from birth certificate	68	84.5	78.9
d) *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*	2012	Payment source from birth certificate	73.7	86.2	81.9

Form 18
Health Systems Capacity Indicator #06(Medicaid eligibility level)
State: KS

INDICATOR #06 *The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.*	YEAR	PERCENT OF POVERTY LEVEL MEDICAID (Valid range: 100-300 percent)
a) *Infants (0 to 1)*	2013	150
b) *Medicaid Children* (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2013	133 100
c) *Pregnant Women*	2013	150

Form 18
Health Systems Capacity Indicator #06(SCHIP eligibility level)
State: KS

INDICATOR #06 *The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, SCHIP and pregnant women.*	YEAR	PERCENT OF POVERTY LEVEL SCHIP
a) *Infants (0 to 1)*	2013	150
b) *Medicaid Children* (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2013	150 150
c) *Pregnant Women*	2013	150

Form Notes for Form 18

None

Field Level Notes

1. **Section Number:** Form18_Indicator 06 - SCHIP
   Field Name: SCHIP_Women
   Row Name: Pregnant Women
   Column Name:
   Year: 2015
   Field Note:
   If they are in CHIP and Pregnant, but that is a rare occurrence.

2. **Section Number:** Form18_Indicator 05
   Field Name: LowBirthWeight
   Row Name: Percent of ow birth weight (<2,500 grams)
   Column Name:
   Year: 2015
   Field Note:
   Data source: Live birth certificate (resident) data, 2012. Bureau of Epidemiology and Public Health Informatics, KDHE.

   The "principal source of payment for this delivery" is based on live birth certificate data. Kansas' birth certificate includes an item inquiring about the "principal source of payment for this delivery" with the following check box items: Medicaid, Private/Employer Ins., Self-pay, Indian Health Service, CHAMPUS/TRICARE, Other government, Other (Specifiy), and Unknown. This does not indicate insurance coverage during pregnancy or imply the source of payment for prenatal care.

   Medicaid population - includes live births records that checked as "Medicaid"
   Non-Medicaid population - includes live birth records that checked as "private/Employer Ins., selfpay, Indian Health Service, CHAMPUS/TRICARE, other government, and other".
   All population - includes all live birth records regardless of "principal source of payment for this delivery" status.
   Live birth records with unknown/missing values for birth weight were excluded from analysis.

3. **Section Number:** Form18_Indicator 05
   Field Name: InfantDeath
   Row Name: Infant deaths per 1,000 live births
   Column Name:
   Year: 2015
   Field Note:
   Data source:
   Numerator: Linked death and birth file, 2012 death cohort. Bureau of Epidemiology and Public Health Informatics, KDHE.
   Denominator: Live birth certificate (resident) data, 2012. Bureau of Epidemiology and Public Health Informatics, KDHE.

   The "principal source of payment for this delivery" is based on live birth certificate data. Kansas' birth certificate includes an item inquiring about the "principal source of payment for this delivery" with the following check box items: Medicaid, Private/Employer Ins., Self-pay, Indian Health Service, CHAMPUS/TRICARE, Other government, Other (Specifiy), and Unknown. This does not indicate insurance coverage during pregnancy or imply the source of payment for prenatal care.

   Medicaid population - includes live births records that checked as "Medicaid"

   Non-Medicaid population - includes live birth records that checked as "private/Employer Ins., selfpay, Indian Health Service, CHAMPUS/TRICARE, other government, and other".

   All population - includes all live birth records regardless of "principal source of payment for this delivery" status.

4. **Section Number:** Form18_Indicator 05
   Field Name: CareFirstTrimester
   Row Name: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester
   Column Name:
   Year: 2015
   Field Note:
   Data source: Live birth certificate (resident) data, 2012. Bureau of Epidemiology and Public Health Informatics, KDHE.

   The "principal source of payment for this delivery" is based on live birth certificate data. Kansas' birth certificate includes an item inquiring about the "principal source of payment for this delivery" with the following check box items: Medicaid, Private/Employer Ins., Self-pay, Indian Health Service, CHAMPUS/TRICARE, Other government, Other (Specifiy), and Unknown. This does not indicate insurance coverage during pregnancy or imply the source of payment for prenatal care.

   Medicaid population - includes live births records that checked as "Medicaid"

   Non-Medicaid population - includes live birth records that checked as "private/Employer Ins., self pay, Indian Health Service, CHAMPUS/TRICARE, other government, and other".

   All population - includes all live birth records regardless of "principal source of payment for this delivery" status.

   Records (i.e., live births) with unknown/missing values for start date for prenatal care were excluded from analysis.

5. **Section Number:** Form18_Indicator 05
   Field Name: AdequateCare
   Row Name: Percent of pregnant women with adequate prenatal care
   Column Name:
   Year: 2015
   Field Note:
   Data source: Live birth certificate (resident) data, 2012. Bureau of Epidemiology and Public Health Informatics, KDHE.

   The "principal source of payment for this delivery" is based on live birth certificate data. Kansas' birth certificate includes an item inquiring about the "principal source of payment for this delivery" with the following check box items: Medicaid, Private/Employer Ins., Self-pay, Indian Health Service, CHAMPUS/TRICARE, Other government, Other (Specifiy), and Unknown. This does not indicate insurance coverage during pregnancy or imply the source of payment for prenatal care.

Medicaid population - includes live births records that checked as "Medicaid"

Non-Medicaid population - includes live birth records that checked as “private/Employer Ins., selfpay, Indian Health Service, CHAMPUS/TRICARE, other government, and other”.

All population - includes all live birth records regardless of "principal source of payment for this delivery" status.

Records (i.e., live births) with unknown/missing values for prenatal care were excluded from analysis.

Form 19
Health Systems Capacity Indicator - Reporting and Tracking Form
State: KS

HEALTH SYSTEMS CAPACITY INDICATOR #09A (General MCH Data Capacity) *(The Ability of the State to Assure MCH Program Access to Policy and Program Relevant Information)*		
DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3) ***	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES **Annual linkage of infant birth and infant death certificates**	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	1	No
REGISTRIES AND SURVEYS **Hospital discharge survey for at least 90% of in-State discharges**	3	Yes
Annual birth defects surveillance system	2	Yes
Survey of recent mothers at least every two years (like PRAMS)	1	No

*Where:
1 = No, the MCH agency does not have this ability.
2 = Yes, the MCH agency sometimes has this ability, but not on a consistent basis.
3 = Yes, the MCH agency always has this ability.

Form 19
Health Systems Capacity Indicator - Reporting And Tracking Form
State: KS

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)*	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes
Other: Kansas Youth Tobacco Survey	2	Yes

*Where:
1 = No
2 = Yes, the State participates but the sample size is not large enough for valid statewide estimates for this age group.
3 = Yes, the State participates and the sample size is large enough for valid statewide estimates for this age group.

Notes:

1. HEALTH SYSTEMS CAPACITY INDICATOR #09B was formerly reported as Developmental Health Status Indicator #05.

Form Notes for Form 19

None

Field Level Notes

None

Form 20
Health Status Indicators #01-#05
Multi-Year Data
State: KS

Form Level Notes for Form 20

None

Health Status Indicator #01A

The percent of live births weighing less than 2,500 grams.

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	7.3	7.1	7.2	7.2	7.2
Numerator	3,021	2,867	2,867	2,888	2,888
Denominator	41,378	40,429	39,628	40,301	40,301
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #01A
   Field Name: HSI01A
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

2. **Section Number:** Form20_Health Status Indicator #01A
   Field Name: HSI01A
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Birth certificate (resident) data, 2012, Bureau of Epidemiology and Public Health Informatics, KDHE; Births for which birthweights are not reported are excluded from the computation of percentages.

3. **Section Number:** Form20_Health Status Indicator #01A
   Field Name: HSI01A
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Birth certificate (resident) data, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE; Births for which birthweights are not reported are excluded from the computation of percentages.

Health Status Indicator #01B

The percent of live singleton births weighing less than 2,500 grams.

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	5.6	5.5	5.6	5.5	5.5
Numerator	2,258	2,167	2,146	2,137	2,137
Denominator	40,055	39,194	38,329	38,904	38,904
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #01B
   Field Name: HSI01B
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

2. **Section Number:** Form20_Health Status Indicator #01B
   Field Name: HSI01B
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Birth certificate (resident) data, 2012, Bureau of Epidemiology and Public Health Informatics, KDHE

3. **Section Number:** Form20_Health Status Indicator #01B
   Field Name: HSI01B
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Birth certificate (resident) data, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE

Health Status Indicator #02A

The percent of live births weighing less than 1,500 grams.

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	1.4	1.2	1.3	1.4	1.4
Numerator	577	491	527	547	547
Denominator	41,378	40,429	39,628	40,301	40,301
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #02A
   Field Name: HSI02A
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

2. **Section Number:** Form20_Health Status Indicator #02A
   Field Name: HSI02A
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Birth certificate (resident) data, 2012, Bureau of Epidemiology and Public Health Informatics, KDHE; Births for which birthweights are not reported are excluded from the computation of percentages

3. **Section Number:** Form20_Health Status Indicator #02A
   Field Name: HSI02A
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Birth certificate (resident) data, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE; Births for which birthweights are not reported are excluded from the computation of percentages

Health Status Indicator #02B

The percent of live singleton births weighing less than 1,500 grams.

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	1.1	0.9	1.0	1.0	1.0
Numerator	430	368	374	394	394
Denominator	40,055	39,194	38,329	38,904	38,904
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #02B
   Field Name: HSI02B
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

2. **Section Number:** Form20_Health Status Indicator #02B
   Field Name: HSI02B
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Birth certificate (resident) data, 2012, Bureau of Epidemiology and Public Health Informatics, KDHE

3. **Section Number:** Form20_Health Status Indicator #02B
   Field Name: HSI02B
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Birth certificate (resident) data, 2011, Bureau of Epidemiology and Public Health Informatics, KDHE

Health Status Indicator #03A

The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	10.2	10.9	9.9	7.9	7.9
Numerator	60	66	60	48	48
Denominator	588,523	606,823	605,120	606,608	606,608
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #03A
   Field Name: HSI03A
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

2. **Section Number:** Form20_Health Status Indicator #03A
   Field Name: HSI03A
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Kansas 2012 Annual Summary of Vital Statistics, Table 64, Bureau of Epidemiolgoy and Public Health Informatics, Kansas Department of Health and Environment.

   Numerator: Number of deaths from all unintentional injuries (ICD-10 Coding, V01-X59, Y85-Y86, Y88) for children (residents) aged 14 years and younger for the reporting period.

   Denominator: Number of children (residents) aged 14 years and younger for the reporting period. US Census - Bridged-Race Vintage series.

3. **Section Number:** Form20_Health Status Indicator #03A
   Field Name: HSI03A
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Kansas 2011 Annual Summary of Vital Statistics, Table 64, Bureau of Epidemiolgoy and Public Health Informatics, Kansas Department of Health and Environment.

   Numerator: Number of deaths from all unintentional injuries (ICD-10 Coding, V01-X59, Y85-Y86, Y88) for children (residents) aged 14 years and younger for the reporting period.

   Denominator: Number of children (residents) aged 14 years and younger for the reporting period. US Census - Bridged-Race Vintage series.

Health Status Indicator #03B

The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	2.7	4.0	2.8	3.3	3.3
Numerator	16	24	17	20	20
Denominator	588,523	606,823	605,120	606,608	606,608
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #03B
   Field Name: HSI03B
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

2. **Section Number:** Form20_Health Status Indicator #03B
   Field Name: HSI03B
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Numerator: Number of deaths from all unintentional injuries due to motor vehicle crashes for children (residents) aged 14 years and younger for the reporting period. Data Source: Kansas 2012 Annual Summary of Vital Statistics, Table 64, Bureau of Epidemiology and Public Health Informatics, Kansas Department of Health and Environment.

   Denominator: Number of children (residents) aged 14 years and younger for the reporting period. Data Source: US Census - Bridged-Race Vintage series.

3. **Section Number:** Form20_Health Status Indicator #03B
   Field Name: HSI03B
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Numerator: Number of deaths from all unintentional injuries due to motor vehicle crashes for children (residents) aged 14 years and younger for the reporting period. Data Source: Kansas 2011 Annual Summary of Vital Statistics, Table 64, Bureau of Epidemiology and Public Health Informatics, Kansas Department of Health and Environment.

   Denominator: Number of children (residents) aged 14 years and younger for the reporting period. Data Source: US Census - Bridged-Race Vintage series.

Health Status Indicator #03C

The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	21.9	27.9	19.4	21.2	21.2
Numerator	93	114	80	88	88
Denominator	423,712	408,275	411,997	414,638	414,638
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #03C
   Field Name: HSI03C
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The 2013 column is populated with 2012 data. 2013 data will be available Fall 2014.

2. **Section Number:** Form20_Health Status Indicator #03C
   Field Name: HSI03C
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Numerator: Number of deaths from all unintentional injuries due to motor vehicle crashes for youth (residents) aged 15 through 24 years for the reporting period. Data Source: Kansas 2012 Annual Summary of Vital Statistics, Table 64, Bureau of Epidemiology and Public Health Informatics, Kansas Department of Health and Environment.

   Denominator: Number of children (residents) aged 15 through 24 years for the reporting period. Data Source: US Census - Bridged-Race Vintage series.

3. **Section Number:** Form20_Health Status Indicator #03C
   Field Name: HSI03C
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Numerator: Number of deaths from all unintentional injuries due to motor vehicle crashes for youth (residents) aged 15 through 24 years for the reporting period. Data Source: Kansas 2011 Annual Summary of Vital Statistics, Table 64, Bureau of Epidemiology and Public Health Informatics, Kansas Department of Health and Environment.

   Denominator: Number of children (residents) aged 15 through 24 years for the reporting period. Data Source: US Census - Bridged-Race Vintage series.

Health Status Indicator #04A

The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	242.6	215.4	190.4	190.4	190.4
Numerator	1,428	1,307	1,152	1,152	1,152
Denominator	588,523	606,823	605,120	605,120	605,120
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #04A
   Field Name: HSI04A
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The 2012 and 2013 columns are populated with 2011 data. The 2012 data will be available in late 2014 and the 2013 data will be available in 2015.

2. **Section Number:** Form20_Health Status Indicator #04A
   Field Name: HSI04A
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 and 2013 columns are populated with 2011 data. The 2012 data will be available in late 2014 and the 2013 data will be available in 2015.

3. **Section Number:** Form20_Health Status Indicator #04A
   Field Name: HSI04A
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Numerator: Number of hospital discharges for resident children ages 14 years and younger with non-fatal unintentional injuries (E800-E869 and E880-E929). Data Source: Kansas Hospital Discharge data, Kansas Hospital Association, Accessed throuth the Bureau of Epidemiology and Public Health Informatics, KDHE.

   Denominator: Number of resident children ages 14 years and younger in the reporting period. Data Source: US Census - Bridged-Race Vintage series.

Health Status Indicator #04B

The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	13.8	14.2	12.6	12.6	12.6
Numerator	81	86	76	76	76
Denominator	588,523	606,823	605,120	605,120	605,120
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #04B
   Field Name: HSI04B
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The 2012 and 2013 columns are populated with 2011 data. The 2012 data will be available in late 2014 and the 2013 data will be available in 2015.

2. **Section Number:** Form20_Health Status Indicator #04B
   Field Name: HSI04B
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 and 2013 columns are populated with 2011 data. The 2012 data will be available in late 2014 and the 2013 data will be available in 2015.

3. **Section Number:** Form20_Health Status Indicator #04B
   Field Name: HSI04B
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Numerator: Number of hospital discharges for resident children ages 14 years and younger with non-fatal unintentional injuries due to MVC (E810-E825). Data Source: Kansas Hospital Discharge data, Kansas Hospital Association, Accessed throuth the Bureau of Epidemiology and Public Health Informatics, KDHE.

   Denominator: Number of youth ages 15 through 24 for the reporting period. Data Source: U. S. Census - Bridged-Race Vintage series.

Health Status Indicator #04C

The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	87.6	84.5	75.7	75.7	75.7
Numerator	371	345	312	312	312
Denominator	423,712	408,275	411,997	411,997	411,997
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #04C
   Field Name: HSI04C
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   The 2012 and 2013 columns are populated with 2011 data. The 2012 data will be available in late 2014 and the 2013 data will be available in 2015.

2. **Section Number:** Form20_Health Status Indicator #04C
   Field Name: HSI04C
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The 2012 and 2013 columns are populated with 2011 data. The 2012 data will be available in late 2014 and the 2013 data will be available in 2015.

3. **Section Number:** Form20_Health Status Indicator #04C
   Field Name: HSI04C
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Numerator: Number of hospital discharges for youth ages 15 through 24 due to non-fatal injuries caused by motor vehicle crashes (E810-E825) in the reporting period. Data Source: Kansas Hospital Discharge data, Kansas Hospital Association, Accessed throuth the Bureau of Epidemiology and Public Health Informatics, KDHE.

   Denominator: Number of youth ages 15 through 24 for the reporting period. Data Source: U. S. Census - Bridged-Race Vintage series.

Health Status Indicator #05A

The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	30.9	27.2	29.4	31.6	28.2
Numerator	2,981	2,682	2,905	3,062	2,736
Denominator	96,536	98,459	98,702	96,979	96,979
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #05A
   Field Name: HSI05A
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Data Source:
   Numerator= KDHE. Bureau of Disease Prevention and Control. STD program data, 2013
   Denominator= U.S. Census, 2012

2. **Section Number:** Form20_Health Status Indicator #05A
   Field Name: HSI05A
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source:
   Numerator= KDHE. Bureau of Disease Prevention and Control. STD program data, 2012
   Denominator= U.S. Census, 2012

3. **Section Number:** Form20_Health Status Indicator #05A
   Field Name: HSI05A
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source:
   Numerator= KDHE. Bureau of Disease Prevention and Control. STD program data, 2011
   Denominator= U.S. Census, 2011

Health Status Indicator #05B

The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	11.2	10.2	11.2	12.2	11.9
Numerator	5,126	4,657	5,129	5,612	5,486
Denominator	457,444	456,125	457,880	460,875	460,875
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #05B
   Field Name: HSI05B
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Data Source:
   Numerator= KDHE. Bureau of Disease Prevention and Control. STD program data, 2013.
   Denominator= U.S. Census, 2012

2. **Section Number:** Form20_Health Status Indicator #05B
   Field Name: HSI05B
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source:
   Numerator= KDHE. Bureau of Disease Prevention and Control. STD program data, 2012.
   Denominator= U.S. Census, 2012

3. **Section Number:** Form20_Health Status Indicator #05B
   Field Name: HSI05B
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source:
   Numerator= KDHE. Bureau of Disease Prevention and Control. STD program data on incident cases reported for CY2011.
   Denominator= U.S. Census, 2011

Form 21
Health Status Indicators
Demographic Data
State: KS

HSI #06A - Demographics (Total Population) *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*
For both parts A and B: Reporting Year: 2012 Is this data from a State Projection? No Is this data final or provisional? Final

CATEGORY TOTAL POPULATION BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	39,830	33,601	4,129	747	1,353	0	0	0
Children 1 through 4	163,437	138,706	16,371	2,930	5,430	0	0	0
Children 5 through 9	203,485	173,984	19,142	3,683	6,676	0	0	0
Children 10 through 14	199,856	172,493	17,542	3,764	6,057	0	0	0
Children 15 through 19	200,937	172,936	18,373	3,958	5,670	0	0	0
Children 20 through 24	213,701	182,652	19,161	3,813	8,075	0	0	0
Children 0 through 24	1,021,246	874,372	94,718	18,895	33,261	0	0	0

HSI #06B - Demographics (Total Population) *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and ethnicity. (Demographics)*

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	32,662	7,168	0
Children 1 through 4	132,074	31,363	0
Children 5 through 9	165,892	37,593	0
Children 10 through 14	166,689	33,167	0
Children 15 through 19	171,839	29,098	0
Children 20 through 24	185,863	27,838	0
Children 0 through 24	855,019	166,227	0

Form 21
Health Status Indicators
Demographic Data
State: KS

HSI #07A - Demographics (Total live births) *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*
For both parts A and B: Reporting Year: 2012 Is this data from a State Projection? No Is this data final or provisional? Final

CATEGORY TOTAL LIVE BIRTHS BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Women < 15	28	18	7	1	0	0	1	1
Women 15 through 17	833	609	87	8	6	0	34	89
Women 18 through 19	2,470	1,903	261	21	22	5	99	159
Women 20 through 34	32,442	27,118	2,159	184	880	60	639	1,402
Women 35 or older	4,530	3,698	236	21	260	5	49	261
Women of all ages	40,303	33,346	2,750	235	1,168	70	822	1,912

HSI #07B - Demographics (Total live births) *Live births to women (of all ages) enumerated by maternal age and ethnicity. (Demographics)*

CATEGORY TOTAL LIVE BIRTHS BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Women < 15	18	10	0
Women 15 through 17	551	282	0
Women 18 through 19	1,862	602	6
Women 20 through 34	27,790	4,622	30
Women 35 or older	3,750	770	10
Women of all ages	33,971	6,286	46

Form 21
Health Status Indicators
Demographic Data
State: KS

HSI #08A - Demographics (Total deaths) *Deaths of Infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*
For both parts A and B: Reporting Year: 2012 Is this data from a State Projection? No Is this data final or provisional? Final

CATEGORY TOTAL DEATHS BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	254	172	39	1	3	0	13	26
Children 1 through 4	42	33	3	0	1	0	3	2
Children 5 through 9	29	23	1	1	0	0	1	3
Children 10 through 14	24	17	3	0	1	0	0	3
Children 15 through 19	105	81	11	1	1	0	2	9
Children 20 through 24	196	155	21	5	1	0	5	9
Children 0 through 24	650	481	78	8	7	0	24	52

HSI #08B - Demographics (Total deaths) *Deaths of Infants and children aged 0 through 24 years enumerated by age subgroup and ethnicity. (Demographics)*

CATEGORY TOTAL DEATHS BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	170	74	10
Children 1 through 4	32	10	0
Children 5 through 9	24	5	0
Children 10 through 14	21	3	0
Children 15 through 19	88	17	0
Children 20 through 24	162	23	11
Children 0 through 24	497	132	21

Form 21
Health Status Indicators
Demographic Data
State: KS

HSI #09A - Demographics (Miscellaneous Data) *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

Is this data final or provisional? Final

CATEGORY Miscellaneous Data BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown	Specific Reporting Year
All children 0 through 19	807,545	691,720	75,557	15,082	25,186	0	0	0	2012
Percent in household headed by single parent	21.5	19.0	53.8	33.5	18.3	19.5	38.6	31.8	2010
Percent in TANF (Grant) families	4.6	3.4	12.0	4.2	3.3	0.0	0.0	0.0	2012
Number enrolled in Medicaid	272,444	203,347	41,659	5,350	6,017	451	0	15,620	2012
Number enrolled in SCHIP	69,017	54,690	6,678	974	1,719	97	0	4,859	2012
Number living in foster home care	8,853	7,084	1,563	145	56	5	0	0	2012
Number enrolled in food stamp program	195,623	139,816	32,674	3,082	3,795	280	6,814	9,162	2012
Number enrolled in WIC	95,543	71,745	10,315	3,495	1,799	243	7,946	0	2012
Rate (per 100,000) of juvenile crime arrests	192.1	674.0	1,972.0	236.6	280.0	0.0	0.0	0.0	2012
Percentage of high school drop-outs (grade 9 through 12)	2.1	1.7	3.7	3.7	1.4	0.0	2.9	0.0	2012

HSI #09B - Demographics (Miscellaneous Data) *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by ethnicity.(Demographics)*

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported	Specific Reporting Year
All children 0 through 19	669,156	138,389	0	2012
Percent in household headed by single parent	0.0	31.8	0.0	2010
Percent in TANF (Grant) families	4.5	5.4	0.0	2012
Number enrolled in Medicaid	202,618	69,825	1	2012
Number enrolled in SCHIP	51,281	17,734	2	2012
Number living in foster home care	7,780	1,010	26	2012
Number enrolled in food stamp program	153,198	42,425	0	2012
Number enrolled in WIC	63,295	32,246	2	2012
Rate (per 100,000) of juvenile crime arrests	736.5	887.6	0.0	2012
Percentage of high school drop-outs (grade 9 through 12)	0.0	3.1	0.0	2012

Form 21
Health Status Indicators
Demographic Data
State: KS

HSI #10 - Demographics (Geographic Living Area) *Geographic living area for all resident children aged 0 through 19 years old. (Demographics)*
Reporting Year: 2012 Is this data from a State Projection? No Is this data final or provisional? Final

GEOGRAPHIC LIVING AREAS	TOTAL
Living in metropolitan areas	495,721
Living in urban areas	579,582
Living in rural areas	199,939
Living in frontier areas	28,024
Total - all children 0 through 19	807,545

Note:
The Total will be determined by adding reported numbers for urban, rural and frontier areas.

Form 21
Health Status Indicators
Demographic Data
State: KS

HSI #11 - Demographics (Poverty Levels) *Percent of the State population at various levels of the federal poverty level. (Demographics)*
Reporting Year: 2012 Is this data from a State Projection? No Is this data final or provisional? Final

POVERTY LEVELS	TOTAL
Total Population	2,885,905
Percent Below: 50% of poverty	5.5
100% of poverty	13.8
200% of poverty	33.1

Form 21
Health Status Indicators
Demographic Data
State: KS

HSI #12 - Demographics (Poverty Levels) *Percent of the State population aged 0 through 19 at various levels of the federal poverty level. (Demographics)*
Reporting Year: 2012 Is this data from a State Projection? No Is this data final or provisional? Final

POVERTY LEVELS	TOTAL
Children 0 through 19 years old	807,545
Percent Below: 50% of poverty	7.6
100% of poverty	18.9
200% of poverty	42.8

Form Notes for Form 21

None

Field Level Notes

1. **Section Number:** Form21_Indicator 06A
   Field Name: S06_Race_Infants
   Row Name: Infants 0 to 1
   Column Name:
   Year: 2015
   Field Note:
   Data Source: U.S. Census Bureau.
   Note-- Asian and Pacific Islander racial categories have been combined.
2. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_Children
   Row Name: All children 0 through 19
   Column Name:
   Year: 2015
   Field Note:
   Source: U.S. Census Bureau, Asian = Asian and Native Hawaiian/Other Pacific Islander
3. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_SingleParentPercent
   Row Name: Percent in household headed by single parent
   Column Name:
   Year: 2015
   Field Note:
   Source: U.S. Census Bureau, American Community Survey - B11003: Family type by presence and age of own children under 18 years. 2010 ACS 5-year (2006-2010), Selected Population tables are available only every 5 years.

   "Total NOT Hispanic or Latino" information is not available.
4. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_TANFPercent
   Row Name: Percent in TANF (Grant) families
   Column Name:
   Year: 2015
   Field Note:
   Source: Kansas Department for Children and Families, ages 0 through 18 that received TANF (Cash) assistance benefits during calender year 2012.

   Asian = Asian and Native Hawaiian/Other Pacific Islander
5. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_MedicaidNo
   Row Name: Number enrolled in Medicaid
   Column Name:
   Year: 2015
   Field Note:
   Source: Kansas Department of Health Environment, Division of Health Care Finance, 2012
6. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_SCHIPNo
   Row Name: Number enrolled in SCHIP
   Column Name:
   Year: 2015
   Field Note:
   Source: Kansas Department of Health Environment, Division of Health Care Finance, 2012
7. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_FoodStampNo
   Row Name: Number enrolled in food stamp program
   Column Name:
   Year: 2015
   Field Note:
   Source: Kansas Department for Children and Families, ages 0 through 18 that received SNAP (food) assistance benefits during calender year 2012.
8. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_WICNo
   Row Name: Number enrolled in WIC
   Column Name:
   Year: 2015
   Field Note:
   Source: Kansas Department of Health Environment, Nutrition and WIC Services, KWIC, 2012.
9. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_JuvenileCrimeRate
   Row Name: Rate (per 100,000) of juvenile crime arrests
   Column Name:
   Year: 2015
   Field Note:
   Source: Kansas Bureau of Investigation, 2012. Rates are arrests of persons ages 10-17 per 100,000 persons ages 10-17 in the resident population.
10. **Section Number:** Form21_Indicator 09A
    Field Name: HSIRace_DropOutPercent
    Row Name: Percentage of high school drop-outs (grade 9 through 12)
    Column Name:
    Year: 2015
    Field Note:
    Source: Kansas Department of Education, 2012-2013 school year,
    http://svapp15586.ksde.org/k12/state_reports.aspx

"Total NOT Hispanic or Latino" information is not available.

11. **Section Number:** Form21_Indicator 10
Field Name: Metropolitan
Row Name: Living in metropolitan areas
Column Name:
Year: 2015
Field Note:
Data Source: U.S. Census Bureau. Bridged Race Population, 2012.
Metropolitan areas are defined as Butler, Douglas, Harvey, Johnson, Leavenworth, Miami, Sedgwick, Shawnee, Sumner, and Wyandotte.

12. **Section Number:** Form21_Indicator 10
Field Name: Urban
Row Name: Living in urban areas
Column Name:
Year: 2015
Field Note:
Kansas Vital records definition of urban and semi-urban counties were used in this analysis. Counties were included if they had population densities of 40 or more persons per square mile. These Kansas counties are: Douglas, Johnson, Leavenworth, Sedgwick, Shawnee, Wyandotte, Butler, Crawford, Franklin, Geary, Harvey, Miami, Montgomery, Reno, Riley, and Saline.

13. **Section Number:** Form21_Indicator 10
Field Name: Rural
Row Name: Living in rural areas
Column Name:
Year: 2015
Field Note:
Kansas Vital records definition of rural and densely-settled rural counties were used in this analysis. Counties included had population densities between 6 and 39 persons per square mile. These counties are: Allen, Atchison, Barton, Bourbon, Cherokee, Cowley, Dickinson, Doniphan, Ellis, Finney, Ford, Jackson, Jefferson, Labette, Lyon, McPherson, Neosho, Osage, Pottawatomie, Seward, Sumner, Anderson, Brown, Clay, Cloud, Coffey, Ellsworth, Grant, Gray, Harper, Haskell, Kingman, Linn, Marion, Marshall, Mitchell, Morris, Nemaha, Norton, Ottawa, Pawnee, Philips, Pratt, Republic, Rice, Russell, Scott, Stevens, Thomas, Wabaunesse, Washington, Wilson, and Woodson.

14. **Section Number:** Form21_Indicator 10
Field Name: Frontier
Row Name: Living in frontier areas
Column Name:
Year: 2015
Field Note:
Kansas Vital records definition of frontier counties was used in this analysis. Counties included had population densities that had fewer than 6 persons per square mile. These counties are: Barber, Chase, Chautauqua, Cheyenne, Clark, Comanche, Decatur, Edwards, Elk, Gove, Graham, Greeley, Greenwood, Hamilton, Hodgeman, Jewell, Kearny, Kiowa, Lane, Lincoln, Logan, Meade, Morton, Ness, Osborne, Rawlins, Rooks, Rush, Sheridan, Sherman, Smith, Stafford, Stanton, Trego, Wallace, and Wichita.

15. **Section Number:** Form21_Indicator 11
Field Name: S11_total
Row Name: Total Population
Column Name:
Year: 2015
Field Note:
Data Source: U. S. Census Bureau. Bridged Race Population, 2012.

16. **Section Number:** Form21_Indicator 11
Field Name: S11_50percent
Row Name: Percent Below: 50% of poverty
Column Name:
Year: 2015
Field Note:
Data Source: U.S. Census Bureau. 2010-2012 American Community Survey 3-Year Estimates. B17002: Ratio of Income to poverty level in the past 12 months. http://factfinder2.census.gov/rest/dnldController/deliver?_ts=386866279838

17. **Section Number:** Form21_Indicator 11
Field Name: S11_100percent
Row Name: 100% of poverty
Column Name:
Year: 2015
Field Note:
Data Source: U.S. Census Bureau. 2010-2012 American Community Survey 3-Year Estimates. B17002: Ratio of Income to poverty level in the past 12 months. http://factfinder2.census.gov/rest/dnldController/deliver?_ts=386866279838

18. **Section Number:** Form21_Indicator 11
Field Name: S11_200percent
Row Name: 200% of poverty
Column Name:
Year: 2015
Field Note:
Data Source: U.S. Census Bureau. 2010-2012 American Community Survey 3-Year Estimates. B17002: Ratio of Income to poverty level in the past 12 months. http://factfinder2.census.gov/rest/dnldController/deliver?_ts=386866279838

19. **Section Number:** Form21_Indicator 12
Field Name: S12_Children
Row Name: Children 0 through 19 years old
Column Name:
Year: 2015
Field Note:
Data Source: U. S. Census Bureau. Bridged Race Population, 2012. Children 0-19 years.

20. **Section Number:** Form21_Indicator 12
Field Name: S12_50percent
Row Name: Percent Below: 50% of poverty
Column Name:

Year: 2015
Field Note:
Data Source: U.S. Census Bureau. 2010-2012 American Community Survey 3-Year Estimates. C17024: Age by ratio of income to poverty level in the past 12 months. Children under 18 years.

21. **Section Number:** Form21_Indicator 12
Field Name: S12_100percent
Row Name: 100% of poverty
Column Name:
Year: 2015
Field Note:
Data Source: U.S. Census Bureau. 2010-2012 American Community Survey 3-Year Estimates. C17024: Age by ratio of income to poverty level in the past 12 months. Children under 18 years.

22. **Section Number:** Form21_Indicator 12
Field Name: S12_200percent
Row Name: 200% of poverty
Column Name:
Year: 2015
Field Note:
Data Source: U.S. Census Bureau. 2010-2012 American Community Survey 3-Year Estimates. C17024: Age by ratio of income to poverty level in the past 12 months. Children under 18 years.

23. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_FosterCare
Row Name: Number living in foster home care
Column Name:
Year: 2015
Field Note:
Source: Kansas Department for Children and Families, SFY 2013.